



**NXP 2018**  
**Summary Plan Description**

**NXP Benefits: Health, Wellness, Life, Savings and More**

U.S. Benefits  
Effective January 1, 2018

# Introduction

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## A Rewards Package to Fit Your Lifestyle

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

## About this SPD

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

In addition, this document is your official Summary Plan Description (SPD) for the NXP Employee Health Benefit Plan and the NXP 401(k) Retirement Plan, as described in and required under the Employee Retirement Income Security Act.

This SPD is divided into the following sections:

- **Participation** includes information about who is eligible for the benefits described in this SPD, how to enroll, when coverage begins, when you can make changes 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** includes:
  - **Medical coverage**, including behavioral health and prescription drug for the Choice Plan, Choice Plus Plan and Medical Savings Plan with Health Savings Account (HSA);
  - **Dental coverage**;
  - **Vision coverage**;
  - **Wellness programs**;
  - **Flexible spending accounts**, describing how you can save on taxes when you pay certain health care and dependent care expenses.
- **Disability income**, including short- and long-term disability;
- **Life and accidental death and dismemberment insurance**, addressing life insurance plans for you and your dependents as well as accidental death and dismemberment and business travel accident coverage.
- **Legal services**, including information about NXP’s Legal Services Plan;
- **Savings and Wealth**, including information about the 401(k) Retirement Plan and how it can help you save for retirement.
- **Work/life programs**, which include information on programs that assist with daily needs such as child care, adoption assistance and long-term care insurance.
- **Life events** (Qualified Status Change) section, describing what to do when you experience various life events, such as marriage, divorce or birth of a child.

- A [claims and appeals](#) section, including information about how benefits are coordinated, your privacy rights.
- A [plan information](#) section with other important information and your ERISA rights under the Employee Health Benefit Plan and the 401(k) Retirement Plan.
- A [definitions](#) section with explanations of terms and phrases commonly used throughout this SPD.
- An [index](#) to help you put your finger on the exact information you need.
- A handy [contact information](#) reference, conveniently located at the back of the SPD, of telephone numbers, websites and other resources available for additional benefit claims and appeals information.

Each section includes, as applicable:

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

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

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

## NXP Benefits

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

Benefit or Program	Domestic Employees	Part-Time Employees*	Interns	U.S. Expatriates on U.S. Payroll	U.S. Inpatriates on U.S. Payroll
<a href="#"><u>401(k) Retirement Plan</u></a>	X	Part time employees completing one year of service are eligible on the first day of the month following completion of one year of service.	X	X	X
<a href="#"><u>Adoption Assistance</u></a>	X	X	X	X	X
<a href="#"><u>Behavioral Health Program</u></a>	X	X	X	Eligible through global medical plan	Eligible through global medical plan
<a href="#"><u>COBRA Continuation Coverage (Medical, Dental, Vision and Health Care Flexible Spending Account (FSA))</u></a>	X	X	X	Limited eligibility through global medical plan	Limited eligibility through global medical plan
<a href="#"><u>Dental Plan</u></a>	X	X	X	Eligible through global medical plan	Eligible through global medical plan

Benefit or Program	Domestic Employees	Part-Time Employees*	Interns	U.S. Expatriates on U.S. Payroll	U.S. Inpatriates on U.S. Payroll
<a href="#"><u>Dependent Care Flexible Spending Account (DCFSA)</u></a>	X	X	X	X	X
<a href="#"><u>Disability Income Benefits</u></a>	X	X	X	X	X
<a href="#"><u>Health Care/Limited Use Health Care Flexible Spending Account (FSA)</u></a>	X	X	X	X	X
<a href="#"><u>Health Savings Account (HSA)</u></a>	X	X	X		
<a href="#"><u>Travel Assistance</u></a>	X	X	X	X	X
<a href="#"><u>Legal Services Plan</u></a>	X	X	X	X	X
<a href="#"><u>Medical Plan</u></a>	X	X	X	Eligible through global medical plan	Eligible through global medical plan
<a href="#"><u>Prescription Drug Program</u></a>	X	X	X	Eligible through global medical plan	Eligible through global medical plan
<a href="#"><u>EAP, Resource &amp; Referral Program</u></a>	X	X	X	X	X
<a href="#"><u>Vision Plan</u></a>	X	X	X	Eligible through global medical plan	Eligible through global medical plan
<a href="#"><u>Life Insurance Plans</u></a>	X	X	X	X	X
<a href="#"><u>Wellness Programs/Activity Centers</u></a>	X	X	X	X	X

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

### ***U.S. Expatriates and U.S. Inpatriates***

- A U.S. Expatriate or U.S. Inpatriate is defined as an NXP employee on the payroll of an NXP entity based in the United States, regardless of where the employee actually performs work.
- U.S. Expatriates are employees of NXP or a participating entity that are on assignment outside the U.S. as determined by NXP Global Mobility. The benefits described in this SPD are available to you as outlined if you are a U.S. Expatriate on U.S. payroll.
- U.S. Inpatriates are employees of NXP or a participating entity that are transferred from their home country to the U.S. for an assignment as determined by NXP Global Mobility. The benefits described in this SPD are available to you as outlined if you are a U.S. Inpatriate on U.S. payroll.

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

## **NXP 2018 Summary Plan Description**

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

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

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

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

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

This Summary Plan Description describes the Plans, as each has been amended to date. Summaries of Material Modifications or new Summary Plan Descriptions will be provided to advise you of changes in the Employee Health Benefit Plan and 401(k) Retirement Plan, as required by ERISA.

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

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## Participation

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*This section includes information about:*

- [Who is eligible](#) (beginning on page 2);
- [When you can enroll](#) (beginning on page 11);
- [Paying for coverage](#) (beginning on page 16);
- [When coverage begins](#) (beginning on page 19);
- [When you can make changes](#) (beginning on page 22);
- [When coverage ends](#) (beginning on page 30); and
- *When and how and when you can [continue coverage](#) (beginning on page 37) after it would otherwise end.*

## Eligibility

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### Employee Eligibility

#### Health and Wellness

You are eligible for NXP's Health and Wellness benefits if:

- You are a U.S. domestic employee of NXP or a participating subsidiary;
- You are a U.S. Expatriate or U.S. Inpatriate;
- You are regularly scheduled to work at least 20 hours per week;
- NXP or a participating subsidiary's payroll department processes your regular paycheck; and
- You have reported to work for your first day of employment on the day your coverage becomes effective. This last requirement does not apply if you are not actively at work on that date because of illness or other medical condition. However, in no event will your coverage begin until you have reported to work on your first day of employment.

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

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

#### ***No Pre-Existing Conditions Exclusions***

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

#### **Flexible Spending Account (FSA)**

You are eligible for NXP's Flexible Spending Account Plan, which includes Health Care (including a Limited Use Health Care) and Dependent Care Flexible Spending Accounts, if:

- You are a U.S. domestic employee of NXP or a participating subsidiary
- You are a U.S. Expatriate or U.S. Inpatriate;
- You are actively at work;
- You are regularly scheduled to work at least 20 hours per week; and
- NXP's or a participating subsidiary's payroll department processes your regular paycheck.

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

If you are a member of a group of employees who become employees of NXP or one of its participating subsidiaries due to a merger, an acquisition or the ending of a joint venture, you will only be eligible if, and to the extent that, NXP expressly extends coverage under the FSA Plan to your group of employees.

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

### **Employee Assistance Program**

You are eligible for NXP's Employee Assistance Program (Resources for Living) if:

- You are a U.S. domestic employee of NXP or a participating subsidiary;
- You are a U.S. Expatriate or U.S. Inpatriate; and
- NXP's or a participating subsidiary's payroll department processes your regular paycheck.

You and anyone living in your household are eligible to use the Employee Assistance Program.

### **Disability Income, Life and Accidental Death and Dismemberment**

You are eligible for NXP's Disability Income, Life and Accidental Death and Dismemberment Plans if:

- You are a U.S. domestic employee of NXP or a participating subsidiary
- You are a U.S. Expatriate or U.S. Inpatriate;
- You are actively at work;
- You are regularly scheduled to work at least 20 hours per week; and
- NXP's or a participating subsidiary's payroll department processes your regular paycheck.

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

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

## 401(k) Retirement Plan

You are eligible to participate in the 401(k) Retirement Plan if you are classified by the Company as a full-time employee of NXP and your base compensation is processed by NXP's (or a participating subsidiary's) U.S. payroll department. If you are a part-time employee of NXP, you are eligible to begin participation on the earlier of the date you become a regular full-time employee, or the first day of the month on or immediately after you complete one year of service with NXP.

You are not eligible to participate if you provide services to NXP or a participating subsidiary under an independent contractor, consultant or employee leasing agreement, or if you are classified as a leased employee or contract labor (even if you are later determined to be or have been an employee of NXP or a participating subsidiary). If you are a collective bargaining employee, you are eligible to participate in the 401(k) Retirement Plan only if your union agreement requires you to be eligible.

If you are a member of a group of employees who become employees of NXP or one of its participating subsidiaries due to a merger, an acquisition or the ending of a joint venture, you will only be eligible if, and to the extent that, NXP expressly extends coverage under the 401(k) Retirement Plan to your group of employees.

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

#### ***U.S. Inpatriate***

- If you are a U.S. Inpatriate on U.S. payroll, the 401(k) Retirement Plan is included in the benefits package offered.
- If you are a U.S. Inpatriate **not** on U.S. payroll, the 401(k) Retirement Plan is **not** included in the benefits package offered.

#### ***U.S. Expatriate***

If you are a U.S. Expatriate who transfers to a foreign subsidiary, you continue to be eligible to participate in the 401(k) Retirement Plan if:

- You are a United States citizen and were an employee of either company immediately before the transfer;
- No contributions are made to any other funded deferred compensation plan or retirement plan (other than the NXP 401(k) Retirement Plan) on behalf of United States citizens or residents employed by the foreign subsidiary; and
- NXP, as applicable, agrees to extend U.S. Social Security coverage to all of the foreign subsidiary's employees who are United States citizens or residents under an agreement filed with the IRS.

As a U.S. Expatriate, you do not continue to participate in the NXP 401(k) Retirement Plan if you are excluded from participation or become ineligible under the rules as described above.

## Work/Life Programs, Including the Legal Services Plan

See [Work/Life Programs](#) beginning on page 230 for additional eligibility requirements for some programs.

You are eligible for NXP's Work/Life programs, including the Legal Services Plan if:

- You are a U.S. domestic employee of NXP or a participating subsidiary
- You are a U.S. Expatriate or U.S. Inpatriate;

In addition, you must:

- Be actively at work;
- Be regularly scheduled to work at least 20 hours per week; and
- Receive a regular paycheck processed by NXP's or a participating subsidiary's payroll department.

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

All NXP employees, globally, are eligible for the Travel Assistance Program.

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

## Dependent Eligibility

For information on enrolling dependents and changing coverage, see [Enrolling Your Eligible Spouse/Domestic Partner and Dependents](#), on page 13.

For information on dependents for which you are eligible for reimbursement under a flexible spending account, see [Health Care/Limited Use Health Care Flexible Spending Account \(FSA\)](#) (beginning on page 140) and [Dependent Care Flexible Spending Account \(DCFSA\)](#) (beginning on page 146). For information on dependents for which you are eligible for reimbursement under a health savings account, see the [Health Savings Account \(HSA\)](#) section beginning on page 96.

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

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

Your eligible dependents include:

- Your legally recognized spouse\* claimed as your federal tax dependent; or
- Your same-sex or opposite-sex domestic partner, meaning a person who has lived with you for at least six months, is not a blood relative of yours, is not legally married or in another domestic partner relationship, and is at least 18 years old; and
- Your married and unmarried children\*\* through the end of the month in which they reach age 26, except for child life insurance. For child life insurance your unmarried children\* through the end of the month in which they reach age 26; married children are not eligible for child life insurance regardless of age; and
- A child who is over age 25 who is:
  - Incapable of working because of a mental or physical disability that began before age 26; and
  - Financially supported by you.

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

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

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

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

### **Incapacitated Dependent Requirements**

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

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

## Domestic Partner Eligibility Rules

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

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

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

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

An affidavit can be requested from the NXP Customer Service Center or downloaded from [NXP.com/files/benefits/CommonLaw\\_Affidavit.pdf](https://www.nxp.com/files/benefits/CommonLaw_Affidavit.pdf).

### ***Tax Implications and Information***

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

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

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

See [Section 152 Dependent](#) on page 321 for more information.

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

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

Different rules may apply for state income tax purposes.

### ***Protection Against Use of Genetic Information***

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

### ***Rescission of Coverage***

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

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

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

Your spouse/domestic partner is eligible for Spouse/Domestic Partner Life Insurance. Your unmarried children and your domestic partner's unmarried children from live birth up to age 26 are eligible for Child(ren) Life Insurance. Children older than age 26 may continue coverage if they are incapacitated; see [Incapacitated Dependent Requirements](#) (beginning on page 6) for details.

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

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

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

- on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard;
- insured under the Group Policy as an employee;
- confined at home under a physician's care;
- receiving or applying to receive disability benefits from any source;
- hospitalized; or
- married.

### **Dependent Legal Services Plan Eligibility**

Once you enroll yourself, your eligible dependents as outlined under the [Dependent Eligibility](#) section of this SPD are also eligible for the Legal Services Plan.

### **If Your Spouse/Domestic Partner or Child Works at NXP**

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

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

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

#### ***Working Beyond Age 64***

If you intend to continue working at NXP past age 64, although you may be entitled to Medicare beginning on your 65th birthday, NXP will continue to be the primary source of coverage for you and possibly for any eligible dependents. Social Security may allow you to defer your Medicare coverage beyond your 65th birthday without penalty until you retire. For information about Medicare, including when and how to enroll, see [When You Reach Age 65](#) beginning on page 268 for details.

**If you need help completing any Social Security Administration (SSA) Form contact NXP Rewards Customer Service at 888- 375-2367.**

## At Retirement

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

Check with NXP Rewards Customer Service if you have any questions about your eligibility for coverage after your retirement.

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

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

## Enrolling in NXP Rewards

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

### ***Social Security Numbers Required***

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

## Automatic Enrollment for Medical and 401(k) Retirement Plans

If you do not complete your benefits enrollment within 30 days of becoming eligible, you will be automatically enrolled as follows:

- **Medical Plan:** You will be automatically enrolled in the NXP Medical Choice Plan with employee-only coverage:
  - If you live in an area served by an NXP provider network, you will be enrolled in the Choice Plan coverage option.
  - If you live “out-of-area,” you will be enrolled in the Out-of-Area Plan.
- **401(k) Retirement Plan:** You will be automatically enrolled in the 401(k) Retirement Plan with a regular (before-tax) contribution of 5% of pay and your contribution percentage will automatically increase 1% each year until you are contributing 10% of your eligible pay. You will also be enrolled in a managed account with GuidedChoice (see [Using GuidedChoice](#), beginning on page 209, to understand this feature and related fees). If you do not want to be automatically enrolled in the 401(k) Retirement Plan or do not want the automatic increase to occur, you can elect your own contribution rate and investment options or choose not to participate. You can also change your contribution rate at any time to be more or less than 5% of pay.

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

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

#### ***U.S. Expatriates***

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

#### ***U.S. Inpatriates***

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

You will be automatically enrolled in the 401(k) Retirement Plan with a regular (before-tax) contribution of 5% of pay. You will also be enrolled in a managed account with GuidedChoice. If you do not want to contribute to the 401(k) Retirement Plan, you must opt out or call NXP Rewards Customer Service at 888-375-2367 within 30 days of your assignment begin date.

**Note: Even if you are transferred back to a non-U.S. employer**, you will not be eligible to take a distribution from the Plan until you separate from NXP and all of its related companies.

### **Opt Out of Medical Coverage and 401(k) Retirement Plan Participation**

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

If you do not want to be automatically enrolled in the 401(k) Retirement Plan, you can elect your own contribution rate and investment options or choose not to participate within 30 days of the day you begin work. You can also change your contribution rate or stop contributing at any time. If you opt out within the required time limit, you will not have any before-tax contributions automatically deducted from your paycheck.

To opt out, simply go online to [NXP.com/rewards](https://nxp.com/rewards) or call NXP Rewards Customer Service at 888-375-2367 within 30 days of the day you begin work.

## FSA Enrollment

You are eligible to enroll in a Health Care Flexible Spending Account (or Limited Use Health Care Flexible Spending Account) and the Dependent Care Flexible Spending Account as of the day you begin work. If you enroll within 30 days of becoming eligible, your participation in that account begins on your first day of eligibility. **However, no enrollments for the current year may begin between November 1 and December 31.**

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

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

## Short-Term Disability Buy-Up Enrollment

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

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

## Legal Services Plan Enrollment

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

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

## Enrolling Your Eligible Spouse/Domestic Partner and Dependents

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

- **Medical coverage:** You may enroll your eligible spouse/domestic partner and dependents:
  - Within 30 days of when you initially meet the eligibility requirements;
  - During annual enrollment;
  - When you have a qualified status change or other applicable life event change (see [When You May Change Your Coverage](#) beginning on page 22); or
  - When special enrollment rights are triggered (see [HIPAA Special Enrollment](#), beginning on page 25).

Contacting your Aetna Personal Health Advocate, requesting precertification and participation in the Maternity Care Program does not automatically enroll your newborn child in the Plans. You must go online to [NXP.com/rewards](http://NXP.com/rewards) or call NXP Rewards Customer Service at 888-375-2367 within 30 days of the date of birth to enroll your newborn.

- **Dental, vision and life insurance coverage:** You may enroll your eligible spouse/domestic partner and dependents:
  - Within the first 30 days of when you initially meet the eligibility requirements;
  - During annual enrollment; or
  - When you have a qualified status change or other applicable life event change (see [When You May Change Your Coverage](#), beginning on page 22).

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

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

#### ***U.S. Expatriates***

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

#### ***U.S. Inpatriates***

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

You will be automatically enrolled in the 401(k) Retirement Plan with a regular (before-tax) contribution of 5% of pay. You will also be enrolled in a managed account with GuidedChoice. If you do not want to contribute to the 401(k) Retirement Plan, you must opt out or call NXP Rewards Customer Service at 888-375-2367 within 30 days of your assignment begin date.

**Note:** You will not be eligible to take a distribution from the Plan until you separate from NXP.

## Your Responsibilities — Enrolling and Certifying Your Spouse/Domestic Partner and Dependents

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

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

- Subject you to discipline up to and including termination of employment;
- Obligate you to reimburse the appropriate NXP Reward plan for any medical (including behavioral health and prescription drug), dental and vision expenses paid by the Plan, as far back as administratively possible, for the ineligible dependent;
- Terminate your spouse's/domestic partner's and/or dependent's coverage prospectively or retroactively or refuse to cover your spouse/domestic partner and/or dependents;
- Take other action as it may determine is appropriate.

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

## Paying for Coverage

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

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

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

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

Contributions for coverage for your **domestic partner** must be paid on an after-tax basis unless he or she qualifies as your dependent under Internal Revenue Code Section 152; see [Section 152 Dependent](#) on page 321 for details.

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

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

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

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

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

For Supplemental Life Insurance and Spouse Life Insurance, tobacco use status cannot change during the calendar year, even if you have a qualified status change (see [Qualified Status Change](#) on page 23).

To be covered by the **Legal Services Plan**, you must make after-tax contributions for the coverage.

## Government Assistance for Children's Coverage

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

If this applies to you, please contact NXP Rewards Customer Service at 888-375-2367.

## Proof of Coverage—IRS Form 1095

Form 1095 is a tax form that is required to be provided under the Affordable Care Act (ACA) as proof to the IRS that you had coverage. You can expect to receive a Form 1095 in January 2018 to use when filing your 2017 taxes. This form shows the months of the year that you and/or your dependents were offered or enrolled in medical coverage. (This form will not replace any state forms you may receive providing proof of medical insurance.)

You will receive Form 1095 if, for at least one day in 2018, you were any of the following:

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

You will need this form when filing your taxes to prove that you are adequately insured, as required under the ACA. If you are not adequately covered, you could face tax penalties—which is why it is important to keep this form with other important tax documents.

Forms for the 2018 tax year will be mailed no later than January 31, 2019. Please allow 7 to 10 business days for delivery. Or, if you would like to receive your Form 1095 earlier, you can sign up for electronic notifications.

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

There are three versions of Form 1095:

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

### ***Form 1095 Questions***

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

### ***Form 1095 Reprints***

If you need a reprint log on to [NXP.com/rewards](https://www.nxp.com/rewards) or contact NXP Rewards Customer Service at 888-375-2367.

## Benefits Value on W-2 Statement

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

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

## Before-Tax Contributions and Social Security

Your before-tax contributions reduce the amount of pay on which your federal income taxes and most state and local income taxes are calculated. For plans other than the 401(k) Retirement Plan, your before-tax contributions also reduce the amount of pay on which your FICA (Social Security and Medicare) taxes are figured. Because these taxes are calculated on a lower taxable income amount, you pay less tax. This has the effect of reducing the cost of your NXP coverage.

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

## When Coverage Begins

### Health and Wellness Coverage

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

Earliest Date Coverage Can Begin		
Plan	You	Your Dependents
<b>U.S. Domestic Employees</b>		
<b>NXP Medical Plan</b>	The day you begin work, if you enroll within 30 days of that date.	The day you begin work, if you enroll your dependents within 30 days of that date.
<b>NXP Dental Plan</b>	The day you begin work, if you enroll within 30 days of that date.	The day you begin work, if you enroll your dependents within 30 days of that date.
<b>NXP Vision Plan</b>	The day you begin work, if you enroll within 30 days of that date.	The day you begin work, if you enroll your dependents within 30 days of that date.
<b>NXP Health Care/Limited Use Health Care and Dependent Care Flexible Spending Account Plans</b>	The day you begin work, if you enroll within 30 days of that date. No enrollments may begin between November 1 and December 31.	Not applicable
<b>U.S. Expatriates and U.S. Inpatriates</b>		
<b>NXP Global Medical Plans</b> (not described in this Summary Plan Description)	The day you begin work, if you enroll within 30 days of that date.	The day you begin work, if you enroll your dependents within 30 days of that date.

### Disability Income Benefits

Generally, both short-term and long-term disability coverage begin on the first day of the month following the date you have been continuously at work for 90 days as an employee regularly scheduled to work at least 20 hours per week. If you are not at work that day, these coverages start on the day you return to work (see the [Pre-Existing Condition](#) section on page 154).

**If your employment terminates and you are rehired within six months, your new coverage will begin on your new date of hire; a new pre-existing condition period will apply.**

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

## Supplemental Life Insurance Coverage

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

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

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

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

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

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

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

### ***Additional Requirements***

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

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

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

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

## **When Business Travel Accident (BTA) Insurance Begins**

Your coverage for BTA Insurance begins on your first day of work, or on the day you first meet the eligibility requirements for plan participation (see [Disability Income, Life and Accidental Death and Dismemberment](#) beginning on page 3).

## **Legal Services Plan**

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

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

## **401(k) Retirement Plan**

If you are eligible, you may begin contributing to the 401(k) Retirement Plan as soon as administratively possible, usually as of the third pay period after you begin work. You are eligible to receive Company Matching Contributions to your account as soon as you begin contributing.

If you do not enroll in the 401(k) Retirement Plan within 30 days of becoming eligible, you are automatically enrolled with a regular (before-tax) contribution of 5% of pay and your contribution percentage will automatically increase 1% each year until you are contributing 10% of your eligible pay. If you do not want to be automatically enrolled in the 401(k) Retirement Plan or do not want the automatic increase to occur, you can elect your own contribution rate and investment options or you can choose not to participate. You can also change your election amount if you would like to contribute more or less than 5% of pay.

## **Work/Life Programs**

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

## When You May Change Your Coverage

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

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

### Annual Enrollment

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

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

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

If you are not actively at work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the 7 calendar days before that date.

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

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

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

## Additional Requirements

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

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

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

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

## Qualified Status Changes and Special Enrollment

If you experience a qualified status change that affects eligibility, you may be eligible to change some or all of your health and wellness, health care/limited use health care flexible spending account, dependent care flexible spending account, life insurance or disability income elections. Qualified status changes include:

- Your marriage, establishment of an eligible [domestic partnership](#) (see page 7), divorce, dissolution of a domestic partnership, legal separation or annulment;
- Death of your spouse/domestic partner;
- The birth, adoption, placement for adoption, or death of a child (including the child of a domestic partner if the child is eligible under the plan);
- A change in custody of the child;
- A change in employment status by you or your spouse/domestic partner or dependent, including:
  - Beginning or ending employment;
  - A switch from part-time to full-time status (or vice versa);
  - A strike, lockout or layoff;
  - Beginning or returning from an unpaid or significantly reduced paid leave of absence;
  - A change in work site; and
  - Any other change in employment status that affects your or your spouse's/domestic partner's or dependent's health coverage;
- Beginning or ending a dependent's eligibility due to age, student status, incapacity or other similar circumstance;
- A change in the place of residence of you or your dependent that affects medical coverage (e.g., moving to or from a network location);
- You or your spouse/domestic partner or dependent enrolls in or loses coverage under Medicare (Part A or B) or Medicaid;

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

A significant change in the cost of coverage may allow a change in some Plans (as described on page 26).

Your change in coverage is approved only if it qualifies as being consistent with the qualified status change as determined under the principles contained in the applicable Internal Revenue Service (IRS) regulations. The approved change in coverage is effective as of the date of the event, except for the life insurance coverage, as described below. **However, no status change will allow you to make any changes to either Health Care/Limited Use Health Care and/or Dependent Care Flexible Spending Account(s) between November 1 and December 31.**

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

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

If you are not actively at work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the 7 calendar days before that date.

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

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

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

## Additional Requirements

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

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

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

**Domestic Partners**—Please note that the Internal Revenue Code limits benefit changes during the year for coverage paid for on a before-tax basis. To make a benefit change for elections paid on a before-tax basis, your domestic partner or child of your domestic partner must qualify as your **Section 152 dependent** (see page 321), as defined under the Internal Revenue Code. For example, the establishment of a domestic partnership will not allow an election change for benefits to be paid on a before-tax basis unless your domestic partner qualifies as your dependent under the Internal Revenue Code. **Any benefit changes during the year due to a domestic partner or child of a domestic partner who does not qualify as your dependent as defined under the Internal Revenue Code can only be made on an after-tax basis.**

You may make the change in coverage by going online to [NXP.com/rewards](https://nxp.com/rewards) or by calling NXP Rewards Customer Service at 888-375-2367 within 30 days of a qualified status change.

## HIPAA Special Enrollment

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

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

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

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

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

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

### **Qualified Medical Child Support Order (QMCSO)**

If you become subject to a Qualified Medical Child Support Order (QMCSO) that requires you to provide health coverage for a child, you may change your Medical Plan, Dental Plan, Vision Plan and/or Health Care/Limited Use Health Care Flexible Spending Account elections accordingly. The change is effective on the date the order is determined by the Plan to be qualified. NXP Rewards Customer Service 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.

NXP Rewards Customer Service has established a special process for requesting information about QMCSOs. You may:

- Email your questions to: [QOCenter@hewitt.com](mailto:QOCenter@hewitt.com); or
- Call NXP Rewards Customer Service at 888-375-2367 and ask to speak with a QMCSO specialist.

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

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

- The cost of your current benefit option significantly increases or significantly decreases;
- An event occurs that significantly curtails coverage or causes you to lose coverage under your current benefit option;
- A benefit option is added or significantly improved under the Medical, Dental or Vision Plan during the year and you are eligible for it;
- You or your spouse/domestic partner or dependent loses coverage under any group health coverage sponsored by a governmental or educational institution; or
- The change corresponds with a change made by you or your dependent (as defined above) under another employer plan in the following circumstances:
  - If the annual enrollment period under the other plan occurs at a different time of year than annual enrollment under the NXP Medical, Dental and Vision Plans; or
  - If the other employer plan allows you or your dependent to change elections due to the reasons described above (qualified status change, special enrollment, QMCSO, Medicare or Medicaid entitlement or significant cost or coverage changes).

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

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

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

## Marriage/Domestic Partnership

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

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

Your child's marital status does not influence their eligibility for Medical, Dental or Vision.

## Domestic Partner

You may enroll your domestic partner for medical, dental, vision and spouse/domestic partner life insurance coverage within 30 days of a qualified status change or during annual enrollment, provided you meet specific eligibility requirements. For more information, see [Domestic Partner Eligibility Rules](#) (beginning on page 7).

## Divorce/End of Domestic Partnership

Your ex-spouse/domestic partner is not eligible to remain on your Plans as outlined in the [Dependent Eligibility](#) section above after your marriage or domestic partnership ends. You must notify NXP Rewards Customer Service within 30 days of the date of your divorce or the date your domestic partnership ends. Your ex-spouse/domestic partner may be eligible for COBRA coverage (see [COBRA Continuation Coverage](#), beginning on page 37).

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 NXP Rewards Customer Service before the date of divorce.

Even if your children meet the eligibility requirements for eligible dependent children, you may not cover your children for medical, dental or vision benefits if your divorce decree states that your former spouse/domestic partner is responsible for the children's health coverage. You may, however, cover your eligible dependent children if required by your divorce decree or by the terms of a [Qualified Medical Child Support Order](#) (see page 319).

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

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

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

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

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

If you are not actively at work on the date coverage would otherwise take effect, coverage will take effect on the day you resume active work. In addition, you must have been actively at work for at least 20 hours during the 7 calendar days before that date.

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

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

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

### Additional Requirements

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

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

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

## FSA Participation

If you elect to participate in a flexible spending account, your election remains in effect for the remainder of the calendar year, unless you have a qualified status change or another event that allows you to make an election change (see [When You May Change Your Coverage](#), beginning on page 22). Your request for a change must be consistent with the qualified status change circumstance. You may change your FSA election and how much you contribute to both accounts for the following year during each annual enrollment.

**Note:** No status change will allow you to make any change to your enrollment or contribution between November 1 and December 31.

### Special Participation Rules — Health Care and Limited Use Health Care Flexible Spending Accounts Only

Because the IRS considers Health Care Flexible Spending Accounts health plans, these health plan enrollment rules apply (these do not apply to the Dependent Care Flexible Spending Account):

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

## Legal Services Plan Participation

The Legal Services Plan requires that you maintain the coverage for the entire plan year.

## 401(k) Retirement Plan

You may start, stop or change your contributions online at any time at [NXP.com/rewards](https://www.nxp.com/rewards) or by contacting NXP Rewards Customer Service at 888-375-2367. Your changes will be processed as soon as administratively feasible. If you elect to stop your regular or Roth 401(k) contributions, generally, you can resume contribution at any time; contributions will be taken from your paycheck as soon as administratively possible.

## When Coverage Ends

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### Health and Wellness

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

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

- The last day of the month in which your employment with NXP (or a participating subsidiary) ends, or in which you die;
- The last day of the month in which you begin a leave of absence (other than a military leave under the NXP Military Service Pay Policy or a disability leave of absence) if you have less than six months of service;
- The last day of the sixth month following the month you begin a leave of absence (other than military leave under the NXP Military Service Pay Policy or a disability leave of absence) if you have more than six months of service;
- The last day of the month for which you paid a contribution, if you have discontinued payments for any reason;
- The last day of the month in which you fail to meet the Plans’ eligibility requirements, other than due to a leave of absence;
- The last day you receive military service pay under the NXP Military Service Pay Policy;
- If you are on a disability leave of absence, the earliest of:
  - The last day of the month you are no longer disabled, unless you return to active employment with NXP or a participating subsidiary;
  - The last day of the month for which you paid a contribution, if you have discontinued payments for any reason;
  - The day you become eligible for coverage under the Post-Employment Benefits Plan (if you are on a disability leave of absence and your disability continues until your termination of employment under NXP’s Medical Leave Policy or you become eligible to retire);
  - The last day of the month your employment ends.
- 90 days after the Plan Administrator requires repayment from you or your covered dependent of amounts subject to reimbursement under any NXP welfare plan, overpayments or mistaken payments, if you fail to repay or set up an acceptable repayment schedule;

- For the Health Care/Limited Use Health Care and Dependent Care Flexible Spending Account Plans:
  - The last day of the month in which you have a qualified status change that allows you to discontinue your participation; or
  - 90 days after the Plan Administrator requests repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you do not repay or set up an acceptable repayment schedule; or
- The date the Plans end or the effective date of an amendment eliminating the coverage.

If you have any questions about coverage or eligibility, call NXP Rewards Customer Service at 888-375-2367.

## When Dependent Coverage Ends

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

- The last day of the month in which he or she ceases to be an eligible dependent;
- The last day of the month in which your coverage ends for any reason, including your death;
- The last day of the period for which you have paid for dependent coverage if you stop making your contributions;
- The last day of the month in which the dependent child enters the military service of any country (unless otherwise required by law);
- The last day of the month in which the dependent spouse/domestic partner enters the military service of any country other than the U.S.;
- 90 days after the Plan Administrator requires repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you fail to repay or set up an acceptable repayment schedule;
- The last day of the month in which your employment with NXP ends for a reason other than death;
- The date after your death on which your dependent child becomes covered by another group health plan that does not contain applicable pre-existing condition limitations;
- The date of your dependent's death; or
- The date the Plans end or the effective date of an amendment eliminating the coverage.

## Continued Protection for Survivors

If you die while employed by NXP, your covered dependents may continue their current Medical, Dental and Vision Plan coverage for up to 36 months under COBRA (see page 37) for more information. NXP subsidizes the cost of the first six months' COBRA coverage for your survivors. Your survivors will pay active employee contributions for the first six months of medical, dental and vision COBRA coverage (if enrolled before your death).

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

If you are eligible for retiree coverage when you die, your dependents who were covered or *eligible* for coverage under the Medical, Dental and Vision Plans will be eligible to enroll in the Post-Employment Benefits Plan. When they enroll, they must make the required contributions and continue to meet all of the other requirements of that Plan. See [At Retirement](#) (beginning on page 10) to see if you are eligible for the Post-Employment Benefits Plan. Then call NXP Rewards Customer Service at 888-375-2367 to review your enrollment options.

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

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

#### ***Coverage History Notice for Dependents***

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

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

### **Health Savings Account Participation**

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

### **Health Care/Limited Use Health Care Flexible Spending Account Participation**

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

## **Rehire**

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

## **Leave of Absence**

If you go on a leave of absence, you may choose to discontinue your contribution to your Health Care/Limited Use Health Care Flexible Spending Account. In this case, you may submit only eligible expenses that you incurred up to the last day of the month in which you stop making contributions. If you elect to continue your Health Care/Limited Use Health Care Flexible Spending Account coverage and the leave of absence is unpaid, you must make contributions on an after-tax basis (see [If You Take a Leave of Absence](#), beginning on page 252 for more information on continuation during an unpaid leave of absence). However, if your leave of absence is paid, your contributions continue to be deducted from your paychecks.

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

## **Dependent Care Flexible Spending Account Participation**

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

When your Dependent Care Flexible Spending Account coverage ends, these rules apply:

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

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

## **Rehire**

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

## **Leave of Absence**

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

## **Short-Term and Long-Term Disability Coverage**

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

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

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

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

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

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

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

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

### **When Business Travel Accident Insurance Plan Insurance Coverage Ends**

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

- Your last day of employment;
- The day you no longer meet the Plan's eligibility requirements;
- The day you begin a leave of absence, including disability leave of absence; or
- The date the Plan terminates or the effective date of a Plan amendment that eliminates your coverage.

## **Legal Services Plan**

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

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

## **401(k) Retirement Plan**

Your regular, Roth and catch-up contributions to the 401(k) Retirement Plan stop when you terminate employment with NXP or you no longer receive pay from NXP. In addition, Company Matching Contributions to your account end when you stop contributing to the 401(k) Retirement Plan.

Your 401(k) Retirement Plan account remains invested in the Plan until you receive a full distribution. You will continue to have access to your account online at [NXP.com/rewards](https://www.nxp.com/rewards) or by calling NXP Rewards Customer Service at 888-375-2367.

## **Work/Life Programs**

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

## **COBRA Continuation Coverage**

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

There may be other coverage options for you and your family. Under the Affordable Care Act, you can buy coverage through the Health Insurance Marketplace (Marketplace). In the Marketplace, you may be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles and out-of-pocket costs will be before you 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.

## Qualifying Events and Maximum COBRA Periods

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

Medical, Dental, Vision and Health Care/Limited Use Health Care Flexible Spending Account Continuation Coverage	
Qualifying Event	Maximum COBRA Period
<ul style="list-style-type: none"> <li>Termination of your employment (for reasons other than gross misconduct)</li> <li>Reduction in your hours of employment</li> <li>Retirement</li> </ul>	You and your covered dependents have the right to continue medical, dental and vision coverage up to 18 months. You may continue Health Care/Limited Use Health Care Flexible Spending Account coverage until the last day of the calendar year in which the qualifying event occurs.
<ul style="list-style-type: none"> <li>Your death</li> <li>Your child or the child of your domestic partner no longer meets the Plan's definition of a dependent</li> <li>Divorce or legal separation between you and your spouse (unless a Qualified Medical Child Support Order provides otherwise)</li> <li>Termination of your relationship with your domestic partner</li> <li>You become entitled to Medicare</li> </ul>	Your covered dependents have the right to continue medical, dental and vision coverage for up to 36 months.
<ul style="list-style-type: none"> <li>You or your covered dependents are determined to be disabled by the Social Security Administration</li> </ul>	COBRA may be extended for medical, dental and vision coverage from 18 months up to 29 months if the Social Security Administration (SSA) determines that you were disabled at any time within 60 days of the qualifying event (i.e., the disability starts at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage). You must notify NXP Rewards Customer Service about the SSA's determination within 60 days of receiving it and before the end of the initial 18-month COBRA period*. This disability extension does not apply to Health Care/Limited Use Health Care Flexible Spending Account coverage.

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

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

## Important Notes

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

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

## Reporting a Qualifying Event

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

- You divorce or become legally separated, or your domestic partnership ends;
- Your domestic partner no longer meets the Plan's definition of an eligible dependent (see the definition of [Domestic Partner](#), beginning on page 308);
- Your child or the child of your domestic partner no longer meets the definition of an eligible dependent under the applicable plan (see [Dependent Eligibility](#), beginning on page 5);
- You (or your covered dependent) are determined to have been disabled under the Social Security Act at any time during the first 60 days of receiving continuation coverage; or
- You become entitled to Medicare.

Your right to continue COBRA coverage is subject to all applicable federal laws and regulations. If you have any questions regarding COBRA, call NXP Rewards Customer Service at 888-375-2367.

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

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

To report a qualifying event, please call NXP Rewards Customer Service at 888-375-2367.

## Deciding Whether to Continue Coverage

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

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

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

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

If you do not choose to continue coverage, you should make the appropriate election online at [NXP.com/rewards](https://nxp.com/rewards) or call NXP Rewards Customer Service at 888-375-2367. In that case, your medical, dental, vision and Health Care/Limited Use Health Care Flexible Spending Account coverage ends on the last day of the month in which the qualifying event occurred.

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

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

## When Continuation Coverage Ends

Continuation coverage ends when any of the following events occurs:

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

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

## Other Continuation Rights

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

## Health and Wellness Benefits

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

See [Participation](#) (beginning on page 1) for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

### ***U.S. Expatriates and U.S. Inpatriates***

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

## Health and Wellness Plans Summary

Plan/Program	What It Is	Who Is Eligible
<a href="#"><u>Medical Plan</u></a>	NXP health insurance benefits provided through its Aetna Choice Plan, Choice Plus Plan, Medical Savings Plan with Health Savings Account (HSA), Out-of-Area (OOA) and Kaiser HMO (if within the Kaiser service area) coverage options. Includes medical, behavioral health and prescription drug coverage.	You, your legal spouse/domestic partner and your eligible dependents, if you enroll yourself and them in medical coverage.
<a href="#"><u>Prescription Drug Program</u></a>	Program through which you purchase prescription drugs through approved retail and home delivery network pharmacies.	You, your legal spouse/domestic partner and your covered dependents if enrolled in medical coverage.
<a href="#"><u>Health Savings Account (HSA)</u></a>	A tax-favored savings account that is used with a High Deductible Health Plan (Medical Savings Plan) to make healthcare more affordable and to save for retirement.	You, your legal spouse/domestic partner and your eligible dependents if you enroll yourself in the Medical Savings Plan with HSA.
<a href="#"><u>Behavioral Health</u></a>	Access to quality behavioral health providers to help you remain healthy.	You, your legal spouse/domestic partner and your covered dependents if enrolled medical coverage.
<a href="#"><u>Wellness Programs/Activity Centers</u></a>	Wellness programs designed to ensure that all NXP employees have resources that assist them in achieving optimal well-being.	You and your spouse/domestic partner, if you enroll yourself and him/her.
<a href="#"><u>Dental Plan</u></a>	Plan provides coverage for preventive and diagnostic dental services, dental treatment, orthodontia and other covered treatment.	You, your legal spouse/domestic partner and your dependents, if you enroll yourself and them in dental coverage.
<a href="#"><u>Vision Plan</u></a>	Routine vision care services, including vision examinations, eyeglasses and contact lenses.	You, your legal spouse/domestic partner and your dependents, if you enroll yourself and them in vision coverage.
<a href="#"><u>Flexible Spending Accounts</u></a>	The Health Care/Limited Use Health Care Flexible Spending Account (FSA) and the Dependent Care Flexible Spending Account (DCFSA) allow you to set aside before-tax dollars into special accounts. When you incur an eligible expense, you file a claim for a tax-free reimbursement of that expense.	You, your spouse and your eligible dependents if you enroll. Note: Each spending account plan has a separate enrollment election.

## NXP Medical Plan

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The NXP Medical Plan offers many features, such as preventive health care coverage, well-baby care, behavioral health care and prescription drug coverage of [non-occupational illness and/or injury](#) (see page 315).

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

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

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

### ***Medical Plan Enrollment Is Automatic***

If you do not complete your benefits enrollment within 30 days of becoming eligible, you are automatically enrolled in the Aetna Choice Plan coverage option with employee-only coverage. See (beginning on page 11) for more information.

Your medical [Participation](#) coverage options include:

- **Aetna Medical Savings Plan with Health Savings Account (HSA):** The Medical Savings Plan is a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). With this coverage option, there is a higher deductible, but you can use your HSA to pay for eligible expenses. To help you meet the higher deductible under the Medical Savings Plan, NXP makes an annual contribution to your HSA and you have the option to make pre-tax contributions to your account as well.
- **Aetna Choice Plus Plan**
- **Aetna Choice Plan**
- **Aetna Out-of-Area:** This coverage option is available to you only if you live in an area where network providers are not available. If you are not sure if you live in a network area, contact NXP Rewards Customer Service. The Medical Savings Plan is available if you live out-of-area.

### ***Kaiser Permanente Medical***

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-464-4000.

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

- If your current providers are not in the network, you may want to consider an option where out-of-network providers are covered;
- If you anticipate having a lot of medical expenses, you may want to consider a plan that provides no deductible for network services; or
- If you do not expect to use your medical benefits often and/or you want to save for future medical costs, you may want to consider the Medical Savings Plan with HSA, which allows you to save unused HSA amounts for future expenses, when you may need them.

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

- **Online:** Meet Alex, your virtual benefit advisor. Alex asks you a few questions to better understand your health care needs and provides you with a comparison of how each plan works and which one may be best for you. Visit Alex at [myalex.com/nxp/2018](https://myalex.com/nxp/2018).
- **On Demand:** Review the detailed outline of the HSA plan posted at [NXP.com/files/company\\_information/benefits/HSAUserGuide.pdf](https://NXP.com/files/company_information/benefits/HSAUserGuide.pdf).
- **By Phone:** Call the NXP Rewards Center and ask to talk with an advocate. An advocate can walk you through the coverage options and help you understand the details for each option. NXP Rewards Customer Service is available at 888-375-2367, Monday through Friday, 8:30 a.m. to 5:30 p.m. Central time.

## Medical Plan Benefits Summary

The following table shows you a side-by-side comparison of various cost-sharing features of each of the available coverage options. More detailed information about Plan coverage is included in [What's Covered](#) (beginning on page 69) and [What's Not Covered](#) (beginning on page 87).

	Medical Savings Plan with HSA		Choice Plus Plan*	Choice Plan		Out-of-Area
	Network	Out-of-Network	Network	Network	Out-of-Network	Out-of-Network
<b>Annual Deductible</b>						
Individual	\$1,500	\$7,500	\$0	\$200	\$1,000	\$0
Family	\$3,000	\$15,000	\$0	\$400	\$2,000	\$0
<b>NXP HSA Contribution</b>						
Individual	\$500		Not applicable	Not applicable		Not applicable
Family (You+Spouse, You+Child(ren) or You+Family)	\$1,000					
<b>Annual Out-of-Pocket Maximum</b> (includes deductible, copayments, if applicable, and coinsurance, including prescription drug spend)						
Individual	\$5,000	\$12,500	\$4,000	\$5,000	\$12,500	\$4,000
Family	\$7,350	\$25,000	\$8,000	\$10,000	\$25,000	\$8,000
<b>Coinsurance</b>						
Preventive Services	You pay 0%; Plan pays 100%	After deductible, you pay 50%; Plan pays 50%	You pay 0%; Plan pays 100%	You pay 0%; Plan pays 100%	After deductible, you pay 50%; Plan pays 50%	You pay 0%; Plan pays 100%
Other Covered Services	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay 10%; Plan pays 90%	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay 10%; Plan pays 90%
<b>Teladoc</b> (Access to a physician anytime, anywhere for minor medical needs, see page 58)						
Teladoc	After deductible, you pay 20%; Plan pays 80%	N/A	You pay \$10 copay/consultation	You pay \$10 copay/consultation	N/A	You pay \$10 copay/visit
<b>Office Visits</b>						
Primary Provider	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay \$20 copay/visit	You pay \$20 copay/visit	After deductible, you pay 50%; Plan pays 50%	You pay \$20 copay/visit

	Medical Savings Plan with HSA		Choice Plus Plan*	Choice Plan		Out-of-Area
	Network	Out-of-Network	Network	Network	Out-of-Network	Out-of-Network
Specialty Provider Within 12 Specialties**	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/ visit	You pay \$30 copay/ visit	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/visit
Specialty Provider Within 12 Specialties** Without Aexcel Rating	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay \$50 copay/ visit	You pay \$50 copay/ visit	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/visit
Specialty Provider Outside the 12 Specialties**	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/ visit	You pay \$30 copay/ visit	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/visit
<b>Emergency Services</b>						
Emergency Room (emergency admission only; any applicable copay waived if admitted)	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 20%; Plan pays 80%	You pay \$100 copay/visit plus 10% coinsurance; network and out-of-network providers	You pay \$100 copay/visit plus 20% coinsurance	You pay \$100 copay/visit plus 20% coinsurance	You pay \$100 copay/visit plus 10% coinsurance
Urgent Care	After deductible, you pay 20%; Plan pays 80%	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/ visit	You pay \$30 copay/ visit	After deductible, you pay 50%; Plan pays 50%	You pay \$30 copay/visit

\* Except for emergency services, only network provider services are covered under the Choice Plus Plan.

\*\* For specialty provider, the 12 specialties include cardiology, cardiothoracic surgery, gastroenterology, general surgery, OB/GYN, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.

For information on prescription drug copayments and coinsurance, see [Prescription Drug Benefit Summary](#) on page 105.

## 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 the [Emergency Services](#) section on page 58. **Medically Necessary:** Medical care determined in the sole and complete discretion of the Claims Administrator 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 the Claims Administrator applies to determine medical necessity. If your claim for health care is denied, you have the right to know the reason for the Claims Administrator's decision.

**Negotiated Network Fee (NNF):** The Plan pays network providers services based on NNF, which is the maximum amount for a specific service or supply agreed upon by the Medical Plan and the network providers.

**Recognized Charge:** For out-of-network medical expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For inpatient and outpatient hospitals and other facilities charges, 140% of the Medicare allowable rate for the geographic area where the service is provided; or
- For professional services and other services or supplies not mentioned above, 105% of the Medicare allowable rate for the geographic area where the service is provided.

## How the Medical Plan Works

### Contributions

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

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

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

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

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

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

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

### **Amounts You Owe When Using the Plan (Cost Sharing)**

- **Deductible:** The annual deductible is the specific amount of eligible expenses you must pay each year before the Plan begins paying benefits for certain covered expenses. The deductible does not apply to in-network preventive care benefits.
  - The deductible starts over each January 1. Eligible expenses do not carry over from one year to the next, across health carriers (ex. Aetna, Kaiser), nor do they carry over from this Plan to the Post-Employment Benefits Plan in the year that your employment ends.
- **Coinsurance:** For some covered expenses, once the annual deductible is met (where required), you and the Plan share the cost; this known as coinsurance. When using in-network providers, the Plan generally pays a higher percentage of covered expenses.
  - **Network Providers:** The Plan pays the network coinsurance percentage. This percentage applies to the negotiated network fee (NNF) for the specific treatment. You pay only the remainder of the negotiated network fee, as long as you follow the Plan's rules for receiving network care.
  - **Out-of-Network Providers:** The Plan pays the out-of-network coinsurance percentage. This percentage applies to the recognized charge for that specific treatment. You pay all remaining charges, including any amounts above the recognized charge. Any charges over the recognized charge do not apply to the out-of-pocket maximum.
- **Copayments:** A copayment is a flat dollar amount you pay for certain services. Once you pay your copayment, the Plan pays covered expenses, up to the negotiated network fee (other benefit provisions may apply).

Separate copayment amounts apply to primary provider and specialty provider office visits. Generally, primary providers include:

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

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

## **Specialists with Aexcel Rating**

You have access to Aetna's Aexcel network, which is an extensive network of specialists with higher than usual standards for quality and efficiency. To be included in the Aexcel network, these providers must have an Aexcel rating, which means they meet one or more of the following measures:

- Show lower complication rates for their patients during hospital stays;
- Use treatments shown to help improve outcomes;
- Get recognition in the areas of health care quality and safety, from medical societies and industry groups;
- Retain their medical board certification by taking part in performance improvement activities available through medical and specialty boards; and/or
- Use technology to make their delivery of health care services more efficient.

To get the best care and pay the least out of pocket, check to see if your specialist is rated as an Aexcel provider with Aetna at [aetna.com/dse/custom/nxp](https://www.aetna.com/dse/custom/nxp). Your specialist copayment is less when you use an Aexcel specialist, which is a specialist with an Aexcel rating in one of the following 12 areas:

- Cardiology
- Cardiothoracic surgery
- Gastroenterology
- General surgery
- OB/GYN
- Orthopedics
- Otolaryngology
- Neurology
- Neurosurgery
- Plastic surgery
- Urology
- Vascular surgery

- **Out-of-Pocket Maximum:** To protect you and your family from financial hardship due to medical expenses, the Plan limits the amount you pay out-of-pocket each year. Once the annual out-of-pocket maximum is met, the Plan pays 100% of the negotiated network fee (network) or recognized charge (out-of-network) for most covered expenses for the remainder of the calendar year.
  - Not all expenses you pay count toward meeting your annual out-of-pocket maximum. The following expenses do not apply toward meeting the out-of-pocket maximum:
    - Contributions;
    - Benefit reductions (expenses that are not paid, or precertification benefit reductions because a required precertification was not obtained);
    - Amounts greater than maximum benefits;

- Any expenses not covered by the Plan; and
- Amount over the recognized charge for out-of-network services.

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

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

### ***How Cost Sharing Works under the Aetna Choice Plan***

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

- **Deductible:** You must reach a deductible before benefits for major services begin.
  - ***In-Network:*** The deductible for in-network services is \$200 for individual (you only or employee-only) and \$400 for family coverage (one or more individuals are covered).
  - ***Out-of-Network:*** The deductible for out-of-network services is \$400 for individual (you only or employee-only) and \$800 for family coverage (one or more individuals are covered).

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

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

- ***Individual:*** Once one member in the family reaches their individual deductible, his or her coinsurance benefit begins.
- ***Family:*** The family deductible can be met by one family member or a combination of family members. Once the family deductible is met, the coinsurance benefit begins for everyone in the family.
- **Coinsurance:** For major medical services, you pay coinsurance once you have met your deductible. You pay coinsurance per major medical service per covered individual.

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

- ***In-Network:*** The in-network coinsurance is 80%--in other words, NXP pays 80% and you pay the remaining 20%.
- ***Out-of-Network:*** The out-of-network coinsurance is 60%--NXP pays 60% and you pay the remaining 40%.
- **Out-of-Pocket Maximum:**
  - ***In-Network:*** The out-of-pocket maximum is \$5,000 per person or \$10,000 of combined expenses for a family.
  - ***Out-of-Network:*** The out-of-pocket maximum is \$10,000 per person or \$20,000 of combined expenses for a family.

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

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

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

### **How Cost Sharing Works under the Aetna Choice Plus Plan**

The Choice Plus option covers a broad range of in-network services, such as preventive care at 100%, doctor visits after a copayment and behavioral health services. With the Choice Plus Plan:

- **Deductible:** There is no deductible to meet before the Plan starts paying benefits. This means that your benefits for major medical services begin immediately.
- **Copayments:** Doctor visits are covered at 100% after a copayment.
- **Coinsurance:** The coinsurance is 90%--in other words, NXP pays 90% and you pay the remaining 10% for most medical services.

#### ***In-Network***

The Choice Plus Plan covers in-network care only, except for emergencies, there are no benefits for services delivered out of network.

You do not need to use an in-network emergency provider, ambulance or emergency room if you experience an emergency. Your emergency care will be covered, regardless of network status for the provider, ambulance or emergency room.

To determine if your providers are in the Choice Plus EPO network, use [Aetna DocFind](#). When prompted for plan or network name, choose Choice Plus EPO (Open Access Aetna Select).

- **Out-of-Pocket Maximum:** The out-of-pocket maximum amount you pay for eligible services is \$4,000 per person or \$8,000 (in combined expenses) for a family.

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

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

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

## How Cost Sharing Works under the Aetna Medical Savings Plan

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

### What Makes the MSP Different?

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

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

### With the Medical Savings Plan

You Only Coverage	You + Spouse, You + Children or You+ Family Coverage
<p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>The deductible does not apply to preventive care services.</li> <li>You are responsible for paying 100% of all other covered expenses for medical and prescription drugs until you meet the deductible.</li> <li>The deductible includes amounts you spend on medical and prescription drug expenses, minus any discounts from manufacturer's prescription coupons.</li> </ul> <p>In the other Aetna medical plans prescription drug expenses are not included in your deductible.</p>	
<p>You must reach the individual deductible before benefits begin.</p> <ul style="list-style-type: none"> <li><b>In-Network:</b> The deductible for in-network services is \$1,500.</li> <li><b>Out-of-Network:</b> The deductible for out-of-network services is \$3,000.</li> </ul>	<p>You and your family must meet the family deductible before benefits begin for any one individual covered under the Plan.</p> <ul style="list-style-type: none"> <li><b>In-Network:</b> The family deductible for in-network services is \$3,000.</li> <li><b>Out-of-Network:</b> The family deductible for out-of-network services is \$6,000.</li> </ul> <p>The family deductible can be met by one family member or a combination of family members; however there are no coinsurance benefits for anyone in the family unit until expenses equaling the family deductible amount have been incurred.</p>

You Only Coverage	You + Spouse, You + Children or You+ Family Coverage
<p><b>Coinsurance</b></p> <ul style="list-style-type: none"> <li>You have the flexibility of using in-network and out-of-network providers; your out-of-pocket costs will be less when you use in-network providers.</li> <li>For medical expenses, if you see an in-network provider, you are responsible for the discounted amount the network has agreed to pay until your deductible is met.</li> <li>For prescription expenses, the same is true—you are responsible for the discounted amount CVS Caremark has negotiated until your deductible is met.</li> </ul>	
<p>Once you meet the individual deductible:</p> <ul style="list-style-type: none"> <li><b>In-Network:</b> The in-network coinsurance is 80%--in other words, NXP pays 80% and you pay the remaining 20%.</li> <li><b>Out-of-Network:</b> The out-of-network coinsurance is 60%--NXP pays 60% and you pay the remaining 40%.</li> </ul>	<p>Once you and your family meet the family deductible:</p> <ul style="list-style-type: none"> <li><b>In-Network:</b> The in-network coinsurance is 80%--in other words, NXP pays 80% and you pay the remaining 20%.</li> <li><b>Out-of-Network:</b> The out-of-network coinsurance is 60%--NXP pays 60% and you pay the remaining 40%.</li> </ul>
<p><b>Out-of-Pocket Maximum</b></p> <ul style="list-style-type: none"> <li>Once the out-of-pocket maximum is met, the Plan pays 100% of covered expenses for medical and prescription drugs for the remainder of the year.</li> <li>The out-of-pocket maximum includes deductibles and coinsurance for medical and prescription drug expenses.</li> </ul>	
<p>The individual out-of-pocket maximum is:</p> <ul style="list-style-type: none"> <li><b>In-Network:</b> \$5,000</li> <li><b>Out-of-Network:</b> \$10,000</li> </ul>	<p>The family out-of-pocket maximum is:</p> <ul style="list-style-type: none"> <li><b>In-Network:</b> \$7,350</li> <li><b>Out-of-Network:</b> \$20,000</li> </ul> <p>The family out-of-pocket maximum can be met by one family member or a combination of family members.</p>

**How Cost Sharing Works under Aetna Out-of-Area Coverage**

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

- Deductible:** There is no deductible to meet before the Plan starts paying benefits. This means that your benefits for major medical services begin immediately.
- Copayments:** Doctor visits are covered at 100% after a copayment.
- Coinsurance:** The coinsurance is 90%--in other words, NXP pays 90% and you pay the remaining 10% for most medical services.

If you are covered under the Out-of-Area option, you and your covered dependents may go to any provider or hospital you want (provided you request precertification, as described on page 61, as required). If you are able to travel to a network location for care, you may reduce your out-of-pocket costs by using an NXP network provider. You will save money because the provider charges will be based on the negotiated network fee. The amounts you pay will be a percentage of the negotiated network fee, rather than the recognized charge, plus any amount exceeding recognized charges.

- **Out-of-Pocket Maximum:** The out-of-pocket maximum amount you pay for eligible services is \$4,000 per person or \$8,000 (in combined expenses) for a family.

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

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

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

## If You Transfer from One Coverage Option or Plan to Another

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

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

## Aetna Health Care Networks

Aetna Health care networks are an integral part of the NXP Medical Plan. Unless you are covered under the Out-of-Area coverage option, you must use providers in the Aetna Network to receive the highest level of benefit available. The Aetna networks in various locations across the U.S. include health care providers and hospitals that meet specific standards established by the network administrators and agree to charge negotiated fees.

## Benefit Details

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

To find a network provider:

- Go online to Aetna DocFind® at [aetna.com/dse/custom/nxp](https://www.aetna.com/dse/custom/nxp); or
- Call Aetna Member Services at 800-626-1987.

## **Aetna Choice Plus Plan: Open Access Select EPO Network**

The **Choice Plus Plan** uses Aetna's Open Access Select EPO network. An Exclusive Provider Organization (EPO) requires you to use network providers to have coverage, except in emergencies. Before enrolling in the Choice Plus Plan, you should consider:

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

When visiting the Aetna DocFind® search tool at [aetna.com/dse/custom/nxp](https://aetna.com/dse/custom/nxp), you will be asked to select a plan, click on *Choice Plus EPO (Open Access Aetna Select)* or call Aetna at 800-626-1987 to speak with a representative. DocFind can help you:

- Search for providers by name and confirm that your current providers belong to the Open Access Select EPO network.
- Locate network primary and specialty care providers near you.
- Find the best care with the least out of pocket cost by utilizing specialists rated as Aexcel providers.

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

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

However, the Choice Plus Plan covers emergency services provided by out-of-network providers for emergency medical conditions, as described in the [Emergency Services](#) section on page 58. If your condition does not meet the definition of an emergency medical condition as defined in that section and you seek out-of-network care while enrolled in the Choice Plus Plan, you are responsible for the full cost of services. Services are not covered by the Choice Plus Plan and Aetna-negotiated discounts are not applied.

## **Aetna Choice Plan and Aetna Medical Savings Plan: Choice POS II Network**

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

You are responsible for paying the remaining charges up to the negotiated network fee and any applicable copayments (if applicable).

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

When visiting the Aetna DocFind® search tool (at [aetna.com/dse/custom/nxp](https://www.aetna.com/dse/custom/nxp)), you will be asked to select a plan. Click on the plan that you are enrolled in or call Aetna at 800-626-1987 to speak with a representative. You can:

- Search for providers by name and confirm that your current providers belong to the Choice POS II network.
- Locate network primary and specialty care providers near you.
- Find the best care with the least out-of-pocket cost by using specialists rated as Aexcel providers.

### ***Aetna 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 a “negotiated network fee,” or a pre-arranged fee for care provided for you and your covered dependents. Specialty hospitals and facilities are included in the Plan’s behavioral health network because of their expertise in psychiatric and chemical dependency services.

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

To find a behavioral health network provider:

- Go online to Aetna DocFind® at [aetna.com/dse/custom/nxp](https://www.aetna.com/dse/custom/nxp); or
- Call Aetna Member Services at 800-626-1987.

### **Aetna Out-of-Network Benefits**

- **Medical Savings Plan and Choice Plan:** If you choose to use the services of out-of-network providers under the Medical Savings Plan or Choice Plan coverage options, your coverage for services is generally at the out-of-network level. You are responsible for paying any expenses that exceed the recognized charge.
- **Choice Plus Plan:** If you chose to use the services of out-of-network providers for non-emergency care under the Choice Plus Plan, you are responsible for the full cost. Out-of-network services are not covered by the Choice Plus Plan and Aetna-negotiated discounts do not apply. If the Claims Administrator 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 the Claims Administrator’s approval before incurring them. Contact Aetna Member Services at 800-626-1987 for more information regarding this process.

## **Emergency Services**

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

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

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

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

## **When You Travel**

If you are traveling or vacationing away from home, you can go to the nearest facility that can treat your illness or injury. If you are admitted into a hospital, remember to request precertification, as described on page 61, within 48 hours to receive network coinsurance.

## **When Your Children Are Away at School**

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

## **Ancillary Providers**

Ancillary providers, such as anesthesiologists, radiologists and assistant surgeons who are out-of-network are paid at the network benefit level (applied to recognized charges) when:

- The care/treatment provided is on an emergency or urgent care basis;
- The services of the ancillary provider are provided in conjunction with care/treatment provided at a network facility;
- The services of the ancillary provider are ordered in conjunction with network office care and the participant is not allowed to choose the ancillary provider (for example, when a network physician is supported by an out-of-network anesthesiologist); or
- The Claims Administrator approves the use of an out-of-network provider because a network provider is not available in the participant's location.

Except as explained above, out-of-network ancillary providers are paid at the out-of-network rate when care/treatment is provided at an out-of-network facility or when ordered in association with out-of-network office care.

Remember if you enrolled in the Choice Plus Plan, out-of-network care is only covered for emergency services, as described in the [Emergency Services](#) section on page 58.

If you receive services from out-of-network providers under the circumstances described in this section, these services are subject to network benefit levels. However, you may be balance billed by the out-of-network ancillary provider for amounts over the network benefit level paid by the Plan. If this occurs, contact Aetna member services to have your claim reviewed to receive the network level of benefits if eligible. Any amount you pay related to those services is applied only to the network annual out-of-pocket maximum and does not count toward the out-of-network annual out-of-pocket maximum.

## Teladoc

When you enroll in an Aetna medical plan, you have access to Teladoc, an added benefit that gives you 24/7 access to a national network of U.S. board-certified doctors.

You can contact Teladoc from anywhere - home, work or on the road. Teladoc doctors diagnose non-emergency medical problems, recommend treatment and even call in a prescription to your pharmacy of choice, when necessary. Get started by registering at [teladoc.com/NXP](https://teladoc.com/NXP) or calling 855-Teladoc (835-2362).

Teladoc makes it easy to request a medical consultation anytime and anywhere you need it for conditions like:

- Respiratory infections;
- Ear infections;
- Urinary tract infections;
- Allergies;
- Colds and flu;
- Sore throat; and
- Pink eye.

Teladoc costs significantly less than urgent care and emergency room visits. Plus, you can use Teladoc at your convenience, allowing you to avoid the hassle of sitting in a waiting room. Your cost when you use Teladoc is:

- \$10 per consultation if you are enrolled in the Choice PPO or Choice Plus Plan option; or
- Up to \$40 per consultation if you are enrolled in the Medical Savings Plan.

## Castlight

When you enroll in an Aetna medical plan, you and your covered family members have access to Castlight. Castlight is a personalized online tool that empowers you to make informed healthcare choices with a clear understanding of costs and likely outcomes. Castlight lets you compare doctors and other medical services based on quality, convenience and estimated cost.

You can use Castlight to:

- Compare nearby doctors, medical facilities and health care services based on the estimated price you will pay and quality of care.
- See personalized cost estimates based on your location, medical plan and whether or not you have met your deductible.
- Review step-by-step explanations of past medical and pharmacy spending so you know how much you paid and why.
- Receive recommendations about ways to save money and find high-quality care.

You can learn about your options and the associated costs and quality for healthcare; past, present and future. For example, use Castlight when you need to find a new doctor or when your doctor recommends labs, specialists and other medical services, such as finding the closest location for an MRI at the lowest out-of-pocket cost. Many doctors suggest these additional services without knowing how much another provider will charge, and to add to the complexity, sometimes the doctor provides you with multiple service options. You can now research these and services for other members of your family on Castlight. And, the tool provides an easy and helpful way to understand your medical plan and past care.

Castlight is a unique service customized for NXP employees with features that are not available from other services. Castlight gives you personalized pricing information to show you how much your estimated out-of-pocket costs will be for medical services based on your medical plan, the doctors in your preferred network and your deductible status. Castlight also provides an overview of your medical plan benefits, tips for making smart health care decisions and details about your past claims.

Castlight lists estimated cost information for doctors and medical services based on the utilization of NXP employees enrolled in an Aetna medical plan and other Aetna customers who also use Castlight. The information is based on visits and/or usage over the past two years and is updated monthly as ongoing medical claims are submitted to the medical plans. Remember, your private data is protected.

The estimated price data you see in Castlight is limited to the doctors/procedures that you and all other employees have visited/completed. Price and quality data for the most commonly used Aetna doctors and services are available in Castlight. Keep in mind, there may be instances where some medical services in areas may not show data. The estimate data available increases as employees use the health care system. It is always a good idea to visit Castlight again to see more service price and quality updates.

Castlight is available to all employees, spouses/domestic partners and adult dependents enrolled in an Aetna medical plan. New and existing users can access Castlight by visiting [NXP.com/castlight](https://www.nxp.com/castlight). Registered users can also call a Castlight Guide at 800-681-4815, Monday through Friday, 7 a.m. – 8 p.m. Central time.

## Informed Health® Line

You and your covered family members have telephone access to a registered nurse, 24/7, through Informed Health Line. The medical professionals on this line can answer questions about medical conditions, treatment and medications. Informed Health Line also offers the Audio Health Library, with information in both English and Spanish on thousands of health conditions.

Call the Informed Health Line at 800-556-1555. This number is also on your Aetna ID card.

## Aetna Navigator™

Aetna Navigator is an online tool with information, tools and self-service features to help you manage your benefits and your health. Once you are registered to use this website, at [AetnaNavigator.com](https://www.aetnavigators.com), you will have a personalized home page. From there, you will have access to benefits information, may make requests, use cost care tools, find network providers, print temporary ID cards, and much more.

## Precertification

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

Requesting precertification does not guarantee that the provider or facility is approved as a network provider, nor does precertification guarantee coverage.

Any questions about coverage should be directed to Aetna Member Services at 800-626-1987.

## When to Request Aetna Precertification

**Choice Plus Plan:** Out-of-network care is only covered for emergency services, as described in the [Emergency Services](#) section on page 58.

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

**When you use Aetna network providers,** your provider will handle the precertification process for you.

**When you use Aetna out-of-network providers,** you are responsible for requesting precertification when required. To request precertification, call Aetna Member Services at 800-626-1987; Member Services representatives are available from 7 a.m. to 5 p.m. Central time, Monday through Friday.

**When you are admitted to an Aetna out-of-network facility**, you are responsible for requesting precertification. You, a family member or your provider must request precertification at least 14 days before non-emergency admissions or medical services. Precertification is not required for a medical emergency or urgent care admission; however you should contact Aetna Member Services at 800-626-1987 within one business day of the emergency.

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

The following table highlights when to call to request precertification:

Benefit or Program	When to Call
<b>Emergency Admission</b>	Precertification is not required; however contact Aetna Member Services at 800-626-1987 within 48 hour or as soon as reasonably possible after admission
<b>Urgent Admission</b>	Request precertification 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)
<b>Emergency Outpatient Medical Services</b>	Request precertification before the care, treatment or procedure if possible or as soon as reasonable possible
<b>Non-Emergency Inpatient Admission</b>	Request precertification at least 14 days before the date you are scheduled to be admitted
<b>Non-Emergency Outpatient Medical Services</b>	Request precertification at least 14 days before the outpatient care is provided or the treatment or procedure is scheduled

**Important Note:** In some instances, as described in [If You Do Not Request Precertification](#) on page 65, failure to request precertification will result in the Plan's coinsurance being reduced to 50% of covered expenses. Any expenses you are responsible for because of a reduction due to failure to precertify do not apply to your annual out-of-pocket maximum.

## When Aetna Precertification Is Required

You may contact Aetna Member Services 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 Aetna network facilities for non-emergency medical and behavioral health care. To receive the highest level of benefit for inpatient behavioral health care, you must use one of the specialty hospitals and facilities that are included in the behavioral health network.

**Choice Plus Plan:** Out-of-network care is only covered for emergency services, as described in the [Emergency Services](#) section on page 58.

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

- Ambulance transportation by fixed-wing aircraft or elective (non-emergency) transportation by ground ambulance;
- Autologous chondrocyte implantation, Carticel;
- Behavioral health outpatient services, including:
  - Biofeedback;
  - Intensive outpatient program care;
  - Neuropsychological testing;
  - Outpatient detoxification.
  - Outpatient electroconvulsive therapy (ECT);
  - Psychiatric home care services; and
  - Psychological testing;
- Clinical trials;
- Cochlear device and/or implantation;
- Cognitive skills development;
- Dialysis visits;
- Dorsal column (lumbar) neurostimulators (trial or implantation);
- Durable medical equipment (rental or purchase) costing \$1,000 or more;
- Electric or motorized wheelchairs and scooters;
- Home health care;
- Hospice Care (inpatient and outpatient);
- Hyperbaric oxygen therapy;
- Infertility treatment;
- Injectable drugs and medications, contact Aetna for more information on which medications are subject to precertification;
- Inpatient confinements, including:
  - Hospital, skilled nursing facility, rehabilitation facility stays for surgical and nonsurgical care, including maternity and newborn confinements that exceed standard lengths of stay;
  - Inpatient residential treatment facility stay for mental disorder or substance use disorder treatment;
  - Partial hospitalization program care for mental disorders or substance use disorder;
- Limb prosthetics;
- Nonparticipating freestanding ambulatory surgical facility services;
- Oncotype DX;
- Private duty nursing care;

- Proton beam radiotherapy;
- Reconstructive or other procedures that may be considered cosmetic, such as:
  - Blepharoplasty/canthoplasty or related procedures;
  - Breast reconstruction/enlargement;
  - Breast reduction/mammoplasty (unless the procedure is in connection with a mastectomy for cancer) and removal of breast implants and capsulotomy of the breast;
  - Cervicoplasty;
  - Chemical peels;
  - Excision of excessive skin due to weight loss;
  - Gastroplasty/gastric bypass;
  - Injection of filling material;
  - Lipectomy or excess fat removal;
  - Rhinoplasty (with or without septoplasty); and
  - Sclerotherapy or surgery for varicose veins;
- Sleep studies;
- Spinal procedures, including intervertebral disc surgery, cervical, lumbar and thoracic laminectomy/laminotomy procedures and spinal infusion surgery;
- Surgeries (inpatient and outpatient) and procedures, including:
  - Abdominoplasty (includes diastasis recti);
  - Dental implants;
  - Extracorporeal shock wave therapy;
  - Gastrointestinal tract imaging through capsule endoscopy;
  - Genioplasty;
  - Jaw joint disorder surgery;
  - Mastectomy;
  - Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of temporomandibular joint;
  - Osseointegrated implant;
  - Osteochondral allograft/knee;
  - Palatopharyngoplasty/uvulectomy;
  - Penile prosthesis operation;
  - Uvulopalatopharyngoplasty, including laser-assisted procedures;
- Temporomandibular joint disorder treatment;
- Transplants, including bone marrow transplants;
- Ventricular assist devices.

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

## In an Emergency

In an emergency, you or your covered dependent should immediately seek whatever care is necessary to safeguard health and well-being. ***If your emergency treatment is from an out-of-network facility***, you should contact Aetna Member Services at 800-626-1987 within one business day of the emergency.

### ***Emergency Behavioral Health Treatment***

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

To request precertification, call Aetna Member Services at 800-626-1987.

## If You Do Not Request Precertification

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

- Inpatient hospital stays;
- Treatment facility stays (intensive outpatient, partial hospitalization and residential treatment centers);
- Convalescent facility stays;
- Home health care;
- Hospice care (inpatient and outpatient); and
- Private duty nursing.

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

## How Precertification Works

When you call for precertification, you must provide the following information:

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

All medical information provided for precertification is held in strict confidence.

Then Member Services will:

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

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

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

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

## **Aetna Disease Management Program**

If you or a covered family member suffers from a chronic condition, the Aetna Medical Plan offers special assistance through the Disease Management Program. Participation is voluntary and confidential.

The Program's services are provided by Aetna. Registered nurses and other health care professionals help Disease Management Program 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 Disease Management Program covers 30 chronic conditions, ranging from asthma to congestive heart failure to sickle cell disease to seizure disorders. The Claims Administrator reviews claims data to identify people who may qualify for the Program. To see if you or your covered family member may qualify, contact your Personal Health Advocate by calling Aetna Member Services at 800-626-1987.

## Behavioral Health Program

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

### ***Kaiser Permanente Medical***

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-464-4000.

<b>Aetna Behavioral Health Benefits Summary</b>	
<b>Benefit</b>	<b>Description</b>
<b>Eligible Providers</b>	Licensed psychiatrists, licensed nurse practitioners, licensed clinical psychologists, licensed social workers and other licensed behavioral health counselors. (If you are enrolled in the Choice Plus, you must use network providers, except for emergency services, or your care will not be covered.)
<b>Inpatient Treatment Program</b>	<ul style="list-style-type: none"> <li>• <b>Acute:</b> 24-hour intensive nursing and medical attention</li> <li>• <b>Sub-Acute:</b> 24-hour nursing and medical monitoring as needed (therapeutic rehabilitation)</li> <li>• <b>Day Care/Evening Treatment or Partial Hospitalization:</b> A structured program in which you meet for individual, group and family therapy</li> </ul> <p>Aetna Personal Health Advocate precertification is required. The program's benefits are determined the same as your inpatient medical benefits. For uncertified treatment, the program's coinsurance is 50% of negotiated rates for covered treatment; you pay the remaining charges.</p>
<b>Residential Treatment</b>	Precertification is required for medically necessary treatment in an overnight environment.
<b>Intensive Outpatient Treatment (beyond office visits)</b>	A structured program in which you meet for individual, group and family therapy at least three hours each day for three days or more per week. The program's benefits are the same as your outpatient medical benefits.

Aetna Behavioral Health Benefits Summary	
Benefit	Description
Outpatient Physician/Therapist Visits	For network care, you pay any applicable office visit copayment for each office visit, and the Plan pays the rest. For out-of-network care, the program's coinsurance is the same percentage of the recognized charges as your other out-of-network outpatient treatment; you pay the remaining charges.

### When You Use a Network Provider

If you use an Aetna 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 negotiated network fee in your medical plan coverage choices. The amounts you pay count toward your coverage option's annual network out-of-pocket maximum. ***Aetna network providers handle precertification 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

**Aetna Choice Plus Plan:** Out-of-network care is only covered for emergency services, as described in the [Emergency Services](#) section on page 58.

When you are enrolled in the Aetna Medical Savings or Choice Plan, you may use providers who are not in the behavioral health network and receive the out-of-network level of benefit of your medical option. You are responsible for all remaining charges, including amounts above the recognized charge. 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 90% of recognized charges for covered medical services. For office visits, you pay your copayment and the Program pays the rest, up to the recognized charge for that service. You are responsible for paying any amounts above the recognized charge.

When you receive care from an out-of-network provider, you may be responsible for paying charges to the provider at the time of service and then filing for reimbursement (See the behavioral health portions of the [Filing for Your Benefits](#) table (beginning on page 271). ***You are responsible for getting precertification for out-of-network care when it is required*** (see [Precertification](#), beginning on page 61). Contact your Aetna Personal Health Advocate by calling Aetna Member Services at 800-626-1987 to request precertification.

## Medical Program: What's Covered

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

Failure to follow the guidelines for contacting your Aetna Personal Health Advocate when required reduces your benefit.

### ***Kaiser Permanente Medical***

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-464-4000.

## Preventive Care

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

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

Voluntary health screenings are sometimes offered outside the Medical Plan at NXP worksites; see [Wellness Programs/Activity Centers](#), beginning on page 116.

Preventive care generally includes:

- **Routine Physical Exams:** A routine exam is a medical exam by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury. Covered expenses include charges made by your physician for routine physical exams, including routine vision and hearing screenings given as part of the exam. The exam may include:
  - Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
  - Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents;

- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration, which may include, but are not limited to:
  - Screening and counseling services, such as interpersonal and domestic violence, sexually transmitted diseases and Human Immune Deficiency Virus (HIV) infections;
  - Screening for gestational diabetes for women; and
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older;
- X-rays, lab and other tests given in connection with the exam; and
- For covered newborns, an initial hospital check-up.
- **Preventive Care Immunizations:** Charges of a physician or facility for immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. This does not include immunizations that are not considered preventive care, such as those required due to employment or travel.
- **Routine Cancer Screenings:** Screenings are subject to age, family history and frequency guidelines of the most current evidence-based items that have in effect a rating of A or B in the current recommendations of the USPSTF and the comprehensive guidelines supported by the Health Resources and Services Administration. Covered expenses include, but are not limited to, the following routine cancer screenings:
  - Mammograms;
  - Fecal occult blood tests;
  - Digital rectal exams;
  - Prostate Specific Antigen (PSA) tests;
  - Sigmoidoscopies;
  - Double Contrast Barium Enemas (DCBE);
  - Colonoscopies; and
  - Lung cancer screening.

This does not include any charges incurred for services that are covered to any extent under any other part of the Plan.

- **Screening and Counseling Services:** Covered expenses include charges made by your physician in an individual or group setting for:
  - Obesity screening and counseling services to aid in weight reduction due to obesity, including:
    - Preventive counseling visits and/or risk factor reduction intervention;
    - Nutrition counseling; and
    - Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

- Misuse of alcohol and/or drug screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- Use of tobacco product screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes preventive counseling visits, treatment visits and class visits to aid in the cessation of the use of tobacco products.
- Sexually transmitted infection counseling services to help you prevent or reduce sexually transmitted infections.
- Genetic risks for breast and ovarian cancer counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

For any visit maximums, each session of up to 60 minutes is equal to one visit.

- **Well Woman Preventive Visits:** A routine well woman preventive exam by a physician, obstetrician, or gynecologist for:
  - A routine well woman preventive exam office visit, including Pap smears (a routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury); and
  - Routine preventive care breast cancer genetic counseling and breast cancer (BRCA) gene blood testing, including charges made by a physician and lab for the BRCA gene blood test and charges made by a genetic counselor to interpret the test results and evaluate treatment.

These benefits will be subject to any age; family history and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
  - Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.
- **Prenatal Care:** Prenatal care is covered as preventive care for pregnancy-related physician office visits services, including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check and fundal height), received by a pregnant female in a physician's, obstetrician's or gynecologist's.
  - **Comprehensive Lactation Support and Counseling Services:** Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided by a certified lactation support provider in a group or individual setting to females during pregnancy or at any time following delivery.

- **Breast Feeding Durable Medical Equipment:** Coverage includes the rental or purchase of breast feeding durable medical equipment for lactation support (pumping and storage of breast milk) as follows:
  - The rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital.
  - The purchase of an electric breast pump (non-hospital grade) or manual breast pump; covered once every three years (if an electric breast pump was purchased within the previous three year period, the purchase of an electric or manual breast pump will not be covered until a three year period has elapsed from the last purchase of an electric pump).

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item that can be safely and effectively provided. The decision to rent or purchase is at the discretion of Aetna.

If a breast pump service or supply that you need is covered under this Plan but not available from a network provider in your area, please contact Member Services at the toll-free number on your ID card for assistance.

- **Family Planning Services - Female Contraceptives:** For females with reproductive capacity, covered expenses include charges incurred for services and supplies provided to prevent pregnancy. All contraceptive methods, services and supplies must be approved by the FDA. Coverage includes individual or group counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Covered contraceptives include:
  - **Voluntary Sterilization:** Charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants (this does not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement);
  - **Contraceptives:** Charges made by a physician or pharmacy for female contraceptives that are brand name or generic prescription drugs, female contraceptive devices including the related services and supplies needed to administer the device and FDA-approved generic emergency contraceptives (when contraceptive methods are obtained at a pharmacy, prescriptions must be submitted to the pharmacist for processing).

Family planning services—female contraceptive benefits do not cover:

- Services and supplies incurred for an abortion.
- Services provided due to complications from a voluntary sterilization procedure and related follow-up care.
- Any contraceptive methods only reviewed, but not approved, by the FDA.

- Male contraceptive methods, sterilization procedures or devices.
- The reversal of voluntary sterilization procedures, including any related follow-up care.

**Other Family Planning Services:** Charges for certain family planning services, even though not provided to treat an illness or injury, such as voluntary sterilization for males. This benefit does not cover:

- Reversal of voluntary sterilization procedures, including related follow-up care.
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.
- Services and supplies provided by an out-of-network provider.

Preventive care expenses do not include:

- Services covered under any other part of this Plan;
- Diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during a stay for medical care;
- Services not given by a physician or under his or her direction; or
- Psychiatric, psychological, personality or emotional testing or exams.

To find more information on eligibility, coverage or networks, contact NXP Rewards Customer Service at 888-375-2367.

## Maternity Coverage

NXP offers maternity benefits and the [Maternity Care Program](#) (see page 314) to all Aetna Medical Plan participants. The Maternity Care Program is a confidential, no-cost service provided by Aetna Personal Health Advocate Services. It is part of NXP's commitment to providing the highest quality care to expectant mothers and their babies.

### ***The Health Care Flexible Spending Account and Maternity Expenses***

Most obstetricians submit a single bill for all physician charges *after* the child is born. In this case, the physician charges are considered "incurred" on the child's birth date. Please take this into account and discuss this with your obstetrician when estimating your share of expenses under your Medical Plan coverage option *and* the [Health Care/Limited Use Health Care Flexible Spending Account \(FSA\)](#) (see page 140).

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.

Remember that if you are covered under a medical option that covers out-of-network care, any **out-of-network** maternity admission requires **precertification** (out-of-network care is not covered under the Choice Plus Plan). If you are not enrolled in the Maternity Care Program described below, you must contact your Aetna Personal Health Advocate by calling Aetna Member Services at 800-626-1987 to have your out-of-network admission precertified. **Network providers will handle precertification 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 Aetna Member Services at 800-626-1987 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).

### **Infertility Treatment**

The Plan covers:

- Basic infertility expenses, which include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility; and
- Comprehensive infertility and Advanced Reproductive Technology (ART) expenses, which are available to you and/or a covered spouse/domestic partner (this does not include a dependent child).

To be eligible for infertility benefits:

- The condition must have a demonstrated cause of infertility recognized by a gynecologist or infertility specialist and your physician who diagnosed you as infertile and the condition must be documented in your medical records;
- The procedures must be done while not confined in a hospital or any other facility as an inpatient;
- FSH levels must be less than 19 miU on day three of the menstrual cycle;
- The infertility must not be caused by voluntary sterilization of either one of the partners (with or without surgical reversal or a hysterectomy); and
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under the Plan.

Precertification is required, see page 58. Aggregate lifetime maximum of \$4,000 applies to treatment, not diagnosis, and excludes benefits for prescription drugs. A separate \$4,000 lifetime maximum benefit applies to prescription drugs for infertility; see [What's Covered](#) under the Prescription Drug Program, beginning on page 113.

Outpatient prescription drugs used to treat infertility are covered under the Plan's Prescription Drug Program *when infertility treatment is precertified*. The separate lifetime maximum benefit of \$4,000 applies to prescription drugs for infertility treatment.

All infertility treatment requires precertification. If you are covered under a medical option that covers out-of-network care and you receive out-of-network treatment, you must request precertification by calling 800-626-1987 to have your out-of-network treatment precertified (out-of-network care is not covered under the Choice Plus Plan). ***Aetna Network providers will handle precertification for you.***

### ***Advanced Reproductive Technology (ART) Treatment***

If comprehensive infertility treatment does not result in a pregnancy in which a fetal heartbeat is detected, the Plan pays benefits for certain ART treatments. ART treatment requires separate precertification. Your physician must refer you to Aetna's infertility case management unit and that unit must precertify any ART services, which must be provided by an ART specialist.

Covered ART treatments are:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection; and
- Ovum microsurgery.

Covered charges include:

- Aggregate lifetime maximum of \$4,000 of any combination of the following ART services received, provided or administered by Aetna or any affiliated company: IVF, GIFT, ZIFT or cryopreserved embryo transfers;
- IVF, Intra-Cytoplasmic Sperm Injection (ICSI), ovum microsurgery, GIFT, ZIFT or cryopreserved embryo transfers;
- Charges for the care of an eligible covered person participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining a spouse's/domestic partner's sperm for ART, when the spouse/domestic partner is also covered by the Plan.

See [Infertility](#) on page 74 for more information about what this benefit does not cover.

### **Transplant Services Program**

The Transplant Services Program includes an Institutes of Excellence™ (IOE) network, which gives you access to a network that specializes in transplants. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

Benefits may vary if an IOE facility or non-IOE or out-of-network provider is used. The network level of benefits is only paid for treatment received at a facility designated by the Plan as an IOE for the type of transplant being performed. In addition, some expenses are payable only within the IOE network. Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility are considered network care expenses.

Covered expenses include charges incurred during a transplant occurrence. A transplant occurrence begins at the point of evaluation for a transplant and ends either 180 days from the date of the transplant or upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The following are considered one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant:

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;

- Intestine;
- Bone marrow/stem cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (stem cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant; and
- Any other single organ transplant, unless otherwise excluded by the Plan.

The following are considered more than one transplant occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;
- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The Plan covers:

- Charges made by a physician or transplant team;
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program;
- Related supplies and services provided by the facility during the transplant process; these services and supplies may include physical, speech and occupational therapy, bio-medicals and immunosuppressants, home health care expenses and home infusion services;
- Charges for activating the donor search process with national registries;
- Compatibility testing of prospective organ donors who are immediate family members (an immediate family member is a first-degree biological relative, such as your biological parents, siblings or children); and
- Inpatient and outpatient expenses directly related to the transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care are considered one transplant occurrence. The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

- **Pre-Transplant Evaluation/Screening:** Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
- **Pre-Transplant/Candidacy Screening:** Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
- **Transplant Event:** Includes:
  - Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant;
  - Prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs;
  - Physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); and
  - Cadaveric and live donor organ procurement.
- **Follow-Up Care:** Includes all covered transplant expenses, home health care services, home infusion services and transplant-related outpatient services provided within 180 days from the date of the transplant event.

### ***How to Use the Transplant Services Program***

When you require an organ transplant, you or your physician should request precertification by calling Aetna Member Services at 800-626-1987 to begin the evaluation process. If the surgery is eligible for coverage, a transplant coordinator works with you, the patient (if a covered dependent), family members and medical personnel to answer questions and help make arrangements. The transplant coordinator may also review the treatment plan and follow up with the patient for up to one year after the surgery.

**Note:** Any expenses for which you are responsible because you do not request and receive precertification do not apply to your annual out-of-pocket maximum.

See [Transplant](#) on page 92 for more information about what this benefit does not cover.

## Clinical Trials

Consistent with the Centers for Medicare & Medicaid Services (CMS) policy and the Patient Protection and Affordable Care Act (PPACA), the Plan covers medically necessary routine patient care costs provided in connection with your participation in a clinical trial for cancer or other life-threatening diseases or conditions due, as defined by Public Health Service Act, Section 2709. For clinical trial coverage:

- Standard therapies must have not been effective or are inappropriate;
- The Claims Administrator determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An approved clinical trial is a clinical trial that:

- The FDA has approved the drug, device, treatment or procedure to be investigated or has granted it Investigational New Drug (IND) or group c/treatment IND status (this does not apply to procedures and treatments that do not require FDA approval);
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization;
- The trial conforms to standards of the NCI or other, applicable federal organization;
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution; and
- You are treated in accordance with the protocols of that study.

Clinical Trial benefits are subject to all of the terms, conditions, provisions, limitations and exclusions of this Plan including, but not limited to, any precertification and referral requirements.

See [Experimental or Investigational Treatment \(Clinical Trials Therapies\)](#) on page 310 for more information about what this benefit does not cover.

## Additional Covered Expenses

- **Applied Behavioral Analysis (ABA):** Educational therapy for autism, Pervasive Development Disorders (PDD) and other similar disorders.
- **Accidental Injury to Sound Natural Teeth:** Oral and maxillofacial treatment of mouth, jaws and teeth covers:
  - Non-surgical treatment of infections or diseases of the mouth, jaw joints and supporting tissues;
  - Surgery needed to:
    - Treat a fracture, dislocation or wound;
    - Cut out teeth that are partly or completely impacted in the bone of the jaw, teeth that will not erupt through the gum, other teeth that cannot be removed without cutting into bone, the roots of a tooth without removing the entire tooth, cysts, tumors or other diseased tissues;
    - Cut into gums and tissues of the mouth (only covered when not done in connection with the removal, replacement or repair of teeth); and
    - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;
  - Hospital services and supplies received for a stay required because of your condition;
  - Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition natural teeth damaged, lost or removed or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury. The treatment must be completed in the calendar year of the accident or in the next calendar year. If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:
    - The first denture or fixed bridgework to replace lost teeth;
    - The first crown needed to repair each damaged tooth; or
    - An in-mouth appliance used in the first course of orthodontic treatment after the injury.
- **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 [Behavioral Health Program](#), beginning on page 66 for details.
- **Allergy Treatment:** Physician-prescribed testing, treatment and injections for allergies. Exclusions apply, see page 87.

- **Ambulance:** Benefits are based on billed charges, including, if medically necessary, 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 safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.
- **Ambulatory Surgery (outpatient):** Professional services and facility fees for outpatient surgery. Aetna Personal Health Advocate precertification is required, see page 58.
- **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 negotiated network fee or recognized charge 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. Aetna Personal Health Advocate precertification is required for rental or purchase in an amount greater than \$1,000.
- **Chiropractic (Spinal Manipulation) Treatment:** Manipulative (adjustive) treatment or other physical treatment for conditions caused by or related to biomechanical or nerve conduction disorders of the spine, by a physician or doctor of chiropractic medicine on an outpatient basis. Limited to 20 office visits per calendar year, network and out-of-network combined. Specialist office visit benefit applies.
- **Contraceptives:** Physician-administered contraceptives such as IUDs, Norplant implants and progestin injections to prevent conception. Excludes prescription contraceptives; for prescription contraceptives, see [What's Covered](#) on page 113.
- **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 under the Medical Plan 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 Medical Plan, but may be eligible for coverage under the Dental 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. Aetna Personal Health Advocate precertification is required, see page 58.
- **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 and Surgical Equipment:** Covered expenses include:
  - Rental of equipment or, in lieu of rental, the initial purchase of equipment if:
    - Long term care is planned; and
    - The equipment cannot be rented or is likely to cost less to purchase than to rent;
  - Repair of purchased equipment (maintenance and repairs needed due to misuse or abuse are not covered); and
  - Replacement of purchased equipment if:
    - The replacement is needed because of a change in your physical condition; and
    - It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The Plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. Covered equipment includes those items covered by Medicare unless otherwise excluded by this Plan. The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item that can be safely and effectively provided. The decision to rent or purchase is at the discretion of the Claims Administrator. Aetna Personal Health Advocate precertification is required for rental or purchase of \$1,000 or more, see page 58.

- **Experimental or Investigational Treatment (Clinical Trials Therapies):** Clinical trials are covered as described in [Clinical Trials](#), on page 79. This coverage does not cover:
  - Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
  - Services and supplies provided by the trial sponsor without charge to you; and
  - The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with the Claims Administrator’s claim policies).
- **Eye Examinations:** Non-refractive examination of the eye performed by an eligible provider due to an injury or illness performed at a hospital, or at a physician’s office. See [Vision Plan](#), beginning on page 131, 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 135, the Medical Plan benefit is secondary.
- **Gastric Bypass:** If medically necessary, gastroplasty, lap banding, and bypass that is approved pursuant to procedures maintained by the Claims Administrator (see [Obesity Treatment](#) on page 84 for more information). Aetna Personal Health Advocate precertification is required, see page 58.
- **Hearing Aids:** Costs for purchase of hearing aids, limited to one pair of hearing aids every two years. Coverage includes cleaning, checking and repairing of hearing aids. No frequency limit applies. Expenses incurred for hearing aids within 30 days of termination of coverage are considered covered hearing care expenses if during the 30 days before the date coverage ends the prescription for the hearing aid was written and the hearing aid was ordered.
- **Hearing Examinations:** Routine hearing exams/care performed by an eligible provider. Limited to one examination during any 24-month period.
- **Home Health Care:** Specified health care services performed in the home that must be:
  - Prescribed by a physician;
  - Provided by a licensed agency;
  - For medically necessary care under a home health care plan; and
  - For the same or a related condition that caused a hospital confinement or in lieu of a hospital confinement.

Benefits limited to 120 visits per calendar year; visits for up to 10 days after inpatient care do not apply toward this limit. Aetna Personal Health Advocate precertification is required, see page 58. Custodial care is not a covered service.

- **Hospice Benefits** (for out-of-network treatment paid at network level): An organization or facility that provides for the physical and psychological aspects of caring for the terminally ill, including bereavement counseling, as part of a hospice care program. Services must be provided through a hospital or other licensed facility, home health care agency or hospice. To qualify, you or your covered dependent must be terminally ill and have a life expectancy of six months or less. Aetna Personal Health Advocate precertification is required.

- **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.) Aetna Personal Health Advocate precertification is required, see page 58.
- **Hospital — Outpatient:** Charges made by a hospital for outpatient treatment, such as outpatient surgery. Aetna Personal Health Advocate precertification is required in some cases, see page 58.
- **Hospital — Emergency Room, ER Physician:** Charges made by a hospital or ER physician for emergency treatment. If an out-of-network provider bills for amounts above the recognized charge, contact Aetna Member Services at 800-626-1987 to have your claim reprocessed, so you will not have to pay those additional charges.
- **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.
 Aetna Personal Health Advocate precertification is required, see page 58.
- **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.

Hospital and physician charges for surgical treatment of morbid obesity are also 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.
- 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 therapy and speech therapy, are limited to 120 visits per calendar year.
- **Oral Surgery:** Surgery for the treatment of fractures or dislocations of the jaw or the cutting procedures of the mouth.
- **Orthognathic Surgery:** Surgery to alter relationships of dental arches and/or supporting bones, usually accomplished with orthodontic therapy. Surgery and postoperative therapy. Covered expenses include charges made for treatment of a congenital cleft lip or palate, or of a condition related to the cleft lip or palate. Aetna Personal Health Advocate precertification is required, see page 58. **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 120 visits per calendar year.
- **Prescription Medicine:** Charges for drugs prescribed by a physician and dispensed in an inpatient setting, outpatient hospital or surgicenter. If network negotiated fee (network) or recognized charge (out-of-network) is not available, benefit is based on average wholesale price of the drug. Certain specialty drugs must be purchased through [CVS Caremark Specialty Pharmacy Services](#) to be covered (see page 109 for details).
- **Private Duty Nursing (Skilled Nursing Care):** Outpatient nursing care when the attending physician states in writing that the care is necessary; covered up to a maximum of 120 visits per calendar year. Private duty nursing care must be provided by a registered nurse or licensed practical nurse. The services provided must be for treatment, not for custodial care.

- **Radiation Therapy and Chemotherapy:** Coverage for radiation therapy (X-ray, radium and radioactive isotope treatment) and chemotherapy. If network negotiated fee (network) or recognized charge (out-of-network) is not available, benefit is based on average wholesale price of the drug. Certain specialty drugs must be purchased through [CVS Caremark Specialty Pharmacy Services](#) to be covered (see page 109 for details).
- **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. See the [Preventive Care](#) section on page 69 for more information.
- **Sleep Studies:** Diagnostic testing for the determination of sleep disorders. Aetna Personal Health Advocate precertification is required, see page 58.
- **Speech Therapy (Short-Term Rehabilitation Therapy Services):** Speech therapy by a licensed and registered therapist, provided the physician who prescribed it regularly reviews the treatment. Benefits, combined with occupational therapy and physical therapy, are limited to 120 visits per calendar year.
- **Sterilization:** Routine sterilization, including vasectomy and tubal ligation for the employee and covered spouse/domestic partner, but not reversal of such procedure.
- **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. See page 58 for rules that apply when the surgical assistant is an [ancillary provider](#) (see page 58).
- **Temporomandibular Joint Disorder (TMD, formerly TMJ) Treatment:** Surgical treatment of temporomandibular joint (TMJ) dysfunction (or similar disorder of the jaw joint) or myofascial pain dysfunction (MPD), or any similar disorder in the relationship between the jaw joint and the related muscles and nerves. Aetna Personal Health Advocate precertification is required, see page 58. **Note:** Non-surgical treatment is not covered under this benefit.
- **Tobacco Cessation Programs:** Physician-prescribed and regularly reviewed medical treatment and prescription medicines provided as part of a tobacco cessation program. Coverage includes preventive counseling visits, treatment visits and class visits to aid in ceasing the use of tobacco products. Annual maximum benefit is two 12-week cycles of treatment.

- **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

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

- **Abortion:** Abortion, except when medically necessary to preserve the mother's health and a physician documents such medical necessity.
- **Allergy Treatment:** Except as provided in [What's Covered](#) (beginning on page 80), specific non-standard allergy services and supplies, including, but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.
- **Behavioral Health Services:**
  - Alcoholism or substance use disorder rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for detoxification or treatment of alcoholism or substance use disorder is specifically listed as covered by the Plan;
  - Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field;
  - Treatment of impulse control disorders, such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use;
  - Treatment of antisocial personality disorder;
  - Treatment in wilderness programs or other similar programs; and
  - Treatment of mental retardation, defects and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in [What's Covered](#), beginning on page 69.
- **Charges for Completion of Forms:** Any charge by a provider for completion of forms.
- **Charges for Missed Appointments:** Any charge by a provider for missed appointments.
- **Charges for Which You Are Not Liable:** Any charge for services that you or covered dependents are not legally required to pay.

- **Cosmetic or Plastic Surgery or Treatment:** Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
  - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
  - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
  - Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
  - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants), except removal of an implant will be covered when medically necessary;
  - Removal of tattoos, except tattoos applied to assist in covered medical treatments, such as markers for radiation therapy;
  - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
  - Surgery to correct gynecomastia;
  - Breast augmentation; and
  - Otoplasty.
- **Custodial Care:** Non-medical services, supplies and treatment to train or assist you or your covered dependents with personal hygiene or other daily living activities.
- **Dental Services:** Any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums and other structures supporting the teeth. This includes, but is not limited to:
  - Services of dentists, oral surgeons, dental hygienists and orthodontists, including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
  - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards and other devices to protect, replace or reposition teeth; and
  - Non-surgical treatment to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and odontogenic cysts.

- **Educational Services:** Educational services include:
  - Any services or supplies related to education, training or retraining services or testing, including special education, remedial education, job training and job hardening programs;
  - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders (including pervasive developmental disorders), training or cognitive rehabilitation, regardless of the underlying cause; and
  - Services, treatment and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.
- **Equipment:** Costs related to the purchase, maintenance or repair of durable equipment such as wheelchair locking devices for vans, electronic dust filters, air conditioners, humidifiers, exercise equipment or conveyance equipment that may be used by other family members of the patient in the absence of illness or injury. Also, rental costs in excess of the purchase price, costs for deluxe durable equipment, maintenance and most repairs of medical equipment, or rental cars.
- **Excessive Charges:** Charges by a network provider in excess of the provider's negotiated network fee, or charges by an out-of-network provider that are in excess of the recognized charge.
- **Experimental or Investigational:** Experimental or investigational drugs, devices, treatments or procedures, as defined by the Claims Administrator (see [Experimental or Investigational Care](#) on page 310), except as specifically covered by the Plan (see [Experimental or Investigational Treatment](#) beginning on page 83).
- **Experimental Surgery:** Experimental surgery and experimental organ transplants, as determined by the Claims Administrator.
- **Fast ForWord:** Acoustic and neural processing computer training program for speech improvement and any similar hearing or speech training program.
- **Governmental Plans:** Expenses paid by any governmental plan or law when coverage is not limited to the government's civilian employees and their dependents.
- **Incarceration:** Expenses incurred while incarcerated or in a penal institution.
- **Infertility:** Unless noted otherwise, infertility services not covered by the Plan include:
  - ART services for a female attempting to become pregnant who has not had at least one year or more of timed, unprotected coitus or 12 cycles of artificial insemination (if under age 35) or six months or more of timed, unprotected coitus or six cycles of artificial insemination (if age 35 or older) before enrolling in the infertility program;
  - ART services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
  - Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle;
  - Purchase of donor sperm and storage, eggs and charges for egg donation and retrieval;
  - Charges for gestational carriers or surrogacy;

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos;
- Home ovulation prediction kits;
- Reversal of sterilization surgery;
- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to, menotropins, hCG, GnRH agonists and IVIG;
- Any services or supplies provided without precertification from Aetna’s infertility case management unit;
- Infertility services that are not reasonably likely to result in success; and
- Ovulation induction and intrauterine insemination services if you are not infertile.
- **Lab Services:** Home test kits, over-the-counter (OTC) lab tests and lab services not prescribed by an eligible physician.
- **Long-Term Residential Treatment and Care:** Long-term residential treatment and care provided in a residential treatment center (except as covered under the Behavioral Health Program).
- **Military Service-Related Injury or Illness:** are for conditions related to current or previous military service.
- **Motor Vehicle Accidents:** Charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.
- **Non-Approved Treatment, Service or Product:** Any service, treatment or product not approved by the Food and Drug Administration or not considered standard medical practice by the American Medical Association.
- **Non-Covered Newborns:** Nursery and any medical expenses for any non-covered newborn dependent (for example, a child of your covered dependent child), except for delivery and postnatal care while the mother is hospitalized for covered maternity care.
- **Non-Covered Providers:** Expenses for care or treatment provided by or ordered by a non-licensed acupuncturist, a certified doula, herbalist, holistic health practitioner, massage therapist/practitioner, non-nurse midwife, operating room technician, oral facial myologist or surgical technologist, Christian Science practitioner, doctor of oriental medicine, emergency medical technician, holistic nurse, homeopathic doctor, hypnotherapist, myotherapist, naturopathic doctor or registered kinesiotherapist.
- **Non-Covered Treatment:** Expenses for complications arising from or related to any non-covered treatment.
- **Non-Emergency:** Any non-emergency charges incurred outside the U.S. if you traveled to another location to obtain medical services, prescription drugs or supplies, even if otherwise covered by the Plan. This includes prescription drugs or supplies if the prescription drug or supply is unavailable or illegal in the U.S. or the purchase of the drug or supply outside the U.S. is considered illegal.
- **Non-Licensed Professional Services:** Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider’s license.

- **Non-Professional Practices:** Services or supplies not provided according to accepted medical or professional standards or practices.
- **Nursing or Rest Home:** Medical care or treatment, services or supplies provided by a nursing home, rest home, convalescent home or similar place, except as specifically provided in the Plans.
- **Out-of-Network Care under the Choice Plus Plan:** Treatment, services or supplies provided by out-of-network providers when covered under the Choice Plus Plan, except as specifically provided as covered in the [Emergency Services](#) section on page 58.
- **Paternity Testing:** Tests performed to establish the paternity of a child.
- **Preimplantation Genetic Screening (PGS) and Embryonic Genetic Screening/Testing:** PGS (i.e., screening embryos for chromosomal abnormalities in the absence of specific inherited genetic conditions identified in either parent), including embryonic genetic screening/testing, is considered experimental and investigational and is not covered. Services not covered include preimplantation genetic screening and comprehensive chromosome screening of polar bodies and blastocysts to enhance delivery rates in advanced reproductive technologies and Aneuploidy Screening (AS) in the setting of PGS (PGD-AS) to optimize IVF outcomes in women with advanced maternal age, history of failed IVF cycles or recurrent miscarriages in the absence of inherited genetic abnormalities.
- **Radiology:** Radiology services not prescribed by an eligible physician.
- **Replacement of Lost or Stolen Supplies:** Replacement of lost or stolen supplies, such as casts, dressings or prosthetic appliances.
- **Reversals of Surgery:** Charges for reversal of a surgical procedure.
- **Routine Scans:** Routine scans such as heart, lung and body.
- **Services Payable Under Any Other Plan or Program:** Any medical service that is payable outside of NXP's Plans.
- **Sex Change:** Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
  - Surgical procedures to alter the appearance or function of the body;
  - Hormones and hormone therapy;
  - Prosthetic devices; and
  - Medical or psychological counseling.
- **Sexual Dysfunction/Enhancement:** Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ; and
  - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
- **Standard (Over-the-Counter) Stock Orthopedic Shoes:** Shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.

- **Surgery Assist:** Services of assisting individuals that are not considered medically necessary or for surgical procedures that do not require the use of a surgical assistant.
- **Telephone Consultation:** Consultations with physicians or other providers except for pre-screening in the Maternity Care program and urgent care and emergency treatment for behavioral health or chemical dependency.
- **Third Party Responsibilities:** Expenses for services or supplies that, in the opinion of the Claims Administrator or its authorized representative, are associated with injuries, illness or conditions suffered due to the acts or omissions of a third party.
- **Transplant:** The Transplant Services program **does not** pay benefits for:
  - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
  - Services covered under any other part of this Plan;
  - Services and supplies provided to a donor when the recipient is not covered under this Plan;
  - Home infusion therapy after the transplant occurrence;
  - Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
  - Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness; and
  - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

Some of these services or supplies may, however, be covered by other provisions of the Medical Plan. If you have questions about how a specific service or supply is covered, contact Aetna Member Services at 800-626-1987.

- **Undocumented Expenses:** Expenses for service or supply claims for which written documentation is not provided to the Claims Administrator.
- **Vision:** Services to treat errors of refraction.
- **Weight:** Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, except as specifically provided in the What's Covered section, including but not limited to:
  - Liposuction, banding, gastric stapling, surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
  - Counseling, coaching, training, hypnosis or other forms of therapy; and
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

- **Wigs and Hairpieces:** Any wig or hairpiece in connection with any physiologic change as part of the aging process or hereditary factors.
- **Wilbarger Protocol:** A form of therapeutic treatment that includes a defined brushing technique for children and adults with sensory defensiveness.
- **Work-Related Injury or Illness:** Any illness or injury related to employment or self-employment, including any illness or injury that arises out of, or in the course of, any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement is considered available to you even if you waive your right to payment from that source. If you are also covered under a workers' compensation law or similar law and submit proof that you are not covered for a particular illness or injury under that law that illness or injury is considered non-occupational regardless of cause.

## **Medical Program Compliance**

### **Maternity or Newborn Infant Coverage**

In compliance with 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)

- **Pre-Existing Condition Limitations:** The Plan does not include any pre-existing condition exclusions. A pre-existing condition is an illness or condition you had before you were under the Plan.
- **Lifetime Limits:** There are no dollar limits on the amount the Plan will pay for essential health benefits, as defined by the ACA. However, the Plan may impose non-dollar limits, such as day or visit limits, consistent with other ACA guidance, on essential health benefits as long as they comply with other applicable statutory provisions. Additionally, the Plan may impose dollar limits on benefits that are not defined by the ACA as essential health benefits.
- **Primary Care Physicians:** You have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you or your family members. In addition, for children, you may designate a pediatrician as the primary care provider.
- **OB/GYN Services:** You do not need precertification for obstetrical or gynecological care from a network health care professional who specializes in obstetrics or gynecology. However, the health care professional may be required to comply with certain procedures, such as requesting precertification for certain services
- **Preventive Care:** The Plan provides preventive care at 100%, with no deductible required when you use network providers. Preventive care provided at 100% is subject to age and/or gender guidelines of the United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA). In addition to preventive procedures, some medications are included as preventive services; however, these medications do require a prescription.
- **Emergency Services:** The Plan does not require precertification for emergency services (as described in the [Emergency Services](#) section on page 58) or require higher copayments or coinsurance for out-of-network emergency services. While copayments and coinsurance are the same for network and out-of-network emergency services, out-of-network providers may bill you for the balance of the out-of-network provider rate over the amount the Plan pays. Remember that the Choice Plus Plan provides network benefits only; except for emergency services.
- **Rescission of Coverage:** Once you or a dependent are covered under this Plan, a retroactive termination (that is, a rescission) is prohibited unless you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact, as prohibited by Plan terms.
- **Health Insurance Consumer Information:** Each state designates an independent office for health insurance consumer assistance (ombudsman). This office is available to work directly or in coordination with insurance regulators and consumer assistance organizations in your state to respond to complaints and inquiries about federal insurance requirements and state law. If you receive a denial on a claim or appeal, the determination notice will include contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes

## 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 286.

## Health Savings Account (HSA)

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The Medical Savings Plan coverage option is a High Deductible Health Plan with a Health Savings Account (HSA).

An HSA is designed to help you pay for eligible expenses now or you can build savings for future medical expenses. There is no “use it or lose it” rule with HSAs, which means you can carry over any unused HSA balance from year to year. Plus, you can take the money with you if you retire or leave NXP.

When you enroll in the Medical Savings Plan with HSA coverage option, Alight Solutions, the Plan Administrator, establishes an HSA with an HSA bank in your name. NXP contributes to your HSA. In addition, you have the option to make pre-tax contributions to your HSA, up to federal limits. And — your HSA earns interest, tax-free.

You can use your HSA to pay for qualified medical expenses that you are required to pay out of pocket, such as expenses that apply toward meeting your deductible or qualified expenses not covered under the Plan. You may also use your HSA to pay for, among other things, certain qualified medical expenses not covered under the Plan. As long as you use your HSA for qualified medical expenses, you pay with tax-free dollars. Contributions go into your HSA pre-tax and you pay qualified medical expenses pre-tax. Amounts may be distributed from the HSA to pay nonmedical expenses; however, these amounts are subject to federal, state or local income tax and may be subject to a 20% penalty.

You must be covered under NXP’s Aetna Medical Savings Plan to be eligible for HSA contributions. The HSA is not available under the Aetna Choice Plus Plan, Choice Plan or Out-of-Area coverage options.

The federal government regulates HSAs, which means there are certain eligibility requirements, restrictions and tax considerations. These provisions affect administration of your HSA and specific benefit provisions. To help you make an informed choice, detailed information will be provided in the enrollment materials that you receive when you are eligible and annually thereafter. Because HSA laws change frequently, the most up-to-date information will be included in your open enrollment materials each year.

### HSA Highlights

- Once money is deposited into your HSA, it is yours — even when you are no longer eligible for coverage under this Plan; any unused balance rolls over from year to year.
- You may elect to contribute to your HSA; you can start, change or stop your contributions at any time (however, changes are effective the first of the following month). You also can contribute different amounts from one year to the next (up to IRS limits).
- Contributions made to your HSA, and any earnings on those contributions, grow tax-free (under federal tax law)—that means your HSA gains interest, and that interest is not taxable as long as you use the money to pay for eligible expenses and you do not contribute more to your HSA than allowed by law.

- If you do not use all the money in your HSA, your HSA balance continues to grow each year. You can use this money in years when you have larger health care expenses, or in retirement.
- You may direct the investment of the money in your HSA (certain fees may apply).
- You can continue to use your HSA to pay for qualified health care expenses, tax-free, when you are no longer eligible under this Plan.
- If you die, your HSA may be transferred to your designated beneficiary. The HSA will continue to be considered an HSA for your spouse. You may designate other beneficiaries (other than your spouse); however, it will no longer be considered an HSA and they will be required to pay taxes on the HSA.
- Money in your HSA may be considered part of your assets when going through divorce proceedings. Therefore, your HSA may be subject to division under the terms of the divorce or a Qualified Domestic Relations Order. If an ex-spouse receives a portion of your HSA, that money is taxable income to your ex-spouse.

## HSA Eligibility

While eligibility for the Medical Savings Plan with HSA is the same as other coverage options, there are certain restrictions as to whether or not you can participate in this coverage option. To enroll:

- You cannot be covered under any other type of health insurance coverage (as an individual, spouse or dependent, including a spouse's Healthcare Flexible Spending Account), unless the other coverage is a High Deductible Health Plan or other permitted insurance. Coverage under an ancillary plan, such as vision or dental or any other permitted insurance as defined by the IRS, is not considered as impermissible.
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be entitled to Medicare due to disability, end-stage renal disease or age, which means that you are age 65 or older and enrolled for or receiving Social Security and/or Medicare benefits. If contributions are made to a Health Savings Account when you are entitled to Medicare, the contributions will be considered taxable income and there may be tax penalties. For those eligible for Medicare, you must decline Part A, Part B and Part D to be eligible to make a contribution to an HSA.

If you are eligible for Medicare, you may be eligible for this coverage option if you are actively working and not receiving (or have not applied for) Social Security and/or Medicare benefits.

Eligibility for HSA contributions continue on a month-by-month basis, as long as you are eligible for this coverage option, do not become covered under another plan that would otherwise make you ineligible or fail to meet any other requirements described above.

## HSA and FSAs, MSAs and HRAs

If you are covered under the Medical Savings Plan with HSA, you (and any of your dependents covered under this coverage option, including your spouse) cannot also have coverage for the same expenses under a:

- Health Care Flexible Spending Account (FSA), except a limited use health care FSA (see [Limited Use Health Care Flexible Spending Account](#));
- Medical Savings Account (MSA); or
- Health Reimbursement Account (HRA).

**Limited Use Health Care Flexible Spending Account:** To help pay other eligible expenses, such as dental and vision expenses, with pre-tax dollars, you may enroll in the Limited Use Health Care FSA.

You should consult with a tax advisor or other qualified professional if you or a dependent have coverage under another health care FSA, MSA or HRA.

## Adult Children

While the NXP Medical Plan covers adult children up to age 26, the IRS has not changed the definition of a dependent eligible for reimbursement from an HSA. This means that you can only use your HSA if your child meets the IRS's definition of a qualifying child. A qualifying child is a daughter, son, stepchild, sibling, stepsibling or any descendant of these who:

- Has the same principal residence as you for more than one-half of the taxable year;
- Has not provided more than one-half of his or her own support during the taxable year;
- Is not yet age 19 (or, if a student, not yet age 24) at the end of the tax year or is permanently and totally disabled.

If you cannot claim the child as a dependent on your tax return, you cannot use your HSA for services provided for that child.

Alternatively, if you can claim an individual as your dependent on your tax return, you may use your HSA for that individual's eligible expenses, even if he or she is not covered under NXP's Medical Plan.

It is your responsibility to determine if an expense is eligible for payment from your HSA. Since NXP cannot offer you any tax or legal advice, you may want to consult with a tax advisor or other qualified professional if you have any questions about a child's expenses.

## ***Domestic Partners***

The same eligibility rules apply to a domestic partner as anyone else for opening an HSA. If the domestic partner meets the HSA eligibility requirements, he or she would be eligible to open an HSA. Furthermore, since domestic partners are not considered spouses by the IRS, domestic partners are considered to be two unattached individuals, and each would have their own HSA contribution limit if they both have HSAs. However, domestic partners cannot use their HSA to pay for their partner's health expenses, unless they claim their partner as a federal tax dependent. Individuals who can be claimed as dependents on another person's tax return are not eligible to open their own HSA.

## Establishing an Account

When you enroll in the Medical Savings Plan with HSA coverage option, NXP works with the Plan Administrator to establish an account in your name with an HSA bank.

You will also receive an HSA debit card that you can use to pay for eligible expenses; see [Accessing and Using Your HSA](#) on page 101 for more information.

There are fees associated with these accounts. NXP pays the initial set-up fee and monthly account fee while you are covered under the Plan. Any other fees are your responsibility, including any fees related to investing your HSA and any monthly fees once you are no longer covered under NXP's Plan. HSAs are standard bank accounts and as such are subject to standard risk and customer due diligence screening both before being opened and during the life of the account. In some circumstances, the HSA bank may request additional information from you or the Plan Administrator to open your HSA. It is possible that the HSA bank could decline to open your HSA.

While NXP works with the Plan Administrator and HSA bank to establish an account in your name, you have the option of opening an HSA account with a bank other than the Plan Administrator's HSA bank. However, any start-up fees or extra monthly fees are your responsibility. You will also not be eligible for payroll deductions to another HSA account.

Neither NXP nor the Plan Administrator insures HSAs described in this SPD. Furthermore, an HSA is not subject to ERISA, the federal law that governs the NXP Medical Plan. As a result, you, not NXP, the Plan Administrator or the Plan Administrator's HSA bank, are responsible for how you invest your account. Accordingly, establishment of an HSA is completely voluntary on your part and NXP does not:

- Limit your ability to move your funds to another HSA or impose conditions on usage of HSA funds beyond those allowed under the Internal Revenue Code of 1986. However, NXP will only fund the HSA as part of the Medical Savings Plan.
- Make or influence the investment decisions relating to funds contributed to an HSA.
- Represent that the HSA is an employee welfare benefit plan established or maintained by the employer.

## HSA Contributions

Your HSA contributions are deposited into a federally insured, interest-bearing savings account with the HSA bank.

## NXP Contributions

Each year that you are enrolled in the Medical Savings Plan with HSA, NXP makes a contribution to your HSA. For 2018, NXP's annual contribution is:

- \$500 if you have individual (employee-only) coverage; or
- \$1,000 if you have family (yourself and one or more dependents) coverage.

Contributions for new hires after the first of the plan year are pro-rated.

NXP's contribution to your HSA is not taxable income to you.

NXP makes a lump sum contribution to your HSA at the beginning of the year or within one month of your enrollment date if you enroll during the year.

Federal regulations do not allow contributions to an HSA and/or Limited Use Health Care Flexible Spending Account and a standard Health Care Flexible Spending Account during the same year. If you enroll in the High Deductible Health Plan, such as the NXP Medical Savings Plan, at any time other than during annual enrollment or when you are first eligible (such as changing from the Choice Plus to the Medical Savings Plan due to moving), no contribution will be made to your account if you were contributing to a Health Care Flexible Spending Account.

## Your Contributions

In addition to NXP's contribution, you can also contribute to your HSA. You choose how and when you want to contribute. You can:

- Have contributions automatically deducted from your pay on a pre-tax basis over the course of the calendar year (reducing your taxable income);
- Make a direct, after-tax, contribution to your HSA and take a deduction on your income tax return; or
- Both.

In addition, you can make a one-time direct trustee-to-trustee transfer from your IRA (other than a Simple IRA or a SEP IRA) to your HSA. The most you can transfer is the maximum HSA contribution limitation for the year. The amount transferred is not included in your income, is not deductible and reduces your HSA contribution limit for the year.

You also choose how much you contribute. However, the IRS sets limits on the maximum amount that may be contributed to an HSA each year. The combined total of NXP's contributions and your HSA contributions cannot exceed IRS limits. For 2018, IRS HSA contribution limits are:

- \$3,450 if you have individual coverage — that means you can contribute up to \$2,950 (\$3,450 limit - \$500 NXP contribution); or
- \$6,900 if you have family coverage — that means you can contribute up to \$5,900 (\$6,900 limit - \$1,000 NXP contribution).

If you contribute more than you are eligible to contribute in a year, you may be responsible for income and excise tax penalties (see [Tax Considerations](#) on page 104 for more information). So, be sure that you do not contribute more than legally allowed, based on the months that you are eligible.

### ***What Happens When HSA Contributions Exceed Legal Limits***

A contribution made by you or NXP to an HSA that exceeds the amount allowed by law, or that is made during any year when you are not eligible to contribute, is called an excess contribution. Excess contributions are not deductible by you or NXP and are included in your gross tax for each year they remain in your HSA. In addition, excess contributions are subject to a 6% excise tax. However, you can avoid the excise tax if you remove the excess contribution from your HSA, together with any net income attributable to the excess contribution, before the due date for filing your federal income tax return, including extensions, for the year for which the excess contribution was made. In this case, the net income attributable to the excess contribution would be taxable as income for the year in which the distribution is made, but, the removed excess contribution would not be taxable as income to you. Rollover contributions do not count in determining whether an excess contribution has been made.

The Plan's HSA bank will return contributions that they believe in good faith would exceed the sum of the maximum annual family contribution plus the catch-up contribution amount as determined by the IRS as soon as administratively possible. Since maximum annual contribution limits may vary depending on whether you have individual or family coverage, you should not rely on the HSA bank to determine if your contributions exceed the maximum annual contribution. The HSA bank will also return contributions when you notify them that you have made an excess contribution. You may be charged a fee if the HSA bank returns a contribution.

Federal regulations do not allow contributions to an HSA and/or Limited Use Health Care Flexible Spending Account and a standard Health Care Flexible Spending Account during the same year (see the [Health Care/Limited Use Health Care Flexible Spending Account \(FSA\)](#) section on page 140).

### ***Catch-Up HSA Contributions***

If you are at least age 55, but not yet age 65 (or otherwise entitled to Medicare), you may make "catch-up" contributions to your HSA each year, up to the IRS limit. The IRS catch-up contribution limit for 2018 is \$1,000, regardless of whether you have individual or family coverage.

## **Accessing and Using Your HSA**

Like any other bank account you have, you own your HSA and have complete access at all times based on your coverage status. You can go online and check your balance, receive balance statements, use your HSA to pay eligible expenses, etc. To access your HSA as an NXP employee visit [NXP.com/rewards](https://www.nxp.com/rewards).

To access your HSA when you no longer work for NXP:

- Upon receiving the appropriate indicator, YSA will send a term notification to the HSA bank at the end of the next month.
- At this point, you are no longer attached to the NXP HSA plan, as provided by YSA.
- Your account is managed via a direct relationship with the HSA bank.
- You will receive a new HSA card, welcome letter, account number, instructions on how to access your account and customer service support number from the HSA bank.

- Standard account fees are charged directly to your account.
- The HSA bank, currently, is UMB Bank. UMB Bank will be listed on the HSA card and welcome letter.

Although NXP's contribution to your HSA is made at one time, as a lump sum contribution, your contributions are made to your account over the course of the year; this means that your entire annual contribution may not be immediately available. So, like a regular bank account, you can only pay eligible expenses up to your account balance. If your eligible health care expenses are more than your account balance, you may need to pay for expenses out of your own pocket and reimburse yourself once your HSA balance grows.

Under federal law, you can use your HSA for anything. However, to avoid taxes and penalties, you should only use your account to pay for qualified medical, prescription drug, dental and vision expenses for you and your eligible dependents.

You may use your HSA, tax-free, to pay for qualified health care expenses for yourself, your spouse and/or your dependents, each as defined by the IRS. When you enroll in Medical Savings Plan with HSA, you will receive your YSA card with more information on how to use the card to access the money in your account to pay for eligible health care expenses. You will also receive a welcome letter from the HSA bank with information on your account and routing numbers. The HSA eligible expenses will be listed on the Your Spending Account "Health Savings Account" page.

To pay for eligible expenses:

- You can use your debit card to pay eligible expenses.
- You can request direct deposit from your HSA directly into a personal checking or savings account at any time to pay for eligible expenses.
- While checks are not offered by the HSA bank, if you would like to make payments by check, you may purchase third-party checks for your HSA.
- You may choose the bill pay option, which directly pays your doctor, hospital or other facility. So, you do not have to do a thing; your claims are paid automatically while there is money in your account.

You have the flexibility to use your account (with NXP's and any of your own contributions) when you want. For example, you may choose to cover your expenses using your own personal funds now and save your HSA balance for medical expenses in future years or in retirement. The balance in your savings account will earn interest.

While you do not need to submit receipts to an administrator for reimbursement, you should save all receipts for expenses paid from your HSA, per IRS rules.

## Eligible Expenses

The HSA is designed to help you pay for qualified medical expenses. In general, qualified medical expenses are non-reimbursed medical, prescription drug, vision, hearing and dental expenses for you and your eligible IRS dependents that you could deduct on your individual tax return.

When you use your HSA to pay qualified health care expenses, the money is not taxed. However, if you pay for an expense through your HSA, you cannot deduct that expense on your individual tax return.

Eligible expenses may include:

- Health care expenses you must pay before you meet your individual or family deductible;
- Coinsurance and copayment amounts;
- Expenses not covered by the Plan but considered eligible medical expenses by the IRS, such as certain prescribed over-the-counter (OTC) medications;
- Expenses in excess of specific Plan limits;
- Additional amounts you pay when you do not use a network provider (for examples, amounts over the recognized charge); and
- Certain coverage costs that you may have when you are not covered under this Plan, such as:
  - Medicare premiums (including Part A, Part B, Part C, Medicare Prescription Drug Coverage) or employer or Plan sponsored health coverage premiums or self-payments once you retire (when you are age 65 or older);
  - COBRA continuation coverage;
  - Coverage you have while you are receiving unemployment compensation benefits;
  - Qualified long-term care insurance contract; and
  - Health plan coverage during a period in which you are receiving unemployment compensation under any federal or state law.

Generally, health insurance may not be purchased with money from your HSA. For example, you cannot use your HSA to pay for coverage while you are employed or for Medigap policies after you retire.

You are responsible for determining if an expense is eligible for payment from your HSA. NXP, the Plan Administrator and/or the HSA bank will not review expenses and cannot offer you any advice. You should keep detailed records of your expenses and payments from your HSA to demonstrate to the IRS that you used the money to pay for eligible expenses. If you use the money in your account to pay for non-eligible expenses, you may have to pay taxes on that money, and in most instances, you may also be subject to a penalty. NXP and the Plan Administrator are not responsible or liable if you misuse HSA funds or if you use HSA funds for nonqualified expenses.

For the most up-to-date listing of expenses eligible for reimbursement from an HSA, go to [irs.gov](https://www.irs.gov), and type "Publication 502" in the Search box. An expense list is also available on the Your Spending Account website.

## Tax Considerations

As long as you use your HSA for eligible expenses, you pay with tax-free dollars. However, there are many rules and tax implications with HSAs, such as:

- Any after-tax contributions you make to your HSA are tax deductible on your federal income tax; however, you cannot deduct NXP's contributions.
- You cannot claim any expenses you pay for with your HSA as a deduction on your tax return.
- While HSA contributions and your Health Savings Account are tax favored for federal tax purposes, HSA contributions and Health Savings Accounts are taxable in Alabama, California and New Jersey. Please check your local state laws for further tax limitations.
- If you use your HSA to pay for non-eligible expenses before age 65 (unless you are disabled), the amount you paid will be treated as ordinary income and be subject to taxes as well as a 20% penalty.
- Contributions that you or NXP makes that exceed IRS annual limits are subject to excise tax and any excess contribution made by NXP is considered taxable income to you; check with a tax advisor for more information.

Since NXP cannot offer you any tax or legal advice, be sure to consult with a tax advisor or other qualified professional if you have any tax questions.

## Prescription Drug Program

As part of the NXP Medical Plan, you and your covered dependents fill your covered prescriptions through the Prescription Drug Program. This program covers medications prescribed by your (or your covered dependent's) doctor as deemed medically necessary by the prescribing doctor and within Federal Drug Administration (FDA) guidelines. Some drugs and medicines are not covered by the program, and certain NXP Plan limitations apply. Contact CVS Caremark Customer Care for information on covered drugs.

You can review the Preferred Drug List and the Generic Drug List online at [Caremark.com](https://www.caremark.com).

All NXP Aetna Medical Plan participants are eligible to use the Prescription Drug Program. There is no need to enroll for these benefits.

### ***Kaiser Permanente Medical***

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on their home address. The HMO is only available if you are in Kaiser's service area. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-464-4000.

## Prescription Drug Benefit Summary

All prescriptions must be filled at a network pharmacy and all benefits are based on negotiated fees.

Type of Prescription Drug	Choice Plus Plan, Choice Plan and Out-of-Area Coverage Options*	Medical Savings Plan Coverage Option**
<b>Retail Pharmacy — up to a 30-day supply</b>		
<b>Generic Drugs</b>	You pay \$5 copayment, Plan pays the rest.	After deductible, you pay 20%, Plan pays the rest.
<b>Preferred Drugs</b>	You pay 30% up to \$75, Plan pays the rest.	After deductible, you pay 20%, Plan pays the rest.
<b>Non-Preferred Drugs</b>	You pay 50% up to \$100, Plan pays the rest.	After deductible, you pay 20%, Plan pays the rest.
<b>Home Delivery Service*** — 90-day supply</b>		
<b>Generic Drugs</b>	You pay \$10 copayment, Plan pays the rest.	After deductible, you pay 20%, Plan pays the rest.
<b>Preferred Drugs</b>	You pay 30% up to \$175, Plan pays the rest.	After deductible, you pay 20%, Plan pays the rest.
<b>Non-Preferred Drugs</b>	You pay 50% up to \$250, Plan pays the rest.	After deductible, you pay 20%, Plan pays the rest.

- \* *The Choice Plus, Choice and Out-of-Area Coverage Plans prescription drug expenses apply toward meeting your medical out-of-pocket maximum.*
- \*\* *The Medical Savings Plan deductible applies to medical and prescription drug expenses and prescription drug expenses apply toward meeting your medical deductible. You must meet your annual medical deductible before the Plan begins to pay for medical and prescription drug expenses. However, generic maintenance medications are available at no cost; for all other generics, you pay 20% after the deductible, as noted above. For the latest list of generic maintenance medications, visit Caremark.com or call CVS Caremark at 877-505-8360.*
- \*\*\* *Required for long-term, maintenance drugs.*

### **Free Nicotine Replacement Drugs**

The Prescription Drug Program includes a special benefit to CVS Caremark plan members: **No-cost nicotine replacement therapy drugs**. When your doctor prescribes a nicotine replacement drug, the Plan pays the full cost of that medicine. There is no copayment or other cost for you to pay. However, benefits are limited to two 12-week cycles or 168 days per year.

## **Prescription Drug Plan Features**

### **Medical Savings Plan Coverage Option**

Here is how the Program works under the Medical Savings Plan coverage option:

- **Deductible:** You must meet your deductible before the Plan begins to pay medical and prescription drug benefits. Amounts you pay for covered prescriptions (and medical expenses) apply toward meeting your deductible. As with your medical benefits, you can use money in your HSA to pay for covered prescription medications. For more information about your deductible, see [Annual Deductible](#) beginning on page 49.
- **Coinsurance:** Once you meet your deductible, you pay 20% of the network negotiated cost of your prescription to the pharmacy, and the Plan pays the rest.

### **Choice Plus Plan, Choice Plan and Out-of-Area Coverage Options**

Here is how the Plan works under the Choice Plus Plan, Choice Plan and Out-of-Area Plan options:

- **Copayment:** You pay only a copayment for generic drugs, as shown in the chart above. You pay your copayment directly to the pharmacy. The Plan pays the remainder of the network negotiated cost of the generic drug.
- **Coinsurance:** For all other covered prescription drugs, you pay a percentage of the network negotiated cost of your prescription, up to the maximums shown in the chart above. If the network negotiated cost of the drug is more than the Plan's coinsurance and your maximum share of the cost, the Plan will pay any remaining cost.

**Example:** Hope has the Choice Plan coverage option. Her doctor prescribes a preferred brand drug with a network negotiated fee of \$280 for a 30-day supply. Here is how Hope and the Plan share the cost of this medicine:

Network negotiated charge	\$ 280
Hope's 30% share	\$ 84
Cap: Hope's actual share	\$ 75
Plan's share (\$280 – \$75)	\$ 205

## Preventive Medications

The Program, which complies with federal legislation, provides certain preventive medications at no cost to you. When your doctor prescribes certain preventive medications, the Plan pays the full cost; there is no copayment or other cost for you to pay. Preventive medications available at no cost with a physician's prescription include:

- Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);
- For infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
- For women, evidence-informed preventive care and screening provided for in the comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

Types of medications included as part of preventive medications include, but are not limited to:

- Aspirin to prevent cardiovascular disease for individuals age 50 to 59;
- Aspirin to prevent morbidity and mortality from preeclampsia for females age 12 to 59 who are capable of pregnancy;
- Oral fluorides for children up to age 5;
- Folic acid supplements for females up to age 55 capable of pregnancy;
- Tobacco cessation products;
- Immunizations (vaccines); limited to specific immunizations depending on gender and age;
- Vitamin D supplements for adults age 65 or older who are at risk for falls in community - dwellings;
- Bowel preparation medications for colorectal cancer screenings for adults age 60 to 74;
- Statins for the primary prevention of cardiovascular disease in adults age 40 to 75; and
- Contraception for females, which may include oral contraceptives, emergency contraceptives, injectables, intrauterine devices, subdermal rods, vaginal rings, transdermal patches, barrier methods, over-the-counter contraceptives and medications for risk reduction of primary breast cancer in women.

If you enroll in the Medical Savings Plan, preventive generic medications (maintenance medications only) are covered at no cost to you.

## Generic Drugs

A generic drug is the chemical copy of a brand name prescription drug. Generic drugs cost about 50% less than brand name drugs and they are:

- Dispensed in the same dosage;

- Taken in the same way; and
- Packaged in the same unit strength.

To help preserve the quality of your health care and help control costs, you are encouraged to use generic drugs whenever they are medically appropriate for your illness or condition. It is standard pharmacy practice to substitute generic equivalents for brand name drugs whenever possible. You will receive generic substitutes unless your physician will not allow it.

If your physician allows a generic and you select a brand name drug, you pay the difference between the generic and brand name drug, in addition to your brand name share of the negotiated charge. If you are enrolled in the Medical Savings Plan this provision applies after you meet your deductible. A Generic Drug List identifying generic drugs covered under the Program is available at [Caremark.com](http://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 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](http://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](http://Caremark.com).

More information on the Step Therapy Program is available online at [Caremark.com](http://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](https://www.caremark.com).

The best way to avoid inconvenience is to have your physician call CVS Caremark's prior authorization department at 888-413-2723 before you go to the pharmacy (this line is not for patient use).

## CVS Caremark Specialty Pharmacy Services

Specialty medications or biotech drugs typically refer to medications made from living sources (e.g. microorganisms, blood cells, proteins), as opposed to traditional drug therapies, which are synthetic. Specialty drugs are often administered by injection by either the patient or the physician. Because biotech drugs are similar to substances found in the human body, they may be more effective in fighting hard-to-treat conditions, such as multiple sclerosis, rheumatoid arthritis and growth hormone deficiency.

CVS Caremark Specialty Pharmacy Services offers specialty medications for a variety of chronic conditions including multiple sclerosis, rheumatoid arthritis, cystic fibrosis, hemophilia, immunologic disorders, Crohn's disease, Gaucher disease, pulmonary hypertension, Fabry disease, MPS 1, blood dyscrasia, growth hormone deficiency, hepatitis C, macular degeneration, infertility, cancer, and more.

If you or a covered dependent has a condition that requires treatment with specialty drugs such as injectable medications, then you must contact Caremark at 800-237-2767 to apply for the Caremark Specialty Guideline Management Program. Clinical specialists at Caremark will discuss treatment options with your physician. When you are approved for the program, you will have direct access to the CVS Caremark Specialty Pharmacy Care Team. Specialty prescriptions must be filled by the Specialty Pharmacy, but in many instances the Specialty Pharmacy will offer you the option to pick up the medicine at a retail CVS pharmacy.

The Caremark Specialty Guideline Management Program supports safe, clinically appropriate and cost-effective use of specialty medications. Their service delivers patient medication within 48 to 72 hours and provides refill and delivery notification calls and easy refill ordering options. The Care Team offers expert care services for participants such as counseling, informative disease-related materials and easy access to health experts 24 hours daily.

Because most specialty drugs require frequent patient care and supervision, it is important for you and your physician to determine the necessary drug treatment plan. Therefore, it is not mandatory for you to refill your specialty medications in 90-day supplies for drugs purchased through the CVS Caremark Specialty Pharmacy Service.

For specialty drugs purchased through CVS Caremark Specialty Pharmacy Service, the length of time covered by your prescription determines your Plan benefits.

- For specialty drug prescriptions you use for 30 days or less, the Plan uses the 30-day retail pharmacy benefit of your coverage option to calculate your benefit.

- 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](https://www.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 charge or a flat copayment for each prescription you purchase through retail or home delivery.

All maintenance prescriptions taken in 90-day supplies must be filled at a CVS retail pharmacy or through the home delivery service. Your doctor may forward your prescription to CVS Caremark by telephone at 800-378-5697 or by fax at 800-378-0323.

### Using a Retail Pharmacy

#### ***Short-Term Prescriptions Only***

You may use a retail network pharmacy for medicines that need to be taken for just a short time. The program has a nationwide network of pharmacies to serve you and your covered dependents. You may fill your original prescription (up to a 30-day supply) and up to two refills at any retail network pharmacy.

Steps to follow:

- Locate a network pharmacy near you by calling 877-505-8360 (TDD: 800-231-4403) or check online at: [Caremark.com](https://www.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.
- Sign the pharmacy's signature log when you receive your prescription, if you are asked to do so.

## **Long-Term Prescriptions Only**

### ***For Maintenance Medications***

Home delivery fulfillment or a CVS retail pharmacy is required for all prescriptions used on a regular basis or for more than 90 days. Through home delivery or a CVS retail pharmacy, your prescription is filled for the exact amount prescribed by your physician (up to the 90-day-supply limit). For home delivery, allow 14 days for receipt of your medicine.

Through the home delivery service, prescriptions are delivered by either the U.S. Postal Service or United Parcel Service. In an emergency, your prescriptions can be shipped overnight for an additional fee. Medications cannot be shipped outside of the United States. If you are planning a trip, have your prescription filled before your departure date.

You have the option to fill a 90-day maintenance medicine prescription at a CVS retail pharmacy, rather than through the home delivery service. Under the Maintenance Choice program, the CVS retail pharmacy will apply the home delivery prescription drug benefits of your coverage option to your 90-day prescription.

Questions about home delivery benefits may be addressed to CVS Caremark at 877-505-8360.

### ***Steps to Follow***

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

### ***Physician Orders by Telephone***

Ask your doctor to call CVS Caremark Home Delivery Service at 800-378-5697 to provide your basic patient health history profile, including any known medication allergies. Your doctor should then fax the prescription to 800-378-0323. This fax line is not for patient use.

### ***Physician Orders by Fax***

Ask your doctor to call CVS Caremark Home Delivery Service at 800-378-5697 for information about the fax program. CVS Caremark Home Delivery Service will fax an order form to the doctor's office. The form includes instructions on how to use the program.

The doctor should include any known medication allergies in the health history section. The form must be faxed directly from the physician's office to the CVS Caremark Home Delivery Service pharmacy at 800-378-0323. This fax line is not for patient use.

### ***Payment for Telephone and Fax Orders***

If your doctor submits your prescription, CVS Caremark Home Delivery Service contacts you to verify your address information and to determine your preferred method of payment. Mail a check (include your prescription plan identification number on your check) for your share of the network negotiated charge or copayment payable to CVS Caremark Home Delivery Service, or provide your credit card number (Visa, MasterCard, American Express or Discover). Please do not send cash.

### ***Does Your Home Delivery Service Require Special Treatment?***

All home delivery prescriptions received by CVS Caremark Home Delivery Service are filled and shipped to you as soon as they are received and processed. If your prescription requires special treatment, such as being held for a period, please call CVS Caremark Home Delivery Service at 877-505-8360 before placing your order by phone, fax or mail.

#### ***Ordering Home Delivery Service by Mail***

To begin home delivery service:

- Online:
  - Go to [Caremark.com](https://www.caremark.com).
  - Select “Start a New Prescription.”
  - Click on “FastStart.”
- By Phone: Call 877-505-8360.
  - Be ready with your prescription ID card, mailing information, long-term medicine, prescription payment method and doctor’s information.

If you transfer a prescription from a retail pharmacy to home delivery, request a new prescription written for a 90-day supply.

To select pharmacy pick-up:

- Online: Register at [Caremark.com](https://www.caremark.com) and select your preferred CVS retail pharmacy.
- In Person: Visit your local CVS pharmacy and talk to a pharmacist.
- 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).
- To order refills online, visit [Caremark.com](https://www.caremark.com).

#### **Drug Utilization and Therapeutic Interchange**

CVS Caremark clinical pharmacists may review your prescription drug use from time to time as part of their drug utilization and therapeutic interchange programs. They may offer suggestions to you and your physicians that can reduce your out-of-pocket expenses with lower-cost drugs or simplified drug therapies. These professionals may also identify potential problems from side effects caused by unnecessary or inefficient prescribing or over- or under-prescribing.

If your physician prescribes a non-preferred brand name drug, CVS Caremark electronically asks your pharmacist to tell you about potential substitute drugs on the Preferred Drug List. With your consent, the pharmacist will contact your physician to get permission to prescribe the substitute medicine. If your physician allows the substitution, you will receive a preferred drug at the preferred drug plan benefit. If not, you will receive the prescribed brand name drug at the non-preferred plan benefit.

## Other Important Facts

You cannot refill a prescription at a retail pharmacy until you have used at least 75% of your current prescription. When filling via mail order, you must use 60 days of the 90-day supply before requesting a refill. For medications with prescription limits, all medication must be used before a refill is requested.

If your physician allows a generic and you select a brand name drug, you pay the difference in price between the generic and brand name drug in addition to your regular share of the negotiated network charge.

If your physician's practice is in Texas, the law requires him or her to hand write "brand necessary" or "brand medically necessary" on prescriptions when he or she feels that generic substitution is not appropriate.

### **ExtraCare® Health Card Saves You Money at CVS**

You can save 20% on regular-priced CVS products with your ExtraCare Health Card. CVS Caremark provides the ExtraCare Health Card to you and your covered family members when you enroll in the Plan. This discount applies to CVS brand health care related items that you buy at a CVS/pharmacy or online at [CVS.com](https://www.cvs.com). See the CVS website for other features of the ExtraCare Health Card.

## What's Covered

Following is a short list of some common drugs that are covered:

- AIDS-related medicines;
- Allergy serum and syringes;
- Blood glucose testing strips and lancets;
- Drugs, biologicals, compound prescriptions or any other medical substance that federal law requires to be dispensed by a qualified pharmacist as prescribed by a physician;
- Fluoride supplements for children through age 18 (limited to two per calendar year);
- Growth hormones;
- Injectables except as otherwise noted;
- Insulin and disposable hypodermic needles and syringes necessary to administer insulin;
- Medicines for precertified treatment of [infertility](#) (see page 74), up to \$4,000 per lifetime;
- Prenatal, pediatric and geriatric vitamins;
- Prescription contraceptives;
- Prescription laxatives;
- Progesterone suppositories;
- Retin-A for patients through age 25 and Retin-A for patients without any age restriction for the treatment of severe acne and acne keratosis;

- Schedule V controlled substances; and
- Smoking deterrents such as nicotine gum and nicotine patches, and medicines for tobacco cessation purposes, such as those covered under the Tobacco Cessation Program.

If you want to find out if a particular drug is covered, call 877-505-8360 (TDD: 800-231-4403).

## What's Not Covered

Following is a list of some common drugs that are not covered under the Program:

- Accutane through mail order (available through retail only);
- Anorexiant;
- Anti-wrinkle agents (e.g., Renova);
- Any retail cost of drugs above the negotiated network fee;
- Cosmetic hair removal products (e.g. Vaniqa);
- Drugs labeled "Caution, limited by federal law to investigational use," or experimental drugs;
- Fluoride supplements for patients older than age 18 (or more than two per year);
- Hair growth stimulants or other medicines for treatment of hair loss;
- Medical devices;
- Mifeprex;
- Norplant;
- Nutritional supplements;
- 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 (see [Preventive Care](#), beginning on page 69);
- 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](https://www.caremark.com).

## /Activity Centers

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### Work Site Wellness Programs

Watch for information at your local U.S. work site about on-site wellness programs that may be available to you. All eligible NXP employees are encouraged to take advantage of work site wellness programs when they are available to them.

- **Onsite Activity Centers:** A fitness and general wellness center available onsite at some U.S. NXP locations.
- **Lactation Rooms:** Dedicated areas for mothers to breast pump while at work.
- **Educational Classes:** Information includes healthy eating, physical activity, resilience and a variety of other topics throughout the year.

### Online Wellness Resources

Visit [AetnaNavigator.com](https://www.aetnavigators.com) for discounts on a variety of quality wellness products, including vitamins, minerals, herbal supplements, sports nutrition products, health-related books and videos, skin care products and more. You must be registered to use this website.

### Enrollment in an NXP Onsite Activity Center

Some U.S. NXP offices have access to an onsite NXP Activity Center. As an NXP employee, you are eligible for a paid membership in an NXP Activity Center, or reimbursement up to \$240 (less applicable taxes) annually for membership in an eligible non-NXP fitness center, or for approved fitness, sports or health education-related activities of your choice.

If you join an NXP Activity Center in the U.S., NXP pays the entire cost of your membership. Membership in one NXP Activity Center gives you access to all other centers if you live near more than one facility or travel to other company locations. You are responsible for paying any additional expenses, such as locker rental. Your spouse/domestic partner may join an NXP Activity Center, but his or her enrollment fees are not paid by NXP.

Membership at an NXP Activity Center renews automatically each January 1, unless you cancel it during the annual Activity Center withdrawal period every December; specific dates are communicated each year through the Activity Center member newsletter and flyers posted in the Activity Center, café, and approved NXP bulletin boards. To cancel your membership, complete a cancellation form at your local Activity Center, or your membership will automatically renew. If you miss the disenrollment deadline because you were traveling out of the country, you may appeal; see your Activity Center manager to inquire about the appeals process.

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

You are eligible for one membership each calendar year at either an onsite NXP Activity Center or a fitness center of your choice, including one abroad.

If you join an onsite NXP Activity Center, NXP pays the entire cost of your membership automatically each calendar year. If you join a fitness center (including one abroad), NXP reimburses you for up to U.S. \$240 (less applicable taxes) of your annual fitness center membership costs.

If you have any questions, contact your onsite NXP Activity Center or call NXP Rewards Customer Service at 888-375-2367.

A physician's release may be required for enrollment if two or more risk factors are present. Risk factors may be identified during the voluntary enrollment interview process and are based on risk factor guidelines set forth by the American College of Sports Medicine. Examples of risk factors include certain diseases or conditions, family history, medications and symptoms. For more information, contact your onsite NXP Activity Center.

### ***If You Retire***

You will be eligible to join as a retiree and pay the applicable membership rate, if you:

- Terminate employment with NXP; and
- Are eligible for a "NXP Activity Center Retiree Membership" because you meet the eligibility requirements for retiree health care benefits (i.e., Rule of 75).

You may re-enroll as a "spouse/domestic partner" and pay the applicable membership rate at selected locations if you:

- Terminate employment with NXP;
- Are a member of an NXP Activity Center; and
- Are a spouse/domestic partner of another NXP employee who is an NXP Activity Center member.

### **When Membership Ends**

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

- Terminate employment with NXP;
- Are a member of an NXP Activity Center;
- Are not eligible for an "NXP Activity Center Retiree Membership" because you do not meet the eligibility requirements for retiree health care benefits (i.e. Rule of 75); and
- Are not a spouse/domestic partner of another NXP employee who is an NXP Activity Center member

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.

### **Enrollment in a Fitness Center, Other than an Onsite Activity Center**

If you join a fitness center (other than an onsite NXP Activity Center), including one outside the U.S., NXP reimburses you for up to \$240 (less applicable taxes) of your annual fitness center membership costs.

An eligible facility must provide the opportunity to improve the following measurable elements of health-related physical fitness:

- Cardiovascular endurance;

- Body composition; and
- Musculoskeletal fitness.

For more information on what wellness activities are considered eligible for reimbursement, call NXP Rewards Customer Service at 888-375-2367.

Examples of fitness centers include YMCA, Gold's Gym, Bally's, Club One, LA Fitness or other professionally run fitness centers.

### ***Eligible Expenses***

Membership fees for the NXP employee are the only expense eligible for reimbursement, up to a maximum of \$240 (less applicable taxes). All additional fees, such as locker rental, are not eligible.

### **Other Eligible Wellness Activities**

You may choose to participate in other fitness, sports or health education-related activities, rather than joining a fitness center. You may be reimbursed for up to \$240 (less applicable taxes) per year for the cost of these approved activities.

### **Eligible Expenses**

To be eligible for reimbursement, you must participate in an approved fitness, sports or health education-related activity.

Fitness or sports activities must provide the opportunity to improve these elements of health-related physical fitness: Cardiovascular endurance, body composition and musculoskeletal fitness.

Examples of eligible fitness or sports activities include:

- Organized community activities such as recreational sports leagues and classes (i.e., aerobics, martial arts, basketball, volleyball or soccer); and
- Individual sports such as running, triathlon, cycling and swimming.

Examples of eligible health education-related activities include:

- Cardiovascular health classes;
- Cancer prevention classes;
- CPR and first aid training;
- Stress management;
- Tobacco cessation programs; and
- Weight management.

## Expenses That Are Not Eligible

Expenses for items such as health food and supplements, sports apparel and sports equipment are not eligible for reimbursement. Also, sports that are considered high-risk activities are not eligible for reimbursement, for example: skiing or snowboarding, skydiving, sports involving the use of firearms and horseback riding.

## Reimbursement for Fitness Centers and Activities

If you join a fitness center or participate in other eligible wellness activities, you submit your reimbursement requests online. To submit a reimbursement request visit [NXP.com/rewards](https://www.nxp.com/rewards).

Keep a copy of your receipts for your records. Receipts and other documentation should be in English. Receipts must include:

- Your name;
- Name of service provider, facility or retailer;
- Date of service or purchase;
- Identification of product or description of service;
- Purchase amount for each product or service in U.S. dollars; and
- Total purchase amount in U.S. dollars.

Incomplete claims cannot be processed. Please include all necessary documentation no later than March 31 of the following year.

Once your claim and receipts are received, a decision will be made within five days. If approved, a reimbursement from your account will be submitted to you through payroll. You will see the reimbursement included on your paycheck, listed as "Other Taxable."

You are reimbursed for up to \$240 (less applicable taxes) per year in membership costs for a non-NXP facility (or, for domestic employees only, for other eligible activities). Once approved, the amount will be reimbursed through your paycheck.

## Deadline

You have until March 31 of the following plan year to submit wellness reimbursement expenses for the prior year.

## NXP Dental Plan

Regular dental care is important to maintaining good health. That's why NXP offers the Dental Plan. Regardless of your medical choice, you can choose cost-effective dental coverage. The Dental Plan is offered to all eligible employees and their eligible dependents.

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

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

## Dental Benefits Summary

<b>Dental Carrier</b>	MetLife Dental
<b><u>Annual Deductible</u></b>	<b>Individual:</b> \$100 <b>Family:</b> \$300
<b><u>Annual Maximum Benefit</u></b>	\$2,000 per person in combined preventive, basic, major and prosthodontic benefits.
<b><u>Preventive Services</u></b>	Plan pays 100% of predetermined charge (network) or R&C charge (out-of-network), no deductible.
<b><u>Basic Services</u></b>	Plan pays 80% of predetermined charge (network) or R&C charge (out-of-network), after deductible.
<b><u>Major Services</u></b>	Plan pays 50% of predetermined charge (network) or R&C charge (out-of-network), after deductible.
<b><u>Prosthodontic Services</u></b>	Plan pays 50% of predetermined charge (network) or R&C charge (out-of-network), after deductible.
<b><u>Orthodontic Services</u></b>	80% of predetermined charge (network) or R&C charge (out-of-network), after deductible, up to \$2,000 per person per lifetime, includes benefits paid under any current or former NXP, Freescale or Motorola dental plan.

### ***Reasonable and Customary(R&C) Charge***

As noted above, the Dental Plan pays out-of-network benefits based on the [reasonable and customary charge](#), as defined on page 319.

## Dental Plan Features

### Network Providers

You may select any dentist to provide your dental care.

To help control costs, the Dental Plan contracts with a network of dentists in the U.S. who have agreed to accept reduced fees for the dental procedures they provide. Using the services of these network dentists reduces your out-of-pocket costs. These dentists have also agreed not to charge you any amount that exceeds the fees agreed upon, aside from deductibles, your share of expenses, and fees for procedures not covered.

If you have questions about whether a particular dentist is a network dentist or need verification about the status of a provider, please contact MetLife Dental at 800-942-0854. You may also visit [MetLife.com/dental](https://www.metlife.com/dental) and click on the “Find a Dentist” link and select “PDP Plus Network” from the drop down menu. Or, you may go to [metlife.com/mybenefits](https://www.metlife.com/mybenefits) and enter “NXP Semiconductors” to register and then review your dental benefits and search for providers.

If you choose to receive your dental care from an out-of-network dentist, or if you receive dental care while you are abroad, covered expenses (listed further in this section) are payable based on the reasonable and customary charge. This means that the Dental Plan will pay its portion based on the reasonable and customary charge for that service, as determined by the Claims Administrator in its sole discretion. You are responsible for paying 100% of any amount greater than the reasonable and customary charge.

### 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 preventive services before the Dental Plan begins paying benefits.

A separate \$100 deductible applies to each covered person in your family. The \$300 family deductible is a combined amount for all family members. However, to meet the family deductible, no more than \$100 for any one family member can be applied.

The deductible starts over each January 1. Eligible expenses do not carry over from one year to the next, nor do they carry over from this Plan to the Post-Employment Benefits Plan.

### Coinsurance

You share the cost of covered dental services with the Dental Plan. Generally, the Dental Plan pays:

- 100% for preventive services, no deductible;
- 80% for basic services, after the deductible;
- 50% for major services, after the deductible;
- 50% for prosthodontic services, after the deductible; and
- 80% for orthodontic services, after the deductible.

You pay the remaining amount, including amounts above the reasonable and customary charge, when you use an out-of-network dentist.

### **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).

### ***Orthodontic Services***

The Dental Plan's deductible must be satisfied before you receive benefits for orthodontic services. The Plan then pays a percentage of covered expenses, up to the 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 or Freescale dental plans.

### **Predetermination of Benefits**

It is a good idea to find out what the Dental Plan will pay before you receive treatment. It is easy to get a predetermination of dental benefits. Just have your dentist submit an itemized description of the recommended procedure and how much it will cost to MetLife Dental. MetLife Dental will review this pretreatment estimate and return it to you and your dentist along with a description of what expenses are covered. MetLife Dental takes into account alternate procedures, services or courses of treatment based on professionally endorsed standards of dental care (see [Alternative Procedures](#) below).

Services are subject to all Dental Plan terms and provisions at the time treatment is provided. A predetermination of benefits remains effective for 90 days. If your treatment begins more than 90 days after the date that treatment is authorized, you should submit another treatment plan.

Before you schedule dental appointments, you should discuss with your dentist the amount to be paid by the Dental Plan and your financial obligation for the proposed treatment.

### **Alternative Procedures**

Some dental care can be provided in different ways to produce the desired result. In determining covered expenses, MetLife Dental considers alternative courses of treatment. Dental Plan benefits are based on the covered expenses for the least expensive services that would produce a professionally satisfactory result, as determined by MetLife Dental.

If you and your dentist decide on a more expensive course of treatment, you will be responsible for 100% of any excess charges. Your benefits are limited to the lesser of the reasonable and customary charge or predetermined charge, and they are subject to any deductible and your share of expenses for the least costly treatment.

## What's Covered

The Dental Plan covers several categories of covered expenses, including preventive services, basic services, major services, prosthodontic services and orthodontic services.

The Dental Plan pays covered expenses only. To be covered, an expense must be incurred while you or your dependent(s) are covered by the Dental Plan for that benefit, and it must be an eligible Dental Plan expense.

If you incur an expense that is not eligible for coverage under the Dental Plan (see [What's Not Covered](#) beginning on page 127), you are responsible for paying 100% of that expense.

For all covered expenses, the following services are considered an integral part of the entire dental service (a separate fee for these services is not considered a covered expense):

- Bases;
- Irrigation;
- Local anesthetics;
- Study models and diagnostic casts;
- Temporary dental services;
- Tissue preparation associated with impression or placement of a restoration; and
- Treatment plans.

Contact MetLife Dental at 800-942-0854 for detailed information regarding covered dental services.

Following are some examples of covered services. If you have any questions about what expenses are covered, call MetLife Dental at 800-942-0854.

### Preventive Services

You are encouraged to see your dentist for preventive dental care to reduce the risk of more serious and costly dental treatment. To help, the Dental Plan pays 100% of the predetermined charge (network) or reasonable and customary charge (out-of-network) for preventive services. These benefits are not subject to the Dental Plan's deductible.

Preventive Services	What's Covered/Limits
Bitewing X-rays	Limited to two sets per calendar year.
Cleanings (routine prophylaxis)	Limited to two per calendar year.
Emergency Care	Emergency evaluations and palliative (emergency) treatment for relief of dental pain.
Full Mouth or Panoramic X-rays	Limited to one each 36 months, unless necessary due to an accidental injury.
Miscellaneous X-rays	Including, but not limited to, periapical X-rays.
Oral Evaluations	Limited to two per calendar year.

<b>Preventive Services</b>	<b>What's Covered/Limits</b>
<b>Sealants</b>	For dependent children through age 14 only. Limited to one per tooth per lifetime on the occlusal surface of permanent molars and bicuspids that are free of decay and restoration.
<b>Space Maintainers</b>	For dependent children through age 13 only. For fixed or removable appliances to maintain a space created by the premature loss of a primary tooth or teeth.
<b>Topical Fluoride</b>	For dependent children through age 18 only. Limited to two per calendar year. A prophylaxis performed in conjunction with a fluoride treatment is considered a separate dental service.

## Basic Services

The Dental Plan pays 80% of the predetermined charge (network) or reasonable and customary charge (out-of-network) for basic services, after you pay your deductible. Treatment records may be required by MetLife Dental to determine benefits. See the chart below for examples of covered basic services.

<b>Basic Services</b>	<b>What's Covered/Limits</b>
<b>Drug Injections</b>	When done in conjunction with oral surgery.
<b>Endodontics</b>	Includes, but not limited to, root canal treatments.
<b>Extractions</b>	Includes routine extractions, orthodontic extractions of primary teeth and surgical extractions of erupted teeth.
<b>Fillings</b>	Amalgam and composite. Multiple restorations on one surface are considered one restoration.
<b>General Anesthesia</b>	When administered by a dentist in connection with oral or dental surgery and when dentally necessary or necessary due to a medical condition that presents a high risk to the patient. Not covered for routine extractions or surgical removal of erupted teeth.
<b>Harmful Habit Appliance</b>	For dependent children through age 13 only. Limited to initial appliance.
<b>Nitrous Oxide</b>	Drugs administered for pain relief.
<b>Occlusal Guards</b>	In connection with periodontal surgery and/or bruxism.

Basic Services	What's Covered/Limits
<b>Oral Surgery</b>	<p>Includes surgical extractions of impacted teeth (pre- and post-operative care), including osseous (bone) surgery.</p> <p>This includes other oral surgical procedures that are covered under medical and dental where benefits are coordinated between coverages.</p> <p>Surgical extractions of impacted teeth are covered under dental only.</p>
<b>Periodontics</b>	<p>Limited to four evaluations per calendar year. Two maintenance procedures per calendar year, but not covered if performed within three months of scaling and root planing and/or periodontal surgery. Scaling and root planing limited to one each 36 months, limited to four quadrants, but not covered if performed within three months of periodontal surgery. Periodontal surgery limited to one per quadrant each 24 months, and treatment includes three months' post-surgical care. If more than one surgical service is performed on the same day, only the most inclusive surgical service performed will be a covered expense. Includes provisional splinting.</p>
<b>Recementation</b>	<p>For inlays/onlays, crowns, bridges and veneers.</p>
<b>Stainless Steel Crowns</b>	<p>On primary teeth.</p>

**Major Services**

The Dental Plan pays 50% of the predetermined charge (network) or reasonable and customary charge (out-of-network) for major services, after you pay your deductible. Treatment records may be required by MetLife Dental to determine benefits. Following are examples of covered major services, including limitations that may apply:

- Crowns, and their maintenance/repair;
- Inlays or onlays, and their maintenance/repair;
- Porcelain/ceramic/resin material;
- Post/core build-ups for crowns;
- Replacement of an inlay/onlay, crown, or veneer that cannot be repaired, covered only after five years from initial placement, or when necessary due to an accidental injury; and
- Veneers and their maintenance/repair, limited to the upper or lower anterior teeth.

## Prosthodontic Services

The Dental Plan pays 50% of the predetermined charge (network) or reasonable and customary charge (out-of-network) for prosthodontic services, after you pay your deductible. Treatment records may be required by MetLife Dental to determine benefits. Following are examples of covered prosthodontic services, including limitations that may apply:

- Fixed or removable bridgework, installation and maintenance/repairs;
- Implant prosthesis (see [What's Covered](#), beginning on page 82);
- Overdentures, installation and maintenance/repairs, and six months' post-installation care;
- Partial and complete dentures, installation and maintenance/repairs, and six months' post-installation care;
- Post/core build-ups for bridgework;
- Relining and rebasing, limited to one each 24 months;
- Replacement of bridge, partial or complete denture, or overdenture that cannot be repaired, covered only:
  - After five years from initial placement;
  - When necessary due to an accidental injury while wearing the appliance; or
  - When dentally necessary due to other treatment (e.g., extraction of natural teeth making a bridge unserviceable) and
- Tissue conditioning, limited to four treatments per appliance per calendar year, only in conjunction with complete or partial dentures or a relining expense covered by the Dental Plan.

Bridges, dentures and overdentures to replace teeth that were extracted before your date of hire are not covered. Bridges, dentures and overdentures will be covered only when other natural teeth are extracted after your date of hire.

## Orthodontic Services

The Dental Plan pays 80% of the predetermined charge (network) or reasonable and customary charge (out-of-network) for orthodontic services, after you pay your deductible. The Dental Plan's lifetime maximum benefit for orthodontic services is \$2,000, which includes orthodontic benefits paid under any current or former NXP or Freescale dental plans.

Treatment records may be required by MetLife Dental to determine benefits. Benefits for orthodontic services do not apply toward the Dental Plan annual benefit maximum.

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
- Treatment and appliances for tooth guidance, interception and correction.

Orthodontic services are considered to begin when the appliance is placed or teeth are extracted in preparation for orthodontic care. Benefit payments are prorated by MetLife Dental over the treatment period. The lower of 25% of the total case fee or the dentist's fee is allowed for the down payment. The balance is prorated monthly over the treatment period. If the treatment plan ends before the treatment is complete, the Dental Plan will stop paying that monthly benefit.

Orthodontic services in progress when your coverage under this Plan begins will be prorated for the remainder of your treatment period. Your coverage will vary based on the time remaining on the treatment plan if treatment was started before joining the NXP Plan. The Dental Plan will pay the balance at 80% of the predetermined charge (network) or reasonable and customary charge (out-of-network), after your deductible, up to \$2,000 per person, per lifetime.

## 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:

- Any accidental injury arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which:
  - Benefits are provided or payable under any workers' compensation or occupational disease act or law; or
  - Coverage was available under any workers' compensation or occupational disease act or law regardless of whether such coverage was actually purchased;
- Any covered expenses to the extent of any amount received from others for the accidental injuries or losses that necessitate these benefits. Without limitation, "amounts received from others" specifically includes, but is not limited to, liability insurance, workers' compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile med-pay payments, or recovery from any identifiable fund regardless of whether the beneficiary was made whole;
- Any expense in excess of the reasonable and customary charge or predetermined charge for the service, treatment or supply in the locality where provided;
- Any expense incurred before your effective date under the Dental Plan or after the date your Dental Plan coverage ends;
- Any hospital charges or for services of any anesthesiologist;
- Any loss caused by or attributed to:
  - War or any act of war, whether declared or not; or
  - Any act of international armed conflict, or any conflict involving armed forces of any international authority;

- Services and supplies:
  - For which no charge is made, or for which you would not be required to pay if you were not covered under the Dental Plan, unless charges are received from and reimbursable to the United States government or any of its agencies as required by law;
  - Provided by or payable under any plan or law through any government or any political subdivision (not including Medicare or Medicaid); or
  - Provided for a military service-connected accidental injury by or under an agreement with a department or agency of the United States government, including the Department of Veterans Affairs;
- Any service that is considered cosmetic dentistry, unless such service is necessary due to an accidental injury. Personalization or characterization of prosthetic devices is considered cosmetic dentistry;
- Appliances or restorations for increasing vertical dimension, restoring occlusion, correction of congenital or developmental malformations, replacing tooth structure lost by attrition, abfraction, abrasion or erosion, or fastening together of two or more teeth for strength or stability by using crowns, inlays, onlays or other restorations;
- Athletic mouth guards;
- Caries susceptibility testing, lab tests, anaerobic cultures, sensitivity testing;
- Completion of forms or failure to keep an appointment with the dentist;
- Consultations;
- Diagnosis and treatment of temporomandibular joint dysfunction (TMJ), including, but not limited to, charges for TMJ X-rays and consultations, TMJ surgery, kinesiographic analysis and muscle testing, TMJ splints and appliances, splint equilibration and adjustments or physical therapy for symptoms including, but not limited to, headaches;
- Duplicate appliances;
- Fees for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist. The treatment must be provided under the dentist's supervision and guidance according to generally accepted dental standards;
- Full mouth debridement;
- General anesthesia unless administered by a dentist in connection with oral and dental surgery and only when dentally necessary or necessary due to a medical condition that presents a high risk to the patient. This also excludes general anesthesia administered in connection with routine extractions and the surgical removal of erupted teeth;
- Gold foil fillings and their maintenance/repairs. Alternate benefits will be applied allowing benefits for an amalgam restoration;
- High noble metal. Alternate benefits will be applied allowing benefits for a noble metal restoration when a more costly material is used;
- Major restorative and prosthodontic services on other than permanent teeth;
- Occlusal adjustments;
- Osteotomies;

- Pre-diagnostic detection of abnormal cells;
- Prescription drugs or pre-medications;
- Precision or semi-precision attachments;
- Preventive control programs including (but not limited to) oral hygiene instruction, plaque control, take home items or dietary planning;
- Pulp caps;
- Pulp tests;
- Reline/repair of occlusal guards;
- Replacement of lost, broken or stolen appliances, unless appliance is more than five years old;
- Site therapy;
- Sterilization/infection control fees;
- Services not dentally necessary or services that do not have uniform professional endorsement;
- Stainless steel crowns on permanent teeth;
- Stressbreakers; and
- Veneers and their maintenance/repairs on bicuspid and molar teeth.

If you have any questions about what expenses are not covered, call MetLife Dental at 800-942-0854.

## **Duty to Cooperate in Good Faith**

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

Cooperation includes:

- Promptly notifying MetLife Dental that you may have a claim;
- Providing MetLife Dental with relevant information, and signing and delivering such documents as MetLife Dental reasonably requests to secure the Dental Plan's recovery rights;
- Getting the Dental Plan's consent before releasing any party from liability for payment of dental expenses;
- Providing MetLife Dental with a copy of any summons, complaint or any other process served in any lawsuit in which you seek to recover compensation for your accidental injury and its treatment;
- Doing whatever is necessary to enable MetLife Dental to enforce the Dental Plan's recovery rights and doing nothing after loss to prejudice the Dental Plan's recovery rights; and
- Not attempting to avoid the Dental Plan's recovery rights by designating all (or any disproportionate part) of any recovery as exclusively for pain and suffering.

If you do not cooperate or provide MetLife Dental with notice, or your actions result in prejudice to the Dental Plan's rights, this will be considered a material breach of the Dental Plan and will result in you being held personally responsible for repayment. In this event, the Dental Plan may deduct from any pending or subsequent claim made under the Dental Plan any amounts you owe the Dental Plan until your cooperation is provided and the prejudice ceases.

## NXP Vision Plan

Routine eye care services are included in the NXP Vision Plan for you and your covered dependents. Services include comprehensive eye examinations, prescription eyeglasses (lenses and frame) or contact lenses. To take advantage of the Vision Plan, you simply enroll yourself, or you and your eligible dependents, pay your contribution, then choose a VSP network doctor or retail chain and pay your share of the cost, as described in the following chart.

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

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

### Vision Benefits Summary

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
<b>Vision Examination</b>	Once per calendar year	You pay \$10 copayment; Plan pays the rest	Plan reimburses up to \$45 after \$10 copayment
<b>Prescription Glasses</b>	See <b>Eyeglass Lenses</b> and <b>Eyeglass Frames</b> below	You pay \$10 copayment; Plan pays the rest	As outlined in the chart below
<b>Eyeglass Lenses</b> <ul style="list-style-type: none"> <li>• Single vision</li> <li>• Lined bifocal</li> <li>• Lined trifocal</li> </ul> Polycarbonate for children is included at no extra cost	Once per calendar year	Your copayment for Eyeglass Lenses is included in the Prescription Glasses copayment	Plan reimburses up to the amounts shown below: <ul style="list-style-type: none"> <li>• Single Vision: Up to \$30</li> <li>• Lined Bifocal: Up to \$50</li> <li>• Lined Trifocal: Up to \$65</li> <li>• Polycarbonate: No benefit</li> </ul>

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
<b>Eyeglass Frames</b>	Once every two calendar years	<ul style="list-style-type: none"> <li>• Your copayment for Eyeglass Frames is included in the Prescription Glasses copayment</li> <li>• Plan pays up to \$150 retail allowance (\$170 allowance for featured frame brands**), plus 20% savings on amounts over your allowance</li> <li>• Plan pays up to \$80 allowance at Costco</li> </ul>	Plan reimburses up to \$70 after your copayment
<b>Lens Enhancements</b>	Once per calendar year	<ul style="list-style-type: none"> <li>• Standard progressive lenses, \$55</li> <li>• Premium progressive lenses, \$95 - \$105</li> <li>• Custom progressive lenses, \$150 - \$175</li> </ul> <p>Average savings of 20-25% on the other lens enhancements</p>	Progressive lenses, up to \$50
<b>Contacts</b>	Once per calendar year, in lieu of eyeglass lenses and frames	<p>\$150 allowance for contacts</p> <p>15% savings on contact lens exam (fitting and evaluation) and will not exceed \$60.</p>	\$105 allowance for contacts and contact lens exam

Service	Frequency	VSP Network Doctor or Retail Chain*	Out-of-Network
<b>Diabetic Eyecare Plus Program</b>	As needed	You pay \$20 copayment for services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Plan pays the rest when provided by a VSP Network Doctor	No benefit
<b>Laser Surgery</b>	No limits	On average, a 15% discount or 5% off promotional pricing from selected VSP Network Providers	No benefit

\* Benefits from a retail chain may be different. Once your coverage begins, visit [VSP.com](https://www.vsp.com) for details.

\*\* Visit [vsp.com/optical-discounts.htm](https://www.vsp.com/optical-discounts.htm) to view VSP featured frames.

## Vision Plan Features

### VSP National Network of Doctors and Retail Providers

The Vision Plan offers a national network of doctors (ophthalmologists and optometrists), administered by VSP, and retail chains contracted by VSP. Retail chains include Costco Optical and Visionworks (formerly Eye Care Centers of America). This is a different network of providers than the NXP Medical Plan network.

Through VSP, you can receive exclusive contact lens rebates, special offers, such as TruHearing Member Plus Program, and savings up to 50% on hearing aids. To take advantage of these offers, visit [vsp.com/hearing-aid-discounts.html](https://www.vsp.com/hearing-aid-discounts.html).

### Locating Your Network Doctor or Affiliate Provider

When you obtain services from a VSP network doctor or retail chain you get the most value from your Vision Plan benefits. VSP offers two convenient ways to locate these providers near your home or work, or to verify that your doctor is in the network or contracted with VSP as an affiliate provider.

- Visit [VSP.com](https://www.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.
- Call VSP's Member Services Department at 800-877-7195 and choose either the automated service or talk with a Customer Service Representative.

## ***Scheduling an Appointment***

Follow these quick steps to schedule an appointment with a network doctor or retail chain:

- Call a network doctor or retail chain for an appointment, and identify yourself as an NXP VSP member. Allow at least 48 hours between your call and your appointment so the provider can verify your eligibility. You will need to provide the NXP employee's name and date of birth, or last four digits of his/her Social Security number when you call, as this information is required to make an appointment.
- After you schedule an appointment, the network doctor or retail chain contacts VSP to verify your eligibility and benefit coverage. If you are not eligible for benefits at that time, the provider will let you know.
- Go to your scheduled appointment. You do not need to take any kind of benefit form with you, and you do not have to submit a claim form when you use a network doctor or retail chain. At your appointment, you will pay the applicable copayment(s) plus any additional amounts for which you are responsible. As you are choosing among your contact lenses and eyeglasses options, you may ask the provider how much you will have to pay for each item.

If your eligibility for benefits is denied, it may be for one of the following reasons:

- You may not be eligible because you are not an NXP Vision Plan participant, or you may be so new to the Vision Plan that your name is not yet in the VSP database. In this case, call VSP Member Services at 800-877-9195 to clarify the situation.
- You may not have waited long enough between provider visits. See the [Vision Benefits Summary](#) chart (beginning on page 131) 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](#), on page 131).

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 employee's name and birth date, last four digits of his/her Social Security number, services rendered and "paid in full" on each receipt you submit.

## What's Covered

The Vision Plan covers the following services and supplies (see [Vision Benefits Summary](#) on page 131 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).
- **Diabetic Eyecare Plus Program:** If you have Type 1 and Type 2 diabetes, glaucoma or Age-Related Macular Degeneration (AMD), you can receive follow-up diabetic eye care services from a network provider. No benefit is paid for treatment by an out-of-network provider.
- **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 Lasik (wavefront technology).

## 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 any 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 65mm);
- Progressive multifocal lenses;
- Photochromic or tinted lenses (Pink 1 or 2 tints are covered);
- Coated or laminated lenses;
- A frame that costs more than the Vision Plan allowance;
- Cosmetic lenses;
- Optional cosmetic processes; and
- UV-protected lenses.

## **Flexible Spending Accounts**

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The Flexible Spending Account (FSAs) Plan offers a significant tax savings. Both the Health Care/Limited Use Health Care Flexible Spending Account (FSA) (as explained beginning on page 140) and the Dependent Care Flexible Spending Account (DCFSA), as explained beginning on page 146, allow you to set aside before-tax dollars into special accounts. When you incur an eligible expense, you file a claim for a tax-free reimbursement of that expense.

### ***Your FSA Participation Agreement***

By participating in either the Health Care/Limited Use Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, you certify that any expense paid by the account has not been reimbursed. You also agree not to seek reimbursement from another plan, or claim a tax credit or deduction, for any expenses paid by the account.

### ***If You Are Enrolled in the Medical Savings Plan with HSA Coverage Option***

By law, if you have a Health Savings Account, you may not contribute to a health care flexible spending account, unless it is a limited use account. Therefore, if you are enrolled in the Medical Savings Plan with HSA coverage option, you can only enroll in the Limited Use Health Care FSA.

The amount you contribute to an FSA is deducted from your pay each pay period before federal and most state and local taxes are calculated. This lowers your taxable income and the resulting tax amount you pay.

## Summary of Flexible Spending Account Plan Benefits

Plan	Covered Expenses	Maximum Contribution	How Claims Are Paid
<a href="#"><u>Health Care Flexible Spending Account (FSA)</u></a>	Medical, pharmacy, dental and vision care expenses not reimbursed by another plan	\$2,600 per calendar year	Full annual contribution is available on your first day of participation
<a href="#"><u>Limited Use Health Care Flexible Spending Account (FSA)*</u></a>	Dental and vision care expenses not reimbursed by another plan	\$2,600 per calendar year	Full annual contribution is available on your first day of participation
<a href="#"><u>Dependent Care Flexible Spending Account (DCFSA)</u></a>	Employment-related dependent care expenses not claimed for the federal dependent care income tax credit	\$5,000 per calendar year	Only amounts already contributed are available

\* If you enroll in the Medical Savings Plan with HSA coverage option and want to contribute to a health care FSA, you must enroll in the Limited Use Health Care FSA.

## How FSAs Reduce Your Taxes

With an FSA, you pay for your health care or dependent care expenses before taxes so your taxable income is reduced.

**Example:** Alexandra earns an annual salary of \$50,000, is married with one child and she contributes \$2,600 a year in a Health Care Flexible Spending Account. Compare the tax savings of using an NXP Health Care Flexible Spending Account and paying health care costs with after-tax dollars.

	Paying Expenses with Health Care Flexible Spending Account	Paying Expenses with After-Tax Dollars
<b>Taxable Income</b>	\$50,000	\$50,000
<b>Health Care FSA Deposit</b>	<u>- \$2,600</u>	<u>- \$0</u>
<b>Net Taxable Income</b>	\$47,400	\$50,000
<b>Estimated Social Security Tax</b>	- \$3,626	- \$3,825
<b>Federal Income Taxes</b>	<u>- \$2,574</u>	<u>- \$2,955</u>
<b>Total Estimated Tax*</b>	\$6,200	\$6,780
<b>Income After Taxes</b>	\$41,200	\$43,220
<b>After-Tax Payment of Expenses</b>	\$0	- \$2,600
<b>Spendable Income</b>	\$41,200	\$40,620
<b>Tax Savings</b>		\$580

\* This is just an example and makes certain assumptions; your individual situation will be different.

## Plan Your Contributions Carefully

You have until March 31 of the following year to submit claims for expenses *incurred* during a **prior** calendar year. You incur an expense on the day you receive the service or buy the supply; this may be different from the date you actually pay the expense.

You cannot start or stop contributing or change your contribution amount during the year unless you experience a qualified status change.

For the Health Care/Limited Use Health Care Flexible Spending Account, the Plan allows you to carry over up to \$500 of any unused amount remaining in your Health Care/Limited Use Health Care Flexible Spending Account from one plan year to the next plan year to be available to pay or reimburse eligible expenses incurred during the following plan year. Previously, any amounts remaining in your Health Care Flexible Spending Account as of the end of the Plan year would be forfeited under the Plan.

If you are changing medical options as of the beginning of the plan year and are enrolled in the Health Care/Limited Use Health Care Flexible Spending Account, any carry over will be credited to the appropriate type of account. For example, if you are changing from the Choice Plan to the Medical Savings Plan, the carry over will automatically be added to a Limited Use Health Care Flexible Spending Account and may only be used to pay for expenses eligible for reimbursement under a Limited Use Health Care Flexible Spending Account.

According to IRS rules, any remaining amounts over \$500 in your Health Care/Limited Use Health Care Flexible Spending Account or any remaining amount in your Dependent Care Flexible Spending Account not claimed for eligible expenses incurred during that year are forfeited and not returned to you. Be sure not to contribute more money than you think you will use. IRS rules require these unused amounts to be forfeited; the Plan uses forfeited amounts to offset its administrative costs. If you have funds in your Health Care/Limited Use Health Care Flexible Spending Account carried over to the following year and elect new FSA coverage as well, there is an order from which account funds are used first—first, amounts contributed due to your new FSA election will be used, then amounts carried over from the previous year will be used.

**Example:** Lai-Ping contributes \$2,500 to her Dependent Care Flexible Spending Account. During the course of the year, she is reimbursed for \$2,000. In December, Lai-Ping incurs another \$500 in expenses for which she wants to be reimbursed. She submits her Dependent Care Flexible Spending Account form and appropriate information in the following February and is reimbursed.

**Example:** At the end of the plan year, Tom still has \$700 left in his Health Care Flexible Spending Account. While he cannot use that money for reimbursement of eligible expenses incurred in the previous year, he can carry over \$500 of his unused Health Care Flexible Spending Account to use for eligible health care expenses in the current year. Since Tom can only carry over up to \$500, Tom loses the additional \$200 that he did not use from his prior year's contributions.

## Special Rules for Eligible Reservists — Health Care Flexible Spending Account Only

If you are an “eligible reservist” and called to active duty for 180 days or more, you may avoid forfeiting money in your Health Care Flexible Spending Account, but not your Dependent Care Flexible Spending Account, by making a taxable withdrawal of the funds in your Health Care Flexible Spending Account. You must make your withdrawal request before December 31 of the year you are called to active duty. For more information, call NXP Rewards Customer Service at 888-375-2367.

### Resources from *Your Spending Account*

Connect with *Your Spending Account* online or by telephone whenever you need information about your FSAs. To access the website, log on to [NXP.com/rewards](https://nxp.com/rewards). The website allows you to review your account balances, check the status of claims, learn about eligible expenses and more.

If you do not have Internet access, you may speak with a service center representative by calling NXP Rewards Customer Service toll free at 888-375-2367. From the main menu, follow the voice prompts to connect to a representative.

### Health Care/Limited Use Health Care Flexible Spending Account (FSA)

The Health Care Flexible Spending Account Plan offers domestic employees and U.S. Expatriates a real financial advantage. It lets you set aside before-tax dollars into an account to pay for eligible health care expenses. The amount you contribute is deducted each pay period before federal and most state and local taxes are calculated. This lowers your taxable income and the resulting tax amount you pay.

Two types of accounts are available:

- **Health Care Flexible Spending Account:** This is the traditional health care flexible spending account that can be used to pay for eligible medical, prescription drug, dental and vision care expenses for you and your dependents. You cannot enroll in a traditional health care flexible spending account if you are enrolled in a High Deductible Health Plan with a corresponding HSA, such as the Medical Savings Plan coverage option.
- **Limited Use Health Care Flexible Spending Account:** If you enroll in a High Deductible Health Plan with a corresponding HSA, like the Medical Savings Plan coverage option, federal regulations limit reimbursements that can be made before your medical deductible is met. As a result, you cannot participate in a traditional health care flexible spending account. However, you may participate in the Limited Use Health Care Flexible Spending Account since this account is only used to pay for eligible dental and vision expenses.

Federal regulations do not allow contributions to an HSA and/or Limited Use Health Care Flexible Spending Account and a standard Health Care Flexible Spending Account during the same year. As a result:

- You are not eligible to contribute to a standard Health Care Flexible Spending Account if you enroll in the Medical Savings Plan with HSA coverage option at any time during the year, have a qualifying life event and change your medical coverage option to any other coverage option other than the Medical Savings Plan.
- You are not eligible to contribute to an HSA or Limited Use Health Care Flexible Spending Account if you contributed to a standard Health Care Flexible Spending Account at any time during the year, have a qualifying life event and enroll in a High Deductible Health Plan, such as the NXP Medical Savings Plan, with HSA coverage option. In addition, if you enroll in a High Deductible Health Plan, such as the NXP Medical Savings Plan, contributions to your standard Health Care Flexible Spending Account will end.

**Note:** You may not join or make any change to your enrollment or contribution between November 1 and December 31.

**Note:** If both you and your spouse work at NXP, you are each eligible to contribute to your own Health Care or Limited Use Health Care Flexible Spending Account, up to the annual maximum during the calendar year. Claims may be submitted under either employee's Health Care or Limited Use Health Care Flexible Spending Account.

## Eligible Dependents

The Health Care Flexible Spending Account Plan reimburses only eligible expenses incurred by you and your eligible dependents. "Eligible dependents" are those you claim as your dependents on your federal income tax return. If your returns are audited, you may be required to provide proof of dependency for any claim for a dependent's expenses. However, the Health Care/Limited Use Health Care Flexible Spending Account may reimburse the eligible expenses you pay for your child who has not reached age 27 as of the end of the calendar year, even if that child is not your federal income tax dependent.

**Example:** Tyler's daughter turns 26 on September 12, 2018, so he may claim the eligible expenses she incurs in 2018. Because his daughter will reach age 27 by the end of 2019, Tyler cannot claim expenses his daughter incurs in 2019.

## Your Health Care/Limited Use Health Care Flexible Spending Account Contribution

During the enrollment process, you may establish a Health Care or Limited Use Health Care Flexible Spending Account and indicate the annual amount you would like withheld from your paycheck. This amount is spread evenly among your pay periods and automatically withheld from each paycheck and deposited into your own Health Care or Limited Use Health Care Flexible Spending Account. Your taxable income is reduced by the amount you choose to contribute.

The minimum amount you may contribute is \$60 annually. The maximum amount is \$2,600 annually. The \$2,600 annual limit applies only to the amount you elect to contribute to your Health Care Flexible Spending Account; any carryover amount (up to \$500) is **in addition to** your contributions for the plan year.

The amount you elect to contribute in one year will carry over from year-to-year, unless you change your choice during an enrollment period.

### How the Accounts Work

When you have an eligible expense, you can:

- Use the Automatic Claim Submission option (see [Automatic Claim Submission Option](#) on page 142). Under this option, you authorize the Plan to automatically reimburse your account for eligible expenses.
- Use a FSA debit card (see [Health Care/Limited Use Health Care FSA Debit Card](#) on page 143). You automatically receive a debit card when you enroll in a Limited Use Health Care Flexible Spending Account. If you enroll in the standard Health Care Flexible Spending Account, you must elect to receive a FSA debit card, after the plan year begins or you enroll in the plan.
- Pay the bill and submit a claim along with your receipts and supporting documentation to the Claims Administrator, as described in [Filing an FSA Claim](#) on page 150.

### *Automatic Claim Submission Option*

When you enroll in a standard Health Care Flexible Spending Account, you are automatically enrolled in the Automatic Claim Submission option. Under the Automatic Claims Submission option, eligible expenses are automatically reimbursed by your Health Care Flexible Spending Account, if you have no other coverage for the eligible expenses. This process saves you both time and paperwork.

When enrolling in the Health Care Flexible Spending Account Plan, you authorize that claims for eligible expenses be submitted directly to your Health Care Flexible Spending Account for payment by our health plan. When these plans pay claims, they automatically send a claim to your Health Care Flexible Spending Account for your share of the covered expense.

### **Health Care/Limited Use Health Care FSA Debit Card Option**

When you enroll in a Limited Use Health Care Flexible Spending Account, you automatically receive an FSA debit card to pay for eligible dental and vision expenses. The same Limited Use FSA debit card is used to pay for eligible medical and prescription expenses from your Health Savings Account. No action is required on your part to coordinate the payment.

When you enroll in a standard Health Care Flexible Spending Account, you may elect to receive an FSA debit card to pay for eligible medical, prescription drug, dental and vision expenses by accessing the Your Spending Account website, via [NXP.com/rewards](https://nyp.com/rewards).

You can use your FSA debit card at approved merchants to pay for eligible expenses directly from your Health Care or Limited Health Care Flexible Spending Account.

Each time you use your FSA debit card you agree to the terms and conditions of cardholder agreement, including card usage limitations and the Plan's right to withhold and offset for ineligible claims, etc.

You must call the toll-free number included with your card to activate the FSA debit card. You only need to activate one of your cards. Your FSA debit card has an expiration date. This expiration date is on the front of the cards. You will be issued a new FSA debit card when your current card expires (as long as you continue to participate in a Health Care or Limited Use Health Care Flexible Spending Account. If you change from the Health Care Flexible Spending Account to the Health Savings Account, you keep the same debit card for use.

Using your FSA debit card allows you to access your account immediately with no out-of-pocket costs to you. While most expenses will be automatically approved, you must save your receipts; this is an IRS requirement. You may need to provide copies of these receipts to substantiate expenses as eligible for reimbursement.

If you receive a request from the Claims Administrator to substantiate an expense, you will need to provide the requested documentation in a timely manner. If you do not provide proper documentation, your standard Health Care Flexible Spending Account debit card will be suspended and you will have to pay future eligible expenses out of pocket and submit manual claims for reimbursement to the Claims Administrator. If you have a Limited Use Health Care Flexible Spending Account debit card, all future expenses will be paid from your Health Savings Account.

If you would like to take advantage of an FSA card for your Health Care Flexible Spending Account, you must change your reimbursement method to pay with YSA card by logging onto Your Spending Account via [NXP.com/rewards](https://nyp.com/rewards) after the year begins. You are only allowed one change per year.

### **Maternity Care and the Health Care Flexible Spending Account**

This information does not apply to the Limited Use Health Care Flexible Spending Account.

Most obstetricians submit a single bill to the Medical Plan for all physician services after the child's birth. In these cases, all the physician charges for maternity care, from prenatal care through delivery and discharge, are considered "incurred" when the child is born.

If you use the Health Care Flexible Spending Account to reimburse your share of covered maternity care expenses, plan your contributions for the calendar year in which you expect the child to be born.

## Eligible Health Care Flexible Spending Account Expenses

The IRS sets guidelines for eligible and ineligible Health Care Flexible Spending Account expenses. Following are some of the expenses that may be reimbursed through your Health Care Flexible Spending Account:

- Deductibles, copayments and your share of covered expenses under NXP's or another group health plan;
- Expenses beyond the limits of NXP's or another group health plan;
- Expenses over reasonable and customary charges;
- Over-the-counter (OTC) items used for medical conditions as defined by the IRS for medical treatment, but OTC medicines are only eligible with a physician's written prescription (except insulin);
- Any deductible health care expense considered under IRS Code Section 213;
- Chiropractic care;
- Smoking cessation programs and products;
- Pre-existing conditions not covered by a spouse's or dependent's plan;
- Expenses for transportation that is essential to and primarily for covered health care;
- Up to \$50 per night per person for lodging that is essential to and primarily for covered health care and that meets IRS rules;
- Laser vision surgery; and
- Orthodontia expenses that exceed the Dental Plan's maximum benefit.

For complete details, contact NXP Rewards Customer Service, or online at [NXP.com/rewards](https://www.nxp.com/rewards).

### **OTC Items**

The OTC items allowed for reimbursement are those used for "medical care" as defined by the IRS. The IRS defines medical care as the "diagnosis, cure, mitigation, treatment or prevention of disease or for affecting any structure or function of the body." The types of OTCs included under this definition are those used to alleviate or treat personal injuries or sickness. This excludes items intended for an individual's overall general health.

- OTC **medicines other than insulin** require a physician's written prescription to be considered for reimbursement by the Health Care Flexible Spending Account.
- OTC health care **supplies**, such as bandages, blood pressure monitors and reading glasses, do not require a physician's prescription to be considered for reimbursement by the Health Care Flexible Spending Account.

The Claims Administrator, *Your Spending Account*, will determine whether an OTC item falls within the guidelines of medical care and the reimbursement definition. Quantity limitations will apply according to product dosage/standard use indications. You will be required to provide the following information to apply for reimbursement:

- Date and proof of purchase (receipt required);
- Physician's written prescription for OTC medicines other than insulin;
- Evidence of the medicine and/or drug name (name of medicine/drug on receipt required); and
- Completion of a claim including the name of the person for whom the OTC item is intended.

### **Eligible Limited Use Health Care Flexible Spending Account Expenses**

The Limited Use Health Care Flexible Spending Account can only be used for eligible dental and vision expenses. Following are some of the expenses that may be reimbursed through your Limited Use Health Care Flexible Spending Account:

- Deductibles, copayments and your share of covered expenses under NXP's or another group dental and/or vision plan;
- Expenses beyond the limits of NXP's or another group dental and/or vision plan;
- Expenses over reasonable and customary charges under NXP's or another group's dental and/or vision plan;
- Laser vision surgery; and
- Orthodontia expenses that exceed the Dental Plan's maximum benefit.

For complete details, contact NXP Rewards Customer Service, or online at [NXP.com/rewards](https://nxp.com/rewards).

### **Expenses That Are Not Eligible**

Following is a list of expenses that are not eligible for reimbursement from a Health Care or Limited Use Health Care Flexible Spending Account. For complete details, contact NXP Rewards Customer Service.

- Premium payments for other health coverage;
- Health club fees, dietary supplements, weight loss programs (unless prescribed by a physician for a health condition);
- Cosmetic surgery, when not medically necessary to improve a deformity arising from a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease; and
- Any health care expenses not deductible under IRS Code Section 213.

In addition to the above, medical and prescription drug expenses are not eligible for reimbursement from a Limited Use Health Care Flexible Spending Account.

### ***Excluded OTC Items***

The following items are not eligible for reimbursement under a Health Care or Limited Use Health Care Flexible Spending Account unless accompanied by an explanation of medical necessity from an eligible provider under the health plans:

- Cosmetics or beauty products (face cream, moisturizers, make-up, etc.);
- Dietary or nutritional supplements (weight loss supplements, vitamins, etc.);
- Feminine hygiene products;
- General use sundries or personal care items not listed;
- Homeopathic or holistic products;
- Lip balms;
- Lotions
- Shampoos and soaps;
- Toiletries (perfume, body sprays, deodorants, etc.); and
- Toothpaste, toothbrushes, dental floss.

All claims are subject to review and approval by the Claims Administrator.

### **COBRA Continuation**

After your Health Care/Limited Use Health Care Flexible Spending Account coverage ends (including any extension periods described in this section), you may continue Health Care/Limited Use Health Care Flexible Spending Account coverage under COBRA. To continue coverage under COBRA, you are required to pay your previous contribution amount plus 2%. COBRA contributions can only be paid on an after-tax basis. COBRA coverage allows you to continue to be reimbursed for eligible expenses from your previously accumulated before-tax contributions. When you stop paying your COBRA contributions, your participation ends. You may continue coverage under COBRA only until the end of the calendar year in which the COBRA qualifying event occurred.

### ***Eligible Expense Deadline Without COBRA***

If you **do not** choose to continue participation in your Health Care/Limited Use Health Care Flexible Spending Account, you may submit only eligible expenses *incurred on or before the day your Health Care/Limited Use Health Care Flexible Spending Account coverage ended*. You must submit these eligible expenses by March 31 of the year following your termination of coverage.

### **Dependent Care Flexible Spending Account (DCFSA)**

The Dependent Care Flexible Spending Account (DCFSA) offers tax savings for eligible NXP employees. You may direct before-tax dollars into an account to be used to reimburse yourself for eligible dependent care expenses. These are expenses you pay that allow you to work and, if you are married, allow your spouse to work or attend school full-time. You save money because your taxable income amount is decreased.

To use a Dependent Care Flexible Spending Account, you must meet one of the following requirements:

- You are a single parent either working or seeking paid employment;
- You are married and must pay dependent care (including child or elder care centers) expenses so you and your spouse can work or look for work;
- You are married, you work and your spouse is a full-time student for at least five months in a plan year;
- You are married, you work and your spouse is disabled and unable to care for himself/herself and has the same principle residence as you do for more than half the year; or
- You are divorced or legally separated and you have custody of your dependent child for more than half of the year (even if the other parent claims the dependent for tax purposes).

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

### Special Tax Considerations

Depending on your income, number of children and the amount of dependent care expenses you incur for each child, it may be more advantageous to take child care credits when calculating income taxes. Refer to IRS Publication 503, *Child and Dependent Care Expenses*, for information on the child care credit. You can calculate your exact child care credit amount by following the instructions on IRS Form 2441. You may want to consult a tax advisor to determine whether a Dependent Care Flexible Spending Account or child care credit is the best choice for you.

If you or your spouse participates in a Dependent Care Flexible Spending Account program outside NXP, or if you are both NXP employees, be certain that your combined Dependent Care Flexible Spending Account contributions do not exceed the IRS limit.

The IRS website at [IRS.gov](https://www.irs.gov) has additional resources to show how establishing a Dependent Care Flexible Spending Account can help you.

### Qualified Dependents

Since a Dependent Care Flexible Spending Account is for expenses related to the care of your dependents, certain guidelines exist. A qualified dependent must meet one of the following definitions:

- A child (including a child of your domestic partner) under the age of 13 who qualifies as your dependent under Internal Revenue Code 152 (see [Tax Implications and Information](#) on page 7 for details) and for whom you may properly claim an exemption on your income tax; or

- A dependent of any age who is physically or mentally incapable of self-care (including your spouse/domestic partner or parent) who qualifies as your dependent under Internal Revenue Code Section 152 and for whom you may properly claim an exemption on your income tax.

You may want to consult your tax advisor if you need more information on whether your dependent qualifies based on IRS guidelines.

In addition, except with regard to your spouse who is incapable of self-care, you must also provide more than one-half of the qualified dependent's financial support. If you are divorced or legally separated, your child or stepchild may qualify if you satisfy custody requirements specified by the IRS.

For a disabled dependent to qualify, he or she must regularly spend at least eight hours each day in your home. You are not reimbursed for the care of a dependent in an institution.

### **Your Dependent Care Flexible Spending Account Contribution**

During the enrollment process, you may establish a Dependent Care Flexible Spending Account and indicate the amount you would like withheld from your paycheck on a before-tax basis. That amount is deducted automatically and deposited into your Dependent Care Flexible Spending Account. Your taxable income is reduced by the amount you choose to contribute.

Contributions for highly compensated employees, as defined by the IRS, are subject to special contribution limits. Highly compensated employees are generally those whose annual earnings exceed the IRS threshold in the prior year. For 2018, the IRS threshold is \$120,000 earned in 2017. If you are affected, you will be notified and your contribution may be refunded or reduced during the plan year to prevent the Dependent Care Flexible Spending Account Plan from becoming discriminatory or violating the Internal Revenue Code.

The minimum amount you may contribute is \$120 annually. The maximum you may contribute is the lesser of:

- \$5,000 (\$2,500 if married but not filing a joint return); or
- Your annual earned income\*; or
- Your spouse's earned income (special rules apply if your spouse is a student or handicapped).

\* *Annual earned income is your total annual compensation (all compensation paid to you during the year, before any amounts you contribute to the 401(k) Retirement Plan, a Health Care Flexible Spending Account, a Dependent Care Flexible Spending Account, medical, dental and vision coverage contributions). This compensation level is reviewed annually by the IRS and is subject to change.*

It is important to note that only claims incurred while you are actively employed are eligible for reimbursement.

The amount you elect to contribute will carry over from year-to-year, unless you change your choice during an enrollment period.

If you and your spouse are both eligible for the Dependent Care Flexible Spending Account as NXP employees, the sum of your annual contributions is limited to \$5,000.

## Eligible Dependent Care Flexible Spending Account Expenses

Eligible expenses must be incurred while you are actively employed with NXP.

- Qualified child or elder care center, babysitter, nanny or au pair payments;
- Services performed outside the home for the care of dependents;
- Nursery school fees;
- Registration fees;
- Payments to relatives who provide care (except children under the age of 19 and relatives who are your dependents);
- Theme camps such as sports camp, music camp, computer camp, etc., if the primary purpose is to care for your child while you (and your spouse, if married) work or attend school full time;
- After-school care; and
- Out-of-home care for a disabled adult dependent, provided the dependent resides in your home at least eight hours per day and you claim him or her as a personal exemption on your federal income tax.

For an online version of the IRS publications, visit [IRS.gov](https://www.irs.gov). Refer to IRS Publication 503, *Child and Dependent Care Expenses*, for a complete list of covered and non-covered expenses.

## Expenses That Are Not Eligible

- Expenses incurred on or after your Dependent Care Flexible Spending Account has ended;
- Clothing expenses;
- Education expenses for a child in kindergarten or higher;
- Payments for services at a child care center that does not comply with all applicable laws;
- Expenses for which a dependent care tax credit is taken on your annual tax return;
- Expenses for any overnight camp, regardless of purpose;
- Expenses for housekeeping services, unless such services are for the well-being and protection of an eligible dependent;
- Deposit fees;
- Supply fees;
- Lesson fees;
- Expenses related to a dependent in a convalescent nursing home; and
- Expenses incurred while you are on a leave of absence.

## Filing an FSA Claim

### ***FSA Debit Cards for Health Care/Limited Use Health Care Flexible Spending Accounts***

A FSA debit card can be used to pay for eligible expenses, which means you do not need to submit claims for reimbursement. See [Health Care/Limited Use Health Care FSA Debit Card](#) on page 143 for more information.

You may file a claim with the Plan when you incur an eligible expense (see [Eligible Health Care Flexible Spending Account Expenses](#) beginning on page 144 and [Eligible Dependent Care Flexible Spending Account Expenses](#), beginning on page 149). When you file a claim to request reimbursements from your Health Care/Limited Use Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, you must provide a completed corresponding Claim Form and eligible forms of documentation, such as an itemized receipt or Explanation of Benefits (EOB) from your health plan.

- **Health Care/Limited Use Health Care Flexible Spending Account:** When you submit a Health Care Flexible Spending Account claim, you are reimbursed the eligible expense amount that does not exceed the total annual amount you elected to contribute for the year. This applies even if your claim exceeds the amount you have actually contributed as of the date you request reimbursement.
- **Dependent Care Flexible Spending Account:** When you submit a Dependent Care Flexible Spending Account claim, you are reimbursed the eligible expense amount that does not exceed the balance on the date the claim is processed. If your claim is for more than the balance in your Plan account, the remainder of your claim will be held and processed when your Plan account is credited with sufficient funds.

To submit a claim visit [NXP.com/rewards](https://www.nxp.com/rewards) or call NXP Rewards Customer Service at 888-375-2367.

If you do not upload your documentation, you must then print and sign the cover sheet and fax with receipts to 888-211-9900.

Or you may mail your documentation to:

#### **Your Spending Account**

P.O. Box 785040

Orlando, Florida 32878-5040

### **What to Remember When Filing Your Health Care/Limited Use Health Care Flexible Spending Account Claim**

- If you have other group health coverage, include the Explanation of Benefits (EOB) from the other carrier.
- Provide a copy of the medical or dental EOB, if applicable.
- Provide the date of service or purchase.
- Provide name of service provider or retailer.
- Provide purchase amount for each product or service.
- Provide total purchase amount.

- Submit receipts for proof of payment.
- Provide identification of drug or product or description of service.
- For prescriptions, submit the tab from the prescription or a printout from the pharmacy, showing the name of the drug, the pharmacy, the date the prescription was filled and your share of the cost.
- For OTC medicines prescribed by a physician, submit the physician's written prescription for the medicine.

NXP cannot accept "balance due" statements as sufficient documentation for payment.

### **What to Remember When Filing Your Dependent Care FSA Claim**

- Write the NXP employee's name and the dependent's name on each bill;
- Provide the date (or range of dates) of service;
- Name of service provider;
- Name of dependent receiving services;
- Description of service; and
- Amount paid.

Unlike the Health Care/Limited Use Health Care Flexible Spending Account, claims payments from your Dependent Care Flexible Spending Account are limited to the balance in the account on the date the claim is processed.

### ***Avoid Sending Receipts and Documentation with Provider's Signature***

You are required to send Your Spending Account itemized receipts or other documentation to prove that your expenses are eligible under the Plan.

However, a simpler alternative is for you to get your dependent care provider to sign the "Provider Certification" section of the claim form. This way, you do not need to send receipts or documentation.

By sending the provider-signed claim, you make the reimbursement process easier for yourself and your provider. To have your dependent care claim processed without receipts, follow these three steps:

- Enter your claim information on the Your Spending Account website.
- Print the claim form and have your provider sign and date it.
- Upload the form to the Your Spending Account website or send a copy by fax or mail (after photographing or scanning it).

NXP reserves the right to make adjustments to flexible spending account elections during the year if there is clear and convincing evidence, as determined by NXP in its sole discretion, that the election was a mistake or made in error and that the adjustment is allowed under applicable IRS rules.

## Disability Income Benefits

This section includes information on:

- [Short-term disability](#) Plan benefits (beginning on page 156);
- [Short-term disability buy-up](#) benefits (beginning on page 159);
- [Long-term Disability](#) Plan benefits (beginning on page 161);
- [Provisions](#) that relate to disability benefits (beginning on page 166); and

See [Participation](#), beginning on page 3, for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The NXP Rewards benefits package includes disability plans that provide benefits for you and your family if you have an illness or injury that prevents you from working. Disability plans are offered to U.S. domestic employees and U.S. Expatriates only.

NXP's Short-Term and Long-Term Disability Plan benefits provide you with income even though you are unable to work. The amount of money you receive for short-term and long-term disability is based on your covered pay as of the last day of work before your disability leave begins. NXP provides Short-Term and Long-Term Disability Plan protection at no cost to you.

You may increase your Short-Term Disability Plan coverage through a [Short-Term Disability Buy-Up Option](#) (see page 157). This extra protection is available to you if you enroll and pay the premiums through before-tax payroll deductions.

This section summarizes your benefits under the disability plans, and it provides information on how to take full advantage of the tools available to help build security for you and your family.

### Summary of Disability Benefits

The chart below lists the various Plans available to NXP employees. To participate in these Plans, you must meet the eligibility requirements as detailed in [Participation](#), beginning on page 3. Some of the Plans require you to enroll for participation, and others are automatic.

Disability Income Plans Summary		
<i>If you are unable to work at your occupation</i>	<i>Short-Term Disability</i>	<i>Short-Term Disability with Buy-Up</i>
<b>What it Is</b>	Provides coverage due to illness, pregnancy or a non-work-related accident that prevents you from working for up to 180 calendar days.	Provides additional benefits during your short-term disability.
<b>Who Is Eligible</b>	You (automatic coverage).	You, if you enroll for coverage.
<b>When Coverage Begins</b>	First of the month after 90 days of employment.	First of the month after 90 days of employment.

Disability Income Plans Summary		
<b>Time Disabled</b> <ul style="list-style-type: none"> <li>• First seven calendar days</li> <li>• Next 90 calendar days</li> <li>• Next 90 calendar days</li> </ul>	No benefit 75% of covered pay (weekly benefit) 60% of covered pay (weekly benefit)	No benefit 90% of covered pay (weekly benefit) 75% of covered pay (weekly benefit)
<i>If you are unable to work at your own occupation for 24 months or any reasonable occupation up to your Social Security normal retirement age</i>	<b>Long-Term Disability</b>	
<b>What it Is</b>	Extends disability coverage beyond 180 calendar days.	
<b>Who Is Eligible</b>	You (automatic coverage).	
<b>Time Disabled</b> After 188 calendar days (period covered by Short-Term Disability Plan)	60% of covered pay, to \$10,000 maximum monthly benefit	

## Disability Plan Features

- **Short-Term Disability Plan** benefits pay you a portion of your covered pay for up to 180 calendar days when you are unable to perform the essential duties of your regular job because of pregnancy or because of an illness or injury that is not covered under workers' compensation. NXP provides this protection at no cost to you. If you elect to increase your coverage with [Short-Term Disability Buy-Up](#) (see page 165), you pay the cost of that additional coverage.
- **Long-Term Disability Plan** benefits pay you a monthly income benefit after you exhaust your Short-Term Disability benefits, if you are considered disabled and eligible for Long-Term Disability Plan benefits. NXP provides this protection at no cost to you.

## If You Become Disabled

If you become disabled, you will want to return to your personal and work activities as soon as you are medically able. NXP works with the Claims Administrator, whose physicians and registered nurses work in conjunction with NXP to effectively manage disability leaves. These physicians and nurses work with your physician, when necessary, to establish a realistic program and timetable for your return to work as soon as possible.

## When Disability Coverage Begins

This example shows important dates for this coverage. It also shows the period used by for pre-existing condition exclusion; see [Pre-Existing Condition](#) (below).

<b>Short-Term Disability — Examples of Important Dates</b>			
<b>Eligible Employee</b>	<b>When Coverage Begins</b>	<b>Pre-Existing Condition Period</b>	<b>Treatment or Medical Care Received During the Pre-Existing Condition Period</b>
<b>New Hire Eligibility Requirements Met</b>	First of the month after 90 days of employment	180 days from the day coverage is effective (begins) If a claim is filed within 180 days of the coverage effective date, there is a required look back period that is the 90 days before that coverage effective date. This review must take place before a decision is made	Yes, then pre-existing condition period applies and claim is denied No, then pre-existing condition period does not apply and claim is processed and a determination (approval or denial) made
<b>January 15 (Date of hire)</b>	May 1 (Coverage effective date)	January 31 – April 30 (Look-back period)	January 31 – April 30

Dates may vary from those shown above. Dates in above example assume a non-leap year.

### **Pre-Existing Condition**

The Short-Term Disability and Short-Term Disability Buy-Up do not pay benefits for disabilities during the first 180 days of coverage that result from pre-existing conditions. A pre-existing condition is an illness, injury or pregnancy for which you have received medical care or treatment during the 90 days before your coverage began (but not before you became eligible).

The Short-Term Disability and Short-Term Disability Buy-Up Plans will no longer exclude pre-existing conditions when:

- Your coverage has been in place for 180 days; and
- You have been disability-free for that condition for 180 consecutive calendar days.

### **Your Covered Pay Determines Your Benefits**

Your Short-Term and Long-Term Disability Plan benefits are a percentage of your “covered pay.” Your covered pay includes your annual base salary, prior year Sales Incentive Plan payments, prior quarter shift differential and lump sum merit as of the date you become disabled. Covered pay does not include overtime, bonuses, Incentive Plan payments, moving allowances, educational allowances, noncash payments or overseas allowances.

Your annual covered pay is then divided by 26 to determine your biweekly rate of pay for Short-Term Disability Plan benefits, and by 12 to determine your monthly rate of pay for Long-Term Disability Plan benefits. If you worked for NXP for less than one year when you become disabled, your covered pay is calculated using figures from your actual period of employment.

The following components of compensation are based on your employee status:

- **Base Salary for Non-Exempt Employees:** Your annual base salary means your annualized base rate of pay.
- **Base Salary for Exempt Employees:** Your annual base salary means your annualized base salary only.
- **Shift Differential:** Any shift premiums you earn are included in determining your benefit. This amount is determined at the beginning of each calendar quarter (January 1, April 1, July 1 and October 1) by calculating the annualized shift premiums earned in the preceding quarter. You must work a full calendar quarter before this method applies.
- **Lump Sum Merit:** If you receive a lump sum merit award instead of an increase to your base salary, your covered pay for disability benefits includes your lump sum merit award.
- **Sales Incentive Plan Employees:** Your coverage includes your current year's earnings plus your prior year's Sales Incentive Plan payments.
- **If You Work Less Than 35 Hours Per Week:** Your coverage is figured at the beginning of each calendar quarter by calculating your highest annualized calendar quarter salary of the previous four quarters. You must work a full calendar quarter before this method applies. If you are a new employee, your coverage is figured according to annualized pay earned during your first 30 days of employment.

**Example:** Karen, an exempt sales representative, has a monthly covered pay of \$2,500. Additionally, in the past year she earned an average sales incentive plan payment of \$250 per month. Her covered pay for calculating disability benefits is \$2,750 per month.

## Short-Term Disability Benefits

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When you have been considered disabled for eight calendar days under the Short-Term Disability Plan, you may begin receiving the plan's biweekly benefits. Any disability benefit payable for a period of less than one week is paid on the basis of 1/7 of the weekly benefit for each day you are disabled.

- For the first seven calendar days, no benefit.
- For the next 90 calendar days, your Short-Term Disability Plan benefit is 75% of your covered pay.
- For the next 90 calendar days, your Short-Term Disability Plan benefit is 60% of your covered pay.

Your Short-Term Disability Plan benefit may be reduced; see [Integration of Benefits](#) beginning on page 167 for details.

You are considered disabled under the Short-Term Disability Plan when an illness or injury leaves you continuously unable to perform the essential duties of your regular job in substantially the same manner as you did before incurring your medically determined physical or mental impairment. "Substantially the same manner" takes into account any adjustments that NXP makes to those responsibilities. If you undergo a cesarean section delivery, you are considered disabled for eight weeks following the procedure. After eight weeks, your condition will be treated the same as any other pregnancy-related condition.

When you are considered disabled, you qualify to receive Short-Term Disability Plan benefits only if you are:

- Under the regular care of a physician;
- Unable to perform the regular duties of your job;
- Earning 80% or less of your covered pay solely because of an illness, injury or a disabling pregnancy-related condition; and
- Providing the Claims Administrator with documentation from your physician certifying your disability.

You must notify the Claims Administrator before engaging in any employment while you are receiving Short-Term Disability Plan benefits.

### If You Have Other Income or Disability Benefits

The Claims Administrator may require you to provide proof of any income you receive from work while you are disabled. You may also be required to show proof of applying for or receiving any other income benefits that you or your family member or dependent may be eligible to receive due to your disability (such as from Social Security or workers' compensation), as well as proof of an appeal if those benefits are denied. You may not waive any other income benefit without the consent of the Claims Administrator.

If you do not provide proof required by the Claims Administrator, your Short-Term Disability Plan benefits may be suspended or adjusted by the estimated amount of those income benefits.

The Claims Administrator requires proof of any other income.

The Claims Administrator may require proof:

- That you, your spouse, child or dependent has applied for all other income benefits that you or they are eligible to receive because of your disability and has made a timely appeal of any denial of benefits through the highest administrative level. “Timely appeal” means making the appeal in the time required, but never more than 60 days after the latest denial.
- That the person applying for other income benefits has provided the necessary proof needed for other income benefits, which include, but is not limited to workers’ compensation benefits;
- That the person has not waived (given up his or her right to) any other income benefits without the Claims Administrator’s written consent;
- That the person has sent the Claims Administrator copies of documents showing the effective dates and amounts of other income benefits;
- Of income you receive from any work or pay for profit.

You do not have to apply for:

- Retirement benefits paid only on a reduced basis;
- Disability benefits under a group life insurance plan, if the disability benefits would reduce your group life insurance amount.

However, if you apply for and receive these benefits, they will be considered as other income benefits and you must provide proof to the Claims Administrator if requested.

If you do not provide the proof that the Claims Administrator may require, the Claims Administrator has the right to suspend or adjust the Plan’s benefits by the estimated amount of the other income benefits.

## **When Short-Term Disability Benefits End**

As long as you are considered disabled and meet the requirements above, your Short-Term Disability Plan benefits continue until the first of these events occurs:

- You have received benefits for 180 calendar days;
- You are no longer considered disabled under the Short-Term Disability Plan;
- You do not provide proof to the Claims Administrator that you meet the Short-Term Disability Plan test of disability;
- You do not notify the Claims Administrator that you are engaging in employment;
- You are convicted of a felony;
- You do not provide satisfactory evidence of your continuing disability;
- You refuse to be examined or do not cooperate with a request for an examination;
- You do not cooperate with a physician’s recommendation for care and treatment;

- The date you refuse to cooperate with or accept changes to your work site or job process designed to suit identified medical limitations, or any adaptive equipment or devices designed to suit your identified medical limitations; that would allow you to perform the duties of your regular job (this applies only if a physician agrees that such changes, adaptive equipment or devices suit your particular medical limitation);
- The date you refuse to participate in an approved rehabilitation plan, which may be recommended by NXP, the NXP nurse case manager and/or the Claims Administrator;
- The date of your death; or
- The date your condition would allow you to work, increase the hours you work or increase the duties you perform in your regular job, but you refuse to do so.

If you are incarcerated because of your conviction or plea of guilty or no contest to a crime other than a felony, the Claims Administrator may suspend your benefits during your period of incarceration.

## **Short-Term Disability Buy-Up**

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The Short-Term Disability Buy-Up option allows you to effectively increase your Short-Term Disability Plan benefit. The Short-Term Disability Buy-Up benefit is 15% of your covered pay, and it is paid in addition to the Short-Term Disability Plan benefits you receive biweekly.

When you choose this coverage, here is how you receive benefits for a short-term disability:

- For the first 90 calendar days, your Short-Term Disability and Buy-Up benefits total 90% of your covered pay.
- For the next 90 calendar days, your Short-Term Disability and Buy-Up benefits total 75% of your covered pay.

All rules governing Short-Term Disability Plan benefits apply to the Short-Term Disability Buy-Up. This means that your Buy-Up benefit is paid only when your Short-Term Disability Plan benefit is paid. If your Short-Term Disability Plan benefit ends, is suspended, or not payable, the same will apply to your Buy-Up benefit.

### **Leave of Absence**

If you are on a leave of absence, you may enroll in Short-Term Disability Buy-Up during annual enrollment. Assuming you are actively at work on the following January 1, your contributions will begin on that date. The period of January 1 – March 31 is your 90-day waiting period, meaning you are not eligible to receive benefits until April 1. But if you are still on leave of absence on that day, your enrollment is retroactively voided for the plan year, and you may not enroll again until the next annual enrollment period.

This chart shows these concepts. It also shows the period used by the pre-existing condition exclusion; see [Pre-Existing Condition](#) on page 154 for details.

<b>Short-Term Disability Buy-Up — Examples of Important Dates</b>					
<b>Eligible Employee</b>	<b>Enrollment Date</b>	<b>When Coverage Begins</b>	<b>When Contributions Begin</b>	<b>Pre-Existing Condition Period</b>	<b>Waiting Period</b>
<b>New Hire Date: January 16</b>	Within 30 days of hire date	May 1	May 1	February 1 – April 30	None
<b>New Hire Date: September 16</b>	Within 30 days of hire date	January 1 of the following year	January 1 of the following year	October 1 – December 31	None
<b>Active Employee</b>	Annual Enrollment	January 1	January 1	None	January 1 – March 31*
<b>Employee on Leave of Absence</b>	Annual Enrollment	If actively at work: January 1	January 1	None	January 1 – March 31*
<b>Employee on Leave of Absence</b>	Annual Enrollment	If on leave of absence on January 1, enrollment is retroactively voided	Not applicable	Not applicable	Not applicable

\* *Approximate 90-day period*

Dates may vary from those shown above. Dates in above example assume a non-leap year.

You may not cancel your coverage at any time during a calendar year in which your coverage is in force. All other rules that govern the beginning and ending of Short-Term Disability Plan benefits also apply to the Short-Term Disability Buy-Up; see [When Short-Term Disability Benefits End](#) on page 157.

## Long-Term Disability Benefits

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If you are eligible, Long-Term Disability Plan benefits begin when your Short-Term Disability Plan benefits end. If after receiving Short-Term Disability Plan benefits for 180 days you are considered disabled under the Long-Term Disability Plan, you may begin receiving the Plan's monthly benefits. Your Long-Term Disability Plan benefit is 60% of your covered pay, to a maximum benefit of \$10,000 a month. Any disability benefit payable for a period of less than one month is paid on the basis of 1/30 of the monthly benefit for each day you are disabled.

If the full 180-day Short-Term Disability Plan benefit is not paid for an illness or injury, no Long-Term Disability Plan benefit will be paid for that same illness or injury.

Your Long Term Disability benefits will not cover a pre existing condition. You have a pre-existing condition if both 1. and 2. are true:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the 3 months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available.
2. Your disability begins within 12 months of the date your coverage under the plan becomes effective.

Your Long-Term Disability Plan benefit may be reduced; see [Integration of Benefits](#) beginning on page 167 for details.

Long-term disability, for the Long-Term Disability Plan, is defined as your ongoing, continuous inability, by reason of a medically determined physical or mental impairment, to work in your *own* or *any* reasonable occupation. For you to remain eligible to receive disability income replacement, you must:

- Be under the regular care of a physician (you will be considered under the care of a physician up to 31 days before you have been seen and treated in person by a physician for the illness, injury, or pregnancy-related condition that caused the disability);
- Be unable to engage in your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months);
- Have earnings 80% or less of your covered pay during the *own* occupation period (the first 24 months) or 60% or less of your covered pay during the *any* reasonable occupation period;
- Be covered by the Long-Term Disability Plan at the time you became disabled;
- Provide the Claims Administrator with documentation from your physician certifying your continuing disability; and
- Provide documentation from the Social Security Administration as the Long-Term Disability Plan requires.

You must notify the Claims Administrator before engaging in any employment while you are receiving Long-Term Disability Plan benefits.

The loss of a professional or occupational license or certification that is required by your regular job does not mean you meet the test of disability. You must meet the above requirements to be considered disabled.

## Own Occupation and Any Reasonable Occupation

Your own or any reasonable occupation means employment that would afford you earnings potential (which may be determined, in the Claims Administrator's discretion, based on evidence of labor market conditions) that equals or exceeds your Long-Term Disability or Short-Term Disability Plan benefits.

### Definitions

- **Own Occupation:** The occupation that you are routinely performing when your disability period begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed for your specific employer or at your location or worksite, and without required to your specific reporting relationship.
- **Any Reasonable Occupation:** This is any gainful activity for which you are, or may reasonably become, fitted by education, training or experience that results in, or can be expected to result in, an income of more than 60% of your adjusted pre-disability earnings.

**Example:** Taylor is eligible for disability benefits, which are paid as follows:

**March 26, 2018:** First day of disability.

**March 26 – April 1, 2018:** Seven-day Short-Term Disability Plan elimination period (before benefits begin).

**April 2 – September 28, 2018:** Period when Short-Term Disability Plan benefits are paid.

**September 29, 2018 - September 30, 2020:** Long-Term Disability Plan 24-month own occupation benefits period when Long-Term Disability Plan benefits are paid.

**October 1, 2020:** Long-Term Disability Plan any occupation benefits period begins.

## Physician Care Requirements

Your physician, or in certain circumstances, your psychologist or certified addictionologist, must be qualified to treat your disabling condition.

## When Long-Term Disability Benefits End

As long as you are considered disabled and meet the requirements above, your Long-Term Disability Plan benefits continue until the first of these events occurs:

- You are no longer considered disabled under the Long-Term Disability Plan;
- The calendar month when you reach your full retirement age under Social Security (65 to 67, depending on your year of birth), as shown in this chart;
- You fail to meet the Social Security filing requirement applicable to you;
- You commit or attempt to commit fraudulent activity against the Long-Term Disability Plan, NXP or any related company;
- You do not provide proof to the Claims Administrator that you meet the Long-Term Disability Plan test of disability, including work or your being able to work at your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months) (when required);
- You do not notify the Claims Administrator that you are engaging in employment;
- You engage in a felony;
- You do not provide satisfactory evidence of your continuing disability;
- You do not cooperate with a request for an examination, or the independent medical examination report or functional capacity evaluation does not, according to the Claims Administrator, confirm that you are disabled;
- The date you are not receiving effective treatment for substance use disorder, if your disability is caused (in whole or in part) by alcoholism or drug abuse;
- You do not cooperate with a physician's recommendation for care and treatment, or you are no longer under the regular care of a physician;
- The date you refuse or cooperate with or accept changes to your work site or job process designed to suit your identified medical limitations; or adaptive equipment or devices designed to suit your identified medical limitations that would allow you to work at your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months) provided that a physician agrees that such changes, adaptive devices or equipment suit your particular limitation;
- The date your condition would allow you to work, increase the hours you work or increase the number or type of duties you perform at your *own* occupation (for the first 24 months) or *any* reasonable occupation (after the first 24 months), but you refuse to do so;

Year of Birth	Full Social Security Retirement Age
1937 or earlier	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

- 90 days after the Claims Administrator requests repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you do not repay or set up an acceptable repayment schedule;
- You die; or
- The day the Long-Term Disability Plan ends or the effective date of an amendment eliminating this coverage.

If you are incarcerated because of your conviction or plea of guilty or no contest to a crime other than a felony, the Claims Administrator may suspend your benefits during your period of incarceration.

## **If You Have a Mental, Nervous, Alcohol or Drug-Related Condition**

If your disability is caused primarily by a mental, nervous, alcohol- or drug-related condition, there is a maximum lifetime cap of up to 24 months of Long-Term Disability Plan benefits. These disabilities require the certification of a psychiatrist or physician certified in addictive disorders if they continue for more than 30 days.

Mental, nervous, alcohol- and drug-related conditions subject to the 24-month limitation may include, but are not limited to, the following:

- Alcohol-/substance-related disorders;
- Schizophrenia and other psychotic disorders;
- Mood/depressive disorders;
- Anxiety disorders; or
- Eating disorders.

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

#### ***Long-Term Disability Benefits in the U.S.***

If you return to the United States before your termination of employment under NXP's Human Resources Leave Policies, and if you remain disabled and eligible for Long-Term Disability Plan benefits, you will receive benefits up to the calendar month when you reach your [Social Security full retirement age](#) (as shown on page 163) if the disability occurs before age 60. If your disability starts at age 60 or older, you are eligible to receive benefits for up to five years (including the 180 days you received Short-Term Disability Plan benefits). There are exceptions to this length of coverage if your disability is primarily caused by a mental, nervous, alcohol- or drug-related condition (see above).

#### ***Long-Term Disability Benefits Abroad***

If you remain disabled and eligible for Long-Term Disability Plan benefits and remain abroad, your Long-Term Disability Plan benefits ends on the last day of the month in which your employment terminates under NXP's Human Resources Leave Policies.

## Filing for Social Security Disability

If your disability continues beyond five months, you may also qualify for Social Security disability benefits. If the Claims Administrator determines that you may be eligible for Social Security disability benefits, the Claims Administrator will assist you in applying for this benefit.

If you continue to be disabled beyond 187 days of long-term disability, you must provide evidence to the Claims Administrator that you have filed for Social Security disability benefits. You are required to exhaust all levels of application and appeal for Social Security benefits.

Proof of filing for a Social Security disability award is required no later than the first anniversary of your disability. If you do not file for Social Security disability benefits within one year after becoming disabled, your Long-Term Disability Plan benefits may be terminated. Documentation of a Social Security disability proof of filing, award or denial of Social Security disability benefits must be received by the Claims Administrator no later than 90 days after the first anniversary of your disability.

If, at any time, the Claims Administrator has a good-faith belief that you are receiving Social Security disability benefits at the same time as you are receiving Long-Term Disability Plan benefits, it may request documentation of your Social Security status. You need to provide the required documentation within 90 days of the Claims Administrator's request.

Check with your Social Security Office for more information on filing for Social Security disability benefits. Or go to [SocialSecurity.gov](https://www.socialsecurity.gov).

## Disability Income Provisions

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### Filing a Claim — Notifying NXP of Your Disability

As soon as you know that you are, or will be, physically unable to work for at least seven calendar days, you must:

- Contact your local Occupational Health nurse first; and
- Call the Claims Administrator (Prudential) at 800-842-1718.

You must apply for disability benefits within 45 days from the onset of your illness or injury.

Your call initiates the disability process:

- The Claims Administrator needs information about you, your physician and your medical condition. Also, you are asked about the work you do, your location and your supervisor's name.
- The Claims Administrator contacts your physician for detailed clinical information and to jointly reach a conclusion as to the expected outcome of your prognosis and expected return-to-work date. A date is established for your anticipated return to work. When appropriate, you may be eligible to return to work initially on a reduced schedule or in a less physically demanding role.
- The Claims Administrator makes the final decision to approve or deny disability benefits. If the Claims Administrator and your physician cannot reach a joint conclusion as to the expected prognosis of your case and establish when you should return to work, the Claims Administrator's conclusion will govern.

If you know in advance that you will need Short-Term Disability Plan benefits, such as for childbirth or planned surgery, you can contact the Claims Administrator for approval of disability benefits. Contact the Claims Administrator, your department manager or supervisor, and Occupational Health Resources to report which day will be your last day of work.

- The Claims Administrator communicates the decision, along with supporting documentation, to you and your local Occupational Health nurse. If communication with your Human Resources representative is necessary, it does not include your confidential medical information.
- Once approved for disability benefits, you must submit proof of your disability on a regular basis (usually every 30 days) that is consistent with your disability and related care and treatment. NXP has the right to have a physician of its choice examine you (at NXP's expense) during the time of your disability. If you do not cooperate with the physician's recommendation for treatment, your disability benefits will cease.
- During the disability period, a claims or case representative stays in contact with you and your physician. You may be contacted before your anticipated return-to-work date to make sure you are able to return to work. If you are unable to return to work at that time, a representative contacts your physician for additional information and, if you are still disabled, jointly establish a new date when you will return to work.

## Taxes and Disability Benefits

Short-Term Disability and Long-Term Disability Plan benefits are taxable income. Applicable tax withholdings are taken from your disability payments. Short-Term Buy-Up benefits are not taxable income since contributions are made on an after-tax basis.

## Integration of Benefits

Your disability benefits from NXP are coordinated with certain other payments for which you are eligible. For example, your benefit from the Short-Term and/or Long-Term Disability Plan is reduced by:

- Any payment for which you are eligible under Social Security, including primary disability or old age, widow(er) or dependent awards;
- Any payment made pursuant to occupational disease act or law or any state compulsory disability benefit law;
- Disability or other income benefits from NXP for the same period as the Plan's payment (except benefits under the 401(k) Retirement Plan);
- Any award given under The Jones Act or The Maritime Doctrine of Maintenance, Wages and Cure;
- Disability, retirement or unemployment benefits required or provided for by government law. This includes (but is not limited to):
  - Unemployment compensation benefits;
  - Temporary or permanent, partial or total, disability benefits under any workers' compensation law or similar law meant to compensate a worker for:
  - Loss of past and future wages;
  - Impaired earning capacity;
  - Lessened ability to compete for jobs;
  - Any permanent impairment; and
  - Any loss of bodily function or capacity.
- Automobile no-fault wage replacement benefits required by law;
- Benefits under the Federal Social Security Act, Railroad Retirement Act, Canada Pension Plan and Quebec Pension Plan;
- Veteran's benefits;
- Disability or unemployment benefits payable by either insured and uninsured plans due to employment by or association with your employer or due to your membership in, or association with, any group, association, union or other organization (both insured and uninsured plans);
- Unreduced retirement benefits for which you are (or may become) eligible under a group pension plan at age 62 or the Plan's normal retirement age, whichever comes later, but only to the benefit amount that was paid by the employer;
- Retirement benefits you elect and receive under any group pension plan, but only to the benefit amount that was paid by an employer;

- Disability payments from under-insured motorist coverage (UIM), uninsured motorist coverage (UM), liability insurance or other sources for a disability caused by a third party (other sources include, but are not limited to, damages or a settlement received through legal action); and
- Disability benefits from an accumulated sick time or salary continuation program, provided they are part of an established group plan maintained by NXP for the benefit of its employees.

## **Other Income Benefits That Do Not Reduce Benefits**

Income from certain sources will not reduce your weekly disability benefits under the Plan. Your benefits under Short-Term Disability Plan coverage will not be reduced by the benefit amounts you were receiving from the following sources, before you became disabled:

- Military and other government service pensions;
- Retirement benefits from a former employer;
- Veteran's benefits for service-related disabilities;
- Individual disability income policies; or
- Retirement benefits from the Federal Social Security Act.

The amount of income or other benefits from the following sources will not reduce your Short-Term Disability Plan benefits:

- Profit sharing plans;
- Thrift or savings plans;
- 401(k) plans;
- Keogh plans;
- Employee stock options plans;
- 403(b) Tax-sheltered annuity plans;
- 457 deferred compensation plans;
- Tax-sheltered annuity plans;
- Individual disability income policies; or
- Individual Retirement Accounts (IRAs).

## **Other Reductions**

Your disability benefits may be reduced as required by a court order, such as a child support order or a garnishment order. Court orders will be recognized if they comply with applicable state law and are not preempted by ERISA.

## If You Work in Certain States

Some states have special laws regarding disability benefits. If you work for NXP in California, Hawaii, New Jersey, New York or Rhode Island, special provisions may apply to you.

- **California:** California State Disability Insurance (SDI) is a state-mandated, partial wage-replacement insurance plan that provides short-term benefits to eligible California workers. SDI provides a benefit to works who suffer a loss of wages when they are unable to work due to a non-work-related illness, injury or disability. It is state-mandated and funded through employee payroll deductions. NXP's Disability Income benefits payable are reduced by benefits paid to you by the California state disability plan. If you would like to purchase additional STD coverage, you may elect STD Buy-Up coverage. For more information on SDI, visit [edd.ca.gov](http://edd.ca.gov).
- **New Jersey and Rhode Island:** Benefits payable under the Short-Term and/or Long-Term Disability Plan are reduced by benefits paid to you by the state disability plan.
- **Hawaii and New York:** Benefits payable from the Short-Term and/or Long-Term Disability Plan are reduced by any benefits payable by any other plan or policy set up by NXP to comply with that state's disability benefits law.

## What's Not Covered

Your plan does not cover any disabilities caused by, contributed to by, or resulting from your:

- Intentionally self-inflicted injuries;
- Active participation in a riot; or
- Commission of a crime for which you have been convicted under state or federal law.
- Your plan does not cover a disability due to a pre-existing condition.
- Your plan does not cover a disability due to war, declared or undeclared, or any act of war.

The Short-Term and/or Long-Term Disability Plan does not pay physician or other service provider charges for completion of forms, missed appointments, telephone consultations or examinations (unless the examination is ordered by the Claims Administrator), or for copying and sending your records, including charges for telephone calls.

Benefits are paid only while you are under the regular care and treatment of a physician. A confirmation from your physician is required for continuation of benefit payments.

## If Your Accident or Illness Is Work-Related

If NXP's Workers' Compensation Administrator (or the carrier or appropriate government authority) deems your claim for an injury or illness to be payable under workers' compensation, benefits under the Short-Term and/or Long-Term Disability Plan are denied, and you receive payments from workers' compensation instead.

Once a claim for an injury or illness is deemed payable under workers' compensation, that injury or illness is not eligible for any future payments from the Short-Term and/or Long-Term Disability Plan.

## **Recurring Disability**

Disability benefits are available more than once during your career with NXP. There is a maximum of 187 calendar days for any one short-term disability period. In most cases, all days you are unable to work because of the same (or a related) cause are considered one “period of disability.” If within 30 days after you return to work you have a second period of disability due to the same (or related) cause, this will be considered part of your first period of disability. But:

- If you return to work from a short-term disability for more than 30 days, any later disability will be considered a new period of disability.
- If you receive Long-Term Disability Plan benefits, return to work and become disabled again within 180 days due to the same (or related) cause, your second period of absence will be considered a continuation of your original disability.

## **Physician’s Statement**

Benefits are paid only while you are under the regular care and treatment of a physician. A confirmation from your physician is required before benefits start, and periodically to confirm your continuing disability. In the Claims Administrator’s discretion, a confirmation from a physician of the Claims Administrator’s choice may be required for continuation of benefit payments.

## **Continuation and Conversion Rights**

Continuation and conversion rights do not apply to the Short-Term (including Buy-Up option) or Long-Term Disability Plan.

## Life, Accidental Death and Dismemberment and Business Travel Accident Benefits

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This section includes information on various life and accidental death and dismemberment benefit features, including:

- [Basic life](#) insurance (beginning on page 177);
- [Supplemental life](#) insurance (beginning on page 177);
- Life insurance for [spouses/domestic partners and children](#) (beginning on page 177);
- [Accidental Death and Dismemberment \(AD&D\)](#) insurance (beginning on page 182);
- [Business Travel Accident \(BTA\)](#) insurance (beginning on page 186); and
- [Additional information](#) that applies to these benefits (beginning on page 179).

See [Participation](#), beginning on page 3, for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The comprehensive NXP Rewards benefits package also includes Life and Accidental Death and Dismemberment (AD&D) Plans that provide benefits for you and your family if you and or a covered family member dies. Coverage is automatic in some cases and optional in others. To participate in these Plans, you must meet the eligibility requirements as detailed in [Participation](#), beginning on page 3.

This section summarizes your benefits under the Life and Accidental Death and Dismemberment Plans, and it provides information on how to take full advantage of the tools available to help build security for you and your family. Refer to this information regularly as your source for building security against what life may bring.

## Summary of Life and Accidental Death and Dismemberment Benefits

NXP provides various means to help ensure your family's security. Life insurance benefits are available to help survivors in the event of a death and accidental death and dismemberment benefits are available to help you when you are seriously injured.

The chart below lists the various Plans available to NXP employees. To participate in these Plans, you must meet the eligibility requirements as detailed in [Participation](#), beginning on page 3. Some of the Plans require you to enroll for participation, and others are automatic.

Life and Accidental Death and Dismemberment Benefits Summary			
Plan	What It Is	Who's Eligible	Benefit Amount
<a href="#">Basic Life Insurance</a> (no cost to you)	Provides a benefit to your survivors if you die.	You (automatic coverage)	<ul style="list-style-type: none"> <li>1 times eligible compensation rounded to the next higher \$100</li> <li>Maximum benefit \$1,000,000</li> </ul>
<a href="#">Supplemental Life Insurance</a>	Life insurance available in addition to Basic Life Insurance.	You, if you enroll for coverage	<ul style="list-style-type: none"> <li>1 to 8 times eligible compensation rounded to next higher \$100</li> <li>Maximum benefit \$1,500,000</li> <li>Non-Medical Issue Amount: The lesser of 3 times your eligible compensation or \$500,000</li> </ul>
<a href="#">Spouse/Domestic Partner Life Insurance</a>	Life insurance for your spouse/domestic partner.	Your spouse/domestic partner	<ul style="list-style-type: none"> <li>\$25,000</li> <li>\$50,000</li> <li>\$100,000</li> <li>\$150,000</li> <li>\$200,000</li> <li>\$250,000</li> <li>Maximum benefit: The lesser of \$250,000 or the level of your combined basic and supplemental life coverage</li> <li>Non-Medical Issue Amount: \$25,000</li> </ul>
<a href="#">Child(ren) Life Insurance</a>	Life insurance for your child(ren).	All your dependent child(ren)	<ul style="list-style-type: none"> <li>\$15,000</li> </ul>

Life and Accidental Death and Dismemberment Benefits Summary			
Plan	What It Is	Who's Eligible	Benefit Amount
<u>Accidental Death and Dismemberment Insurance</u> (no cost to you)	Extra protection for you or your survivors if you should die or become disabled due to an accident.	You (automatic coverage)	<ul style="list-style-type: none"> <li>• 1 times eligible compensation rounded to the next higher \$100</li> <li>• Maximum benefit \$1,000,000</li> <li>• Full amount paid for accidental death</li> <li>• A percentage of benefit paid for accidental injury resulting in a covered loss, depending on extent of injury</li> </ul>
<u>Business Travel Accident Insurance</u> (no cost to you)	Protection for you or your survivors if something happens while you are traveling on NXP business.	You (automatic coverage)	<ul style="list-style-type: none"> <li>• 3 times eligible compensation, rounded to the next higher \$100</li> <li>• Minimum benefit \$50,000</li> <li>• Maximum benefit \$2,000,000</li> <li>• 100% of benefit paid for death while traveling on business for NXP</li> <li>• A percentage of benefit paid for accidental injury resulting in a covered loss while traveling on business for NXP, depending on extent of injury</li> </ul>

## Your Compensation Determines Your Coverage

Eligible compensation for life, accidental death and dismemberment and business travel accident insurance benefits includes your annual base salary, prior year Sales Incentive Plan payments, prior quarter shift differential annualized and lump sum merit. As your compensation goes up, so does your protection. When your compensation changes, your coverage for Basic Life, Supplemental Life, Accidental Death and Dismemberment and Business Travel Accident Insurance will be adjusted per the policy. Eligible compensation does not include overtime, incentive pay, bonuses, moving allowances, educational allowances, noncash payments or overseas allowances.

Your eligible compensation is rounded to the next higher \$100. The following components of compensation are calculated according to your employee status:

- **Non-Exempt Employees:** Your annual base salary means your annualized base rate of pay.
- **Exempt Employees:** Your annual base salary means your annualized base salary only.
- **Shift Differential:** Shift premiums you earn are included in determining your coverage. This amount is determined at the beginning of each calendar quarter (January 1, April 1, July 1 and October 1) by calculating the annualized shift premiums earned in the preceding quarter. You must work a full calendar quarter before this method applies.
- **Lump Sum Merit:** If you receive a lump sum merit award in lieu of an increase to your base salary, eligible compensation includes your lump sum merit award.
- **Sales Incentive Plan Employees:** Your coverage includes your current year's earnings plus prior year's Sales Incentive Plan payments.
- **If You Work Less Than 40 Hours Per Week:** Your coverage is figured at the beginning of each calendar quarter by calculating your highest annualized calendar quarter salary of the previous four quarters. You must work a full calendar quarter before this method applies.

## If Your Salary Decreases

Because the amount of your Basic Life, Supplemental Life, Accidental Death and Dismemberment and Business Travel Accident Insurance depends on your salary, the amount decreases if your eligible compensation decreases.

## Naming Your Beneficiaries

### Life Insurance

It is important for you to name beneficiaries for your Basic Life and Supplemental Life Insurance. You can name one or more primary beneficiaries and one or more contingent beneficiaries, and you may name different beneficiaries for each type of coverage.

To change a primary or contingent beneficiary, you can designate them online at [NXP.com/rewards](https://www.nxp.com/rewards) or you can call NXP Rewards Customer Service at 888-375-2367.

No other type of agreement or document (such as a will or divorce settlement agreement) may be used to change your beneficiary. However, the Claims Administrator will recognize a valid Qualified Domestic Relations Order that assigns your benefits. If you do not designate a beneficiary, then the Plan will pay your benefits according to the Basic Life Insurance Policy. This policy provides that if you do not designate a beneficiary, benefits are paid to the first of the following beneficiary classes in which there is a surviving person:

- Your lawful spouse;
- Your children (by birth or adoption);
- Your parents;
- Your brothers and sisters; or
- Your estate.

The beneficiary you designate will also receive any death benefit from your Accidental Death and Dismemberment Insurance.

### **Spouse/Domestic Partner and Child(ren) Life Insurance Beneficiaries**

You are the beneficiary of both Spouse/Domestic Partner and Child(ren) Life Insurance covering your family. You receive any benefit payable due to the death of a covered dependent (i.e., spouse/domestic partner and/or child).

### **Business Travel Accident (BTA) Beneficiaries**

It is important for you to name beneficiaries for your BTA Insurance. You can name one or more primary beneficiaries and one or more contingent beneficiaries.

To change a primary or contingent beneficiary, you can designate them online at [NXP.com/rewards](https://www.nxp.com/rewards) or you can call NXP Rewards Customer Service at 888-375-2367.

No other type of agreement or document (such as a will or divorce settlement agreement) may be used to change your beneficiary. However, the Claims Administrator will recognize a valid Qualified Domestic Relations Order that assigns your benefits. If you do not designate a beneficiary, then the Plan will pay your benefits according to the BTA Policy. This policy provides that if you do not designate a beneficiary, benefits will be paid to the first of the following beneficiary classes in which there is a surviving person:

- Your lawful spouse;
- Your children (by birth or adoption);
- Your parents;
- Your brothers and sisters; or
- Your estate.

## How the Benefit Is Paid

If you die while you are covered by Basic Life, Supplemental Life, Accidental Death and Dismemberment or Business Travel Accident Insurance, the total benefit is paid to your designated beneficiary or beneficiaries. Benefits will be paid in a lump sum or in another mutually agreed form. Your beneficiary or beneficiaries can get more information from NXP Rewards Customer Service regarding the form in which they may receive benefits.

A primary beneficiary is a person, trust or estate designated to receive the benefit under your insurance plan.

A contingent beneficiary is designated to receive the benefit if no primary beneficiary is living at the time the benefit becomes payable.

### Tax Alert

Company-paid life insurance is tax-free if your coverage does not exceed \$50,000. If your Basic Life Insurance coverage exceeds \$50,000, the cost of the excess coverage will be imputed and included in your gross income. If enrolled, the cost of your Supplemental and Spouse/Domestic Partner Life Insurance coverage, less your after-tax contributions, will also be included. For this purpose, the cost is computed using a uniform premium table published by the IRS. The taxable amount, if any, is reported to you on your Form W-2 ("C" in Box 12) and on your paycheck ("Group Term Life").

Talk to your accountant or financial advisor for more information regarding taxation of life insurance coverage.

### Information for Survivors Filing a Claim

If a covered person dies, NXP Rewards Customer Service provides assistance to survivors. The beneficiary or personal representative should call 888-375-2367 to start the claims process.

## Life Insurance Plans

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### Basic Life Insurance

Basic Life Insurance is the foundation of your survivor income benefits. As an eligible NXP employee, you are provided Basic Life Insurance coverage at no cost to you. You are covered under Basic Life Insurance on the first day you are actively at work or on the day you first meet the eligibility requirements for plan participation.

**Basic Life Insurance coverage** is equal to your annual eligible compensation rounded to the next higher \$100. The maximum Basic Life Insurance benefit is \$1,000,000.

You do not have to complete any enrollment forms to participate in Basic Life Insurance. However, you must designate a beneficiary as explained in the [Naming Your Beneficiaries](#), on page 174.

### Supplemental Life Insurance

Because everyone's needs are different, you can add more life insurance protection by electing Supplemental Life Insurance. This coverage is in addition to your Basic Life Insurance.

#### Supplemental Life Insurance Coverage Options

There are eight Supplemental Life Insurance coverage options, from one to eight times your annual eligible compensation. Supplemental Life Insurance coverage is limited to \$1,500,000.

**Example:** Marcus would like to have additional life insurance benefits paid to his family if he dies. His annual salary is \$35,350.

**Marcus's Basic Life Insurance**

(his annual eligible compensation, rounded to the next higher \$100) \$35,400

**Plus**

He chooses the **Two Times Annual Eligible Compensation** coverage option

(\$35,350 x 2, rounded to the next higher \$100) + \$70,800

**Equals**

Total Life Insurance Coverage paid if Marcus dies = \$106,200

### Supplemental Life Insurance Exclusions

If you commit suicide within two years from the date your coverage takes effect, the Supplemental Life Insurance benefit will not be paid. If you commit suicide within two years from the date an increase in your coverage takes effect, the Supplemental Life Insurance benefit in effect on the day before the increase will be paid.

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

You can enroll for Spouse/Domestic Partner Life Insurance for your spouse/domestic partner. You can also enroll for Child(ren) Life Insurance for your eligible children. See [Spouse/Domestic Partner and Child\(ren\) Life Insurance Eligibility](#), beginning on page 8, for the definition of an "eligible child" for life insurance.

## Spouse/Domestic Partner Life Insurance Coverage Options

You have six different Spouse/Domestic Partner Life Insurance coverage options from which to choose:

- \$25,000
- \$50,000
- \$100,000
- \$150,000
- \$200,000
- \$250,000

The amount of Spouse/Domestic Partner Life Insurance coverage cannot be more than your “total life insurance coverage” amount. Your total life insurance coverage amount includes your Basic and Supplemental Life Insurance coverages combined.

## Child(ren) Life Insurance Coverage Option

- You have the option to elect Child(ren) Life Insurance coverage. Child(ren) Life Insurance coverage is \$15,000 per eligible child.

## Spouse/Domestic Partner and Child(ren) Life Insurance Exclusions

If your spouse/domestic partner or child (as applicable) commits suicide within two years from the date the coverage takes effect, the Life Insurance benefit will not be paid. If your spouse/domestic partner or child (as applicable) commits suicide within two years from the date an increase in coverage takes effect, the Life Insurance benefit in effect on the day before the increase will be paid.

## Contribution Amount

Your after-tax contribution, or cost, depends on your choice of coverage options. For Supplemental Life Insurance and Spouse/Domestic Partner Life Insurance, the cost is based on age and tobacco use status. When you enroll each year, you and your spouse/domestic partner complete a certification of tobacco use. The Plan offers discounted rates when you certify that the insured:

- Has not used tobacco products for the past six months; or
- Is enrolled in a smoking cessation program.

For Life Insurance, tobacco use status cannot be changed during the calendar year, even if you have a qualified status change (see [Qualified Status Change](#) on page 23).

For Child(ren) Life Insurance, the cost of coverage is the same regardless of the number of eligible children covered. You may visit [NXP.com/rewards](https://www.nxp.com/rewards) or call NXP Rewards Customer Service at 888-375-2367 for current contribution amounts.

## Evidence of Insurability

In some instances, you may be required to provide evidence of insurability to MetLife. When evidence of insurability is required, coverage begins on the day MetLife approves your application.

Evidence of insurability must be provided at your own expense.

If evidence of insurability is required and not provided or not satisfactory to and accepted by MetLife, your Supplemental, Spouse/Domestic Partner or Child(ren) Life Insurance amount will be limited to the greater of the non-medical issue amount or current level of coverage.

If your coverage choice requires evidence of insurability, you must complete an evidence of insurability form online by following the link provided when you elect coverage on the NXP Rewards website. If you do not complete this form online, the NXP Rewards Center will send you the *Statement of Health Form* to complete and return. The coverage requiring evidence of insurability will begin on the day MetLife approves your application.

**Example:** Brian chooses no Supplemental Life Insurance coverage when he joins NXP. During the following year's annual enrollment, Brian chooses the Supplemental Life coverage option of five times his eligible compensation.

Because this election is more than three times his eligible compensation, Brian must complete the *Statement of Health Form*. Brian will be enrolled for three times eligible compensation coverage. If his application is approved, he will be enrolled for five times eligible compensation coverage.

## Supplemental Life Insurance

For Supplemental Life Insurance, the non-medical issue amount is the lesser of three times your eligible compensation or \$500,000.

Evidence of insurability is required for Supplemental Life Insurance if you request an amount greater than the non-medical issue amount.

## Spouse/Domestic Partner Life Insurance

For Spouse/Domestic Partner Life Insurance, the non-medical issue amount is \$25,000.

Evidence of insurability is required for Spouse/Domestic Partner Life Insurance if you request coverage for your Spouse/Domestic Partner of more than \$25,000.

## Additional Services

### Will Preparation Services

Along with your Basic Life Insurance coverage, MetLife includes an online will and legal services program. Having an up-to-date will is one of the most important things you can do for your family.

Like life insurance, a carefully prepared will is important. With a will, you can document important decisions, such as who will care for your children or inherit your property. Will Preparation Services also include the preparation of living wills and power of attorney.

You and your dependents may take advantage of these services. This online document preparation service assists you in preparing a will, living will or power of attorney. Visit [WillsCenter.com](http://WillsCenter.com) for more information.

When you enroll in Supplemental Life coverage, you have access to face-to-face will preparation services. You and your dependents may take advantage of will preparation and legal services available through Hyatt Legal Plans' network of more than 13,400 participating attorneys. This service includes face-to-face access to a participating Hyatt Legal Plans attorney for preparing or updating a will, living will or power of attorney at no additional cost to you.

Call Hyatt Legal Plans' at 800-821-6400, and a Client Service Representative will help you find a participating plan attorney in your area.

## **Grief Counseling**

MetLife offers grief counseling, provided by Harris, Rothenberg International (HRI), Inc. for you, your dependents and your beneficiaries. Facing a loss is never easy and this service provides up to five confidential counseling sessions per event. Assistance is available for any situation you perceive as a major loss, including, but not limited to, death of a loved one, divorce, receiving a serious medical diagnosis or losing a pet. Research specialists can also refer services and providers, they can help you locate funeral homes, find specific types of support groups, find estate sale planners and more.

Call 855-609-9989 to speak with a licensed professional counselor. You can also log on to [griefcounseling.harrisrothenberg.net/default.aspx](http://griefcounseling.harrisrothenberg.net/default.aspx) (username: MetLife, password: grief).

## **Delivering the Promise**

This service helps beneficiaries sort through the details and serious questions regarding claims and financial needs. MetLife representatives are available to provide in person or telephone assistance to beneficiaries and their family members, including:

- Completing and filing life insurance claims;
- Contacting government agencies about benefits;
- Locating grief counseling and support resources;
- Identifying important issues, including updating necessary documents such as titles or deeds; and
- Planning for current and future financial needs.

Call 877-275-6387 to get in touch with a Delivering the Promise specialist in your area.

## Estate Resolution Services

MetLife Estate Resolution Services, offered through Hyatt Legal Plans, Inc., a MetLife company, is part of a robust continuum of services offered as part of MetLife Group Supplemental Life Plans. Estate Resolution Services can be used for your estate as well as your spouse's/domestic partner's estate.

Estate Resolution Services gives estate representatives access to participating attorneys for face-to-face or telephone consultation to get the legal help they need, including:

- Face-to-face consultations: estate representatives can meet with an attorney to discuss matters relating to probating your and your spouse's/domestic partner's estates.
- Preparation and representation: document preparation and representation needed at court proceedings is available to execute the transfer of probate assets from the deceased's estate to the heirs.
- Correspondence and tax filings: any correspondence needed to transfer non-probate assets may be completed by an attorney, as well as any associated filings.
- Coverage for attorney fees: All participating plan attorney fees for included services are covered through the plan. If a non-network attorney is chosen, the individual will be responsible for any attorney's fees that exceed the reimbursed amount.

Beneficiaries can also use this benefit to consult an attorney to discuss general questions about the probate process. Call Hyatt Legal Plans' at 800-821-6400, and a Client Service Representative will help you find a participating plan attorney in your area.

## Travel Assistance Benefit

Your Basic Life Insurance coverage includes a travel assistance benefit. AXA Assistance USA, Inc. provides travel assistance to you and your family when you are traveling for business or pleasure.

Key features include:

- Identify theft solutions;
- Concierge services;
- General travel information;
- Emergency evacuation; and
- Medical referrals, appointment and hospital admission validation.

Information about this benefit is available by contacting Travel Assistance at 800-454-3679 or visiting [webcorp.axa-assistance.com](http://webcorp.axa-assistance.com) (login: axa; password: travelassist).

## Living Benefit — Life Insurance Coverage

If you have a life expectancy of 24 months or less, you may request up to 100% of your eligible Basic Life and Supplemental Life Insurance benefits as a "living benefit." The minimum living benefit from all coverage is \$20,000, and the maximum is \$2 million. Life expectancy must be certified by your physician. ***This benefit payment may be taxable; consult your tax advisor.*** Your death benefit amount is reduced by any living benefit paid.

For details on the Living Benefit, contact NXP Rewards Customer Service at 888-375-2367.

## Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment Insurance pays benefits when an accidental bodily injury is the sole cause of your death, dismemberment, or another covered loss. Your coverage for Accidental Death and Dismemberment Insurance begins on your first day of work, or on the day you first meet the eligibility requirements for Plan participation.

Your Accidental Death and Dismemberment Insurance coverage amount is known as the “principal sum.”

**Accidental Death and Dismemberment Insurance coverage (principal sum)** is equal to your Basic Life Insurance amount. The maximum Accidental Death and Dismemberment Insurance benefit is \$1,000,000.

Accidental Death and Dismemberment Insurance pays its principal sum for your accidental death. For other covered losses, Accidental Death and Dismemberment Insurance pays a percentage of its principal sum as your benefit. If a covered accident results in more than one covered loss, only the largest benefit will be paid, and the total amount of Accidental Death and Dismemberment Insurance payable, not including those described in the [Special Accidental Death and Dismemberment Insurance Benefits](#) on page 184, cannot be more than your principal sum.

### How Accidental Death and Dismemberment Insurance Pays Benefits

Accidental Death and Dismemberment Insurance pays a benefit when an accidental bodily injury is the sole cause of your death, dismemberment, or another “covered loss.” The covered loss must occur within 365 calendar days after the accident and while Accidental Death and Dismemberment Insurance coverage is in force.

Benefits for accidental death are paid to the beneficiary you named as your Basic Life beneficiary as described above. Benefits for all other covered losses are paid to you.

This chart shows the Accidental Death and Dismemberment Insurance benefit paid for each covered loss.

### Accidental Death and Dismemberment Insurance Benefit Schedule

Covered Loss	Benefit Amount	Important Definitions
Life	Principal sum	N/A
Both Hands	Principal sum	Permanently severed at or above the wrist but below the elbow, or at or above the ankle but below the knee.
Both Feet	Principal sum	
One Hand and One Foot	Principal sum	
One Hand or One Foot	One-half principal sum	
One Arm or One Leg	Three-fourths principal sum	Permanently severed at or above the elbow or at or above the knee.
Sight in Both Eyes	Principal sum	

<b>Covered Loss</b>	<b>Benefit Amount</b>	<b>Important Definitions</b>
<b>Sight in One Eye</b>	One-half principal sum	Permanent and uncorrectable loss of sight. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.
<b>Any Combination of Hand, Foot or Sight in One Eye</b>	Principal sum	See above.
<b>Speech and Hearing</b>	Principal sum	Entire and irrecoverable loss of speech or hearing in both ears that continues for six consecutive months following an accidental injury.
<b>Speech or Hearing</b>	One-half principal sum	
<b>Thumb and Index Finger of Same Hand</b>	One-fourth principal sum	Permanent severance of the thumb and index finger through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.
<b>Paralysis of Both Arms and Both Legs</b>	Principal sum	Permanent, complete and irreversible loss of use of a limb, without severance.
<b>Paralysis of Both Legs</b>	One-half principal sum	
<b>Paralysis of the Arm and Leg on Either Side of Body</b>	One-half principal sum	
<b>Paralysis of One Arm or Leg</b>	One-fourth principal sum	
<b>Brain Damage</b>	Principal sum	Permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. The damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persist for 12 consecutive months after the date of the accidental injury.

## Special Accidental Death and Dismemberment Insurance Benefits

Your Accidental Death and Dismemberment Insurance includes these special benefits that are paid *in addition* to the benefit shown in the chart above.

- **Seatbelt Benefit:** If you die in an accident while traveling in a passenger vehicle *and* you were properly wearing your seatbelt, your accidental death and dismemberment insurance will pay its seatbelt benefit equal to 10% of your principal sum, up to a maximum of \$25,000. A police officer investigating the accident must certify that the seat belt was properly fastened and a copy of the certification must be provided to MetLife with the claim.
- **Air Bag Benefit:** If you die in an accident while traveling in a passenger vehicle *and* you were properly wearing your seatbelt, *and* your seat was equipped with an air bag, your accidental death and dismemberment insurance will pay its air bag benefit equal to 5% of your principal sum, up to a maximum of \$10,000. A police officer investigating the accident must certify that the seat belt was properly fastened and that the passenger vehicle in which the deceased was traveling was equipped with air bags; a copy of the certification must be provided to MetLife with the claim.

Neither the seatbelt nor air bag benefit are payable if the driver of the vehicle is intoxicated, impaired or under the influence of alcohol or drugs, or not a licensed driver.

- **Coma Benefit:** If you are in a coma for at least seven consecutive days as the result of an accidental injury and the coma began within 31 days of the injury, your accidental death and dismemberment insurance will pay its coma benefit. Coma means a state of deep and total unconsciousness from which the person cannot be aroused. This benefit is paid monthly and is 1% of the principal sum. This benefit begins on the seventh day of the coma for the duration of the coma, up to a maximum of 60 months.
- **Common Carrier Benefit:** If you die due to an accidental injury while traveling in a common carrier, accidental death and dismemberment insurance will pay a benefit equal to 100% of your principal sum. A common carrier is a government-regulated entity that is in the business of transporting fare-paying passengers. This does not include chartered or other privately arranged transportation, taxis or limousines.

## Exclusions

**Accidental Death and Dismemberment Insurance** benefits are **not** payable for loss resulting directly or indirectly from:

- Intentionally self-inflicted injury;
- Suicide or attempted suicide;
- Committing or attempting to commit a felony;
- Physical or mental illness or infirmity or diagnosis or treatment of the illness or infirmity;

- The voluntary intake or use, by any means of:
  - Any drug, medication or sedative, unless it is taken or used as prescribed by a physician or an over-the-counter (OTC) drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication or sedative; or
  - Poison, gas or fumes;
- Any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident. Intoxicated means that the injured person's blood alcohol level meets or exceeds the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurs.
- Infection, other than infection occurring in an accidental external wound;
- Any incident related to:
  - Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
  - Travel in an aircraft for parachuting purposes or otherwise exiting from the aircraft while it is in flight;
  - Parachuting or otherwise exiting from an aircraft while the aircraft is in flight, except for self-preservation; or
  - Travel in an aircraft or devised used for testing or experimental purposes, by or for any military authority or for travel or designed for travel beyond the earth's atmosphere;
- War or any act of war, whether declared or undeclared;
- Participation in an insurrection, rebellion or riot; or
- Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless when in connection with reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. Reserve forces here means as reserve forces of any branch of the military of the United States or of any other country or international authority, including, but not limited to, the National Guard of the United States or the national guard of any other country.

## Business Travel Accident Insurance

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### Business Travel Accident Insurance

Business Travel Accident (BTA) Insurance pays benefits if an accidental injury results in your death, dismemberment, or another covered loss, **but only if the accident occurs while you are traveling on NXP business**. BTA Insurance begins on your first day of work, or on the day you first meet the eligibility requirements for plan participation. Your BTA Insurance coverage amount is also known as your “principal sum.” BTA Insurance coverage (principal sum) is equal to three times your eligible compensation.

BTA pays its principal sum for your accidental death. For other covered losses, BTA pays a percentage of its principal sum as your benefit. If multiple losses occur, only one benefit amount, the largest, will be paid for all losses due to the same covered accident.

BTA insurance coverage is provided by a contract written in the Netherlands. Benefit amounts are listed in Euros.

### How BTA Insurance Pays Benefits

BTA Insurance pays a benefit when you have a “covered loss” while you are traveling on NXP business. Covered business trips begin when you leave your home, regular place of employment, or other location to travel to another location to work on NXP business. The trip ends when you return to your home, regular place of employment or you deviate for personal reasons for more than seven days, whichever occurs first. Unless noted otherwise, the covered loss must occur within 365 calendar days of the accident.

BTA Insurance also pays a benefit when you have a covered loss:

- During a bomb scare, bomb search or bomb explosion directed at NXP or its property;
- During a felonious assault on NXP property;
- Due to a terrorist act on NXP property; or
- Resulting from a hijacking of an aircraft during a business trip.

Benefits for accidental death are paid to the beneficiary(ies) you named for BTA Insurance, but benefits for other covered losses are paid to you.

## Detailed Insured Amounts and Benefits (per Insured)

Covered Loss	Benefit Amount
<b>Personal Accident Per Event</b>	
<b>Accidental Death</b>	
Per Person (3 times annual salary)	Up to 1.000.000,00 EUR
Accompanying Children	Up to 15.000 EUR
Accompanying Partner	Up to 50.000 EUR
<b>Permanent Disablement as a Result of an Accident</b>	
Per Person (3 times annual salary)	Up to 1.000.000,00 EUR
Accompanying Children	Up to 15.000 EUR
Accompanying Partner	Up to 50.000 EUR
<b>Additional Covers</b>	
Paraplegia	25.000,00 EUR
Quadriplegia	50.000,00 EUR
Dependent Children	5.000,00 EUR
Retraining Costs	Up to 10.000,00 EUR
Hospitalization	Per day 50,00 EUR
Coma	Per day 50,00 EUR
Cosmetic Surgery	Up to 5.000,00 EUR
Psychological Counselling	Up to 5.000,00 EUR
Personal Belongings	Up to 5.000,00 EUR
Funeral Expenses	Up to 7.500,00 EUR
Whiplash, % of the Insured Amount	Up to 8%
Seatbelt	5.000,00 EUR
Life Saver	25.000,00 EUR
Home Modifications	Up to 5.000,00 EUR
Partner/Child	25.000,00 EUR
Scars	5 or 10%
<b>Medical Expenses and Assistance</b>	
Medical Expenses Abroad (secondary)	Real expenses
Medical Expenses in the Place of Residence	Up to 25.000,00 EUR
Medical Assistance	At costs
Direct Payment of Medical Expenses	At costs
Medical Referral	At costs
Medical Transport	Real expenses

<b>Covered Loss</b>	<b>Benefit Amount</b>
Supervising the Clinical Condition	At costs
Sending a Physician	At costs
Sending Medication	Shipping costs
Repatriation to Hospital or Place of Residence	Real expenses
Accommodation	Real expenses
Presence of Relative	Real expenses
Search and Rescue	Up to 25.000,00 EUR
Repatriation of the Body	Real expenses
Funeral Expenses	Up to 7.500,00 EUR
<b>Travel Assistance</b>	
Premature Return	Real expenses
Message Relay	Dispatching costs
Travel Advice	Real expenses
Referral	Real expenses
Lost Documents or Luggage	Real expenses
Cash Advance	Real expenses
Unforeseen Delay	Real expenses
<b>Cancellation and Interruption of the Business Trip up to 10,000.00 EUR (per trip)</b>	
Cancellation	Service included
Interruption	Service included
Change of Travel	Service included
Travel Delay	Up to 1.500,00 EUR
Travel Extension	Service included
<b>Personal Belongings and business equipment</b>	
Loss, Theft or Damage	Up to 7.500,00 EUR
Luggage Delay	Up to 1.500,00 EUR
Travel and Identity Documents	Up to 2.500,00 EUR
Cash, Valuable Documents and SIM Cards	Up to 2.500,00 EUR
<b>Personal Liability</b>	
Bodily and Material Damage (per policy per year)	Up to 5.000.000,00 EUR
<b>Legal Assistance</b>	
Legal Assistance	Up to 15.000,00 EUR
Detention	Up to 5.000,00 EUR
Bail Bond	Up to 50.000,00 EUR

<b>Covered Loss</b>	<b>Benefit Amount</b>
<b>Kidnap, Hijack and Unlawful Detention</b>	
Daily Cover, 400,00 EUR per day	Up to 20.000,00 EUR
Advisory Fee	Up to 125.000,00 EUR
<b>Political Evacuation and Crisis Containment</b>	
Costs of Evacuation	Up to 50.000,00 EUR
Crisis Containment and Disaster Evacuation	Up to 50.000,00 EUR
<b>Limits (Cumulation limit (Article 1.32))</b>	
In Case of Using Any Airplane	30.000.000,00 EUR
In All Other Events	50.000.000,00 EUR

## Legal Services Plan

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Hyatt Legal Plans, Inc. provides the Legal Services Plan. Services are provided through a panel of carefully selected participating law firms. Lawyers in the network are called Services Plan attorneys.

### How to Get Legal Services

#### Website

To use MetLaw<sup>®</sup> visit the Hyatt Legal Plans' member website at [members.legalplans.com](https://members.legalplans.com). To login enter the last four digits of your Social Security Number and zip code. After you login you will jump to a page that is specific for member services. On this page you can choose the following options:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number
- Life Guide
- Self-Help Documents/Forms

#### Client Service Center

You can also contact MetLaw<sup>®</sup> by calling Hyatt Legal Plans' Client Service Center at 800-821-6400, Monday-Friday, 7 a.m. to 6 p.m., Central Time. Be prepared to give the last four digits of your Social Security Number and zip code. If your spouse/domestic partner or eligible dependent child calls, he or she will need the last four digits of your Social Security Number and zip code. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Services Plan attorney will make the final determination of coverage);
- Give you a case number, which is similar to a claim number (you will need a new case number for each new case you have);
- Give you the telephone number of the Services Plan attorney most convenient to you; and
- Answer any questions you have about the Legal Services Plan.

You then call the Services Plan attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select your own attorney. If there are no participating law firms near you, you will be asked to select your own attorney. In both of these circumstances, Hyatt Legal Plans will reimburse you for these non-Services Plan attorneys' fees according to a set fee schedule.

For services to be covered, you or your eligible dependents must obtain a case number, retain a Services Plan attorney and the Services Plan attorney must begin work on the covered legal matter while you are an eligible member of the Legal Services Plan.

## What's Covered

The Legal Services Plan allows you and your eligible dependents to receive certain personal legal services, as described in this section. The benefits available are comprehensive, but there are limitations and other conditions that must be met.

All benefits are available to you and your spouse/domestic partner and dependents, unless otherwise noted.

## Advice and Consultation

Advice and consultation services cover:

- **Office Consultation:** You have the opportunity to discuss with a Services Plan attorney any personal legal problems that are not specifically excluded. A Services Plan attorney will explain your rights, point out your options and recommend a course of action. The Services Plan attorney will identify any further coverage available under the Plan and represent you if you request. If representation is covered by the Plan, you are not charged for the Services Plan attorney's services. If representation is recommended, but is not covered by the Plan, the Services Plan attorney will provide a written fee statement in advance. You may choose whether to retain the Services Plan attorney at your own expense, seek outside counsel or do nothing. There are no restrictions on the number of times per year that you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Services Plan attorney to seek advice that would allow you to undertake your own representation.
- **Telephone Advice:** You have the opportunity to discuss with a Services Plan attorney any personal legal problems that are not specifically excluded. The Services Plan attorney will explain your rights, point out your options and recommend a course of action. The Services Plan attorney will identify any further coverage available under the Plan and represent you if you request. If representation is covered by the Plan, are not charged for the Services Plan attorney's services. If representation is recommended, but is not covered by the Plan, the Services Plan attorney will provide a written fee statement in advance. You may choose whether to retain the Services Plan attorney at your own expense, seek outside counsel or do nothing. There are no restrictions on the number of times per year that you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Services Plan attorney to seek advice that would allow you to undertake your own representation

## Consumer Protection

Consumer protection services include:

- **Consumer Protection Matters:** Coverage for you as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This does not include disputes over real estate, construction, insurance or collection activities after a judgment.
- **Small Claims Assistance:** Counseling on prosecuting a small claims action, helping you prepare documents, advising on evidence, documentation and witnesses and preparing for trial. The does not include the Services Plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.
- **Personal Property Protection:** Counseling over the phone or in the office on any personal property issue, such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. This includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

## Debt Matters

Debt matter services include:

- **Debt Collection Defense:** Services Plan attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial, if necessary. Services include a motion to vacate a default judgment. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters, including support and post decree issues or any matter where the creditor is affiliated with NXP or Hyatt.
- **Identity Management Services:** Access to LifeStages Identity Management Services provided by IDT911. These services include both proactive services when you believe your personal data has been compromised as well as resolution services to assist you in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications and provides victims with credit and fraud monitoring. Theft support, fraud support, recovery and replacement services are covered by this service.
- **Identity Theft Defense:** Consultations with a Services Plan attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. Defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft, such as foreclosure, repossession or garnishment, up to and including trial, if necessary. The service also provides you with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters or any matter where the creditor is affiliated with NXP or Hyatt.

- **Personal Bankruptcy or Wage Earner Plan:** Service for you and your spouse/domestic partner in pre-bankruptcy planning, preparation and filing of a personal bankruptcy or wage earner petition and representation at all court hearings and trials. This service is not available if a creditor is affiliated with NXP, even if you or your spouse/domestic partner chooses to reaffirm that specific debt.
- **Tax Audits:** Reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning your tax return, negotiating with the agency, advising you on necessary documentation and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

## Defense of Civil Lawsuits

Civil lawsuit defense include:

- **Administrative Hearing Representation:** Provides defense in civil proceedings before a municipal, county, state or federal administrative board, agency or commission. Services include the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by an insurance policy and does not include family law matters, post judgment matters or litigation of a job-related incident.
- **Civil Litigation Defense:** Provides defense for an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by an insurance policy and does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.
- **Incompetency Defense:** Defense of any incompetency action, including court hearings when there is a proceeding to find you incompetent.

## Document Preparation

Document preparation services include:

- **Affidavits:** Preparation of any affidavit in which you are the person making the statement.
- **Deeds:** Preparation of any deed for which you are either the grantor or grantee.
- **Demand Letters:** Preparation of letters that demand money, property or some other property interest, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.
- **Mortgages:** Preparation of any mortgage or deed of trust for which you are the mortgagor. This does not include documents pertaining to business, commercial or rental property.
- **Promissory Notes:** Preparation of any promissory note for which you are the payor or payee.

- **Document Review:** Review of any personal legal document, such as letters, leases or purchase agreements.
- **Elder Law Matters:** Counseling for you over the phone or in the office on any personal issues relating to your parents as they affect you. This includes reviewing documents of the parents to advise you on the effect on you. Documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. This also includes preparing deeds involving parents when you are either the grantor or grantee and preparing promissory notes involving parents when you are the payor or payee.

## Family Law

Family law services cover:

- **Name Changes:** Necessary pleadings and court hearings for a legal name change.
- **Prenuptial Agreement:** Your representation and includes the negotiation, preparation, review and execution of a prenuptial agreement between you and your fiancé/partner before your marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse/domestic partner. Representation is provided only to you, the employee. Your fiancé/partner must have separate counsel or must waive his or her right to representation. This does not include subsequent litigation arising out of a prenuptial agreement.
- **Protection from Domestic Violence:** This applies to you only; not your spouse/domestic partner or dependents, as the victim of domestic violence. It includes representation for you to obtain a protective order, including all required paperwork and attendance at all court appearances. This does not include representation in suits for damages, defense of any action or representation for the offender.
- **Adoption and Legitimization (Contested and Uncontested):** Legal services and court work in a state or federal court for an adoption by you and your spouse/domestic partner. Legitimization of your or your spouse's/domestic partner's child, including reformation of a birth certificate, is also covered.
- **Guardianship or Conservatorship (Contested or Uncontested):** Establishing a guardianship or conservatorship over a person and his or her estate when you or your spouse/domestic partner are appointed as guardian or conservator. This includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing paperwork, attending the hearing and preparing the initial accounting. This does not include representation of the person over whom guardianship or conservatorship is sought or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

## Immigration

Immigration assistance covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping you prepare for hearings.

## Personal Injury

Personal injury (25% network maximum), subject to applicable law and court rules, Services Plan attorneys will handle personal injury matters (where you are the plaintiff) at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all costs.

## Real Estate Matters

Real estate matter services include:

- **Boundary or Title Disputes (Primary Residence):** Negotiations and litigation arising from boundary or real property title disputes involving your primary residence, where coverage is not available under your homeowner or title insurance policies. This includes filing to remove a mechanic's lien.
- **Eviction and Tenant Problems (Primary Residence – Tenant Only):** For you as a tenant, matters involving leases, security deposits or disputes with a residential landlord. This includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.
- **Security Deposit Assistance (Primary Residence – Tenant Only):** For you as a tenant, counseling you in recovering a security deposit from your residential landlord for your primary residence, reviewing the lease and other relevant documents and preparing a demand letter to the landlord for the return of the deposit. This also covers assisting you in prosecuting a small claims action, helping prepare documents, advising on evidence, documentation and witnesses and preparing you for the small claims trial. This does not include the Services Plan attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.
- **Home Equity Loans (Primary Residence):** Review or preparation of a home equity loan on your primary residence.
- **Home Equity Loans (Second or Vacation Home):** Review or preparation of a home equity loan on your second or vacation home.
- **Property Tax Assessment (Primary Residence):** Review and advice on a property tax assessment on your primary residence, including filing the paperwork, gathering the evidence, negotiating a settlement and attending the hearing necessary to seek a reduction of the assessment.
- **Refinancing of Home (Primary Residence):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on your primary residence. This also includes attendance of a Services Plan attorney at closing. This includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.

- **Refinancing of Home (Second or Vacation Home):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on your second home or vacation home. This also includes attendance of a Services Plan attorney at closing. This includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.
- **Sale or Purchase of Home (Primary Residence):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your primary residence or of a vacant property to be used for building a primary residence. This also includes attendance of a Services Plan attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.
- **Sale or Purchase of Home (Second or Vacation Home):** Review or preparation, by a Services Plan attorney representing you, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of your second home or vacation home or of a vacant property to be used for building a second home or vacation home. This also includes attendance of a Services Plan attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.
- **Zoning Applications:** Services of a lawyer to help get a zoning change or variance for your primary residence. Services include reviewing the law, reviewing the surveys, advising you, preparing applications and preparing for and attending the hearing to change zoning.

## Traffic and Criminal Matters

Traffic and criminal matter services cover:

- **Juvenile Court Defense:** Your or your dependent child's defense in any juvenile court matter, provided there is no conflict of interest between you and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides a Services Plan attorney for you only, including services for parental responsibility.
- **Traffic Ticket Defense (No DUI):** Representation in defense of any traffic ticket including traffic misdemeanor offenses, except driving under the influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.
- **Restoration of Driving Privileges:** Representation in proceedings to restore your driving license.

## Wills and Estate Planning

Will and estate planning services cover:

- **Trusts:** Preparation of revocable and irrevocable living trusts for you. It does not include tax planning or services associated with funding the trust after it is created.
- **Living Wills:** Preparation of a living will for you.
- **Powers of Attorney:** Preparation of any power of attorney when you are granting the power.
- **Probate:** Subject to applicable law and court rules, Services Plan attorneys will handle probate matters at a fee 10% less than the Services Plan attorney's normal fee. It is your responsibility to pay this reduced fee and all costs.
- **Wills and Codicils:** Preparation of a simple or complex will for you. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

## Exclusions

Excluded services are those legal services that **are not** provided under the Plan. No services, not even a consultation, is provided for the following matters:

- Employment-related matters, including company or statutory benefits.
- Matters involving the NXP, MetLife® and affiliates and Services Plan attorneys.
- Matters in which there is a conflict of interest between you and your spouse/domestic partner or dependents in which case services are excluded for your spouse/domestic partner and dependents.
- Appeals and class actions.
- Farm, business or investment matters and matters involving property held for investment or rental or issues when you are the landlord.
- Patent, trademark and copyright matters.
- Costs or fines.

- Frivolous or unethical matters.
- Matters for which a Services Plan attorney-client relationship exists before you became eligible for benefits.

## Limitations

- **If Other Coverage Is Available to You:** If you are entitled to receive legal representation provided by any other organization, such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you are still eligible for benefits under this Plan as long as you meet the eligibility requirements.
- **Legal Disputes with Your Dependents:** You may need legal help with a problem involving your spouse/domestic partner or your children. In some cases, each of you may need an attorney. If it would be improper for one attorney to represent you, only you will be entitled to representation by a Services Plan attorney. Your spouse/domestic partner or dependent will not be covered under the Plan.
- **Legal Disputes with Another Employee:** If you, your spouse/domestic partner or your dependents are involved in a dispute with another eligible employee or that employee's dependents, Hyatt Legal Plans will arrange for legal representation with independent and separate counsel for both parties.
- **Court Awards of Attorneys' Fees as Part of a Settlement:** If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

## Claims and Appeals Procedures

### Eligibility

Hyatt verifies eligibility using information provided by NXP. When you call for services, you will be advised if you are ineligible and Hyatt Legal Plans will contact NXP for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

#### **NXP USA, Inc.**

Human Resources Department, OE 331  
6501 William Cannon Drive West  
Austin, Texas 78735

Within 30 days, you will be provided with a written explanation.

## **Appeals**

If you are denied coverage by Hyatt Legal Plans or by any Services Plan attorney, you may appeal by sending a letter to:

**Hyatt Legal Plans, Inc.**  
Director of Administration  
Eaton Center  
1111 Superior Avenue  
Cleveland, Ohio 44114-2507

The Director will issue Hyatt Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under ERISA Section 502(a).

## **Confidentiality, Ethics and Independent Judgment**

Your use of the Plan and the legal services is confidential. Your Services Plan attorney will maintain strict confidentiality of the traditional lawyer-client relationship. NXP will know nothing about your legal problems or the services you use under the Plan. Plan administrators will have access only to limited statistical information needed for administration of the Plan.

No one will interfere with your Services Plan attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The Services Plan attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Plan. The Services Plan attorney's obligations are exclusively to you. The Services Plan attorney's relationship is exclusively with you. Hyatt Legal Plans, Inc. or the law firm providing services under the Plan is responsible for all services provided by their Services Plan attorneys.

The Plan has no liability for the conduct of any Services Plan attorney. You have the right to file a complaint with the state bar concerning Services Plan attorney conduct under the Plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Services Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or to harass another person. If you have a complaint about the legal services you have received or the conduct of a Services Plan attorney, call Hyatt Legal Plans at 800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan.

## Savings and Wealth — 401(k) Retirement Plan

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This section provides information on your 401(k) Retirement Plan, including:

- Your [eligible compensation](#) (beginning on page 201);
- Your [contributions](#) (beginning on page 203);
- [Company Matching Contributions](#) (beginning on page 206);
- How you [vest](#) in your benefit (beginning on page 206);
- [Investing your Plan account](#) (beginning on page 207);
- [401\(k\) investment funds](#) (beginning on page 210);
- How to [access your account](#) (beginning on page 212);
- [Loans](#) (beginning on page 214);
- [Withdrawals](#) from your account (beginning on page 215);
- When you are eligible for a [distribution](#) (beginning on page 217);
- [Survivor benefits](#) (beginning on page 217);
- [How your account is paid](#) (beginning on page 218);
- [Taxes and penalties](#) (beginning on page 219); and
- [Additional](#) information (beginning on page 227).

See [Participation](#), beginning on page 4, for information on who is eligible, automatic enrollment, when participation begins, when you can make changes and when participation ends.

### **Fee Disclosure**

There are fees associated with this Plan. For example, there is a fee if you take a loan against your Plan account. Fee information is provided in the annual 401(k) Fee Disclosure Notice; this notice can be found online at [NXP.com/rewards](http://NXP.com/rewards), under *Plan Information*.

As part of NXP's comprehensive Rewards benefits package for eligible employees, the 401(k) Retirement Plan plays an integral role in helping you build your personal financial security. This section summarizes your 401(k) Retirement Plan benefits and helps provide the information and tools necessary for you to make informed choices and decisions.

Helping you create financial security is important to NXP. That's why NXP offers the 401(k) Retirement Plan, along with financial planning resources to help you meet your goals.

Three major reasons to contribute to the 401(k) Retirement Plan include:

- **Tax Advantages:** Your before-tax contributions and before-tax catch-up contributions are not considered part of your current earnings, so they are not subject to U.S. federal income taxes, or the income taxes of most states and cities, until you withdraw them from your account. This means that more of your earnings will go directly into your account and that you will have more money to invest. Your Roth 401(k) contributions and Roth 401(k) catch-up contributions are subject to taxes when you make them, but they offer tax advantages in the future.
- **Investment Options:** You decide how to invest your contributions among a range of investment options. Any earnings your investments make remain in your account to be further invested.
- **Company Matching Contributions:** Currently, if you contribute to the 401(k) Retirement Plan, you will be eligible for Company Matching Contributions to your account.

## Your Eligible Compensation

“Eligible compensation” or “pay” in the 401(k) Retirement Plan refers to your regular earnings, Sales Incentive Plan payments, annual bonuses, shift differentials, overtime and lump-sum pay. All other awards and individual spot bonuses, and any severance payments, moving allowances, educational allowances, noncash payments or overseas allowances, are excluded from your eligible compensation under the 401(k) Retirement Plan.

Annual eligible compensation for Plan purposes may not exceed the 401(a)(17) limit imposed by the Internal Revenue Code in any year. For 2018, that limit is \$275,000.

## Your 401(k) Retirement Plan Contributions Compared

Only you can determine what type of contributions to the 401(k) Retirement Plan are right for you. This chart compares the rules and operation of the before-tax regular contributions with after-tax Roth 401(k) contributions.

	Regular 401(k) (Before-Tax)	Roth 401(k) (After-Tax)
<b>What is the maximum contribution each year?</b> <i>See <a href="#">Contribution Limits</a> on page 204</i>	The combination of regular (before-tax) and Roth (after-tax) contributions cannot be more than the annual IRS limit (the 2018 limit is \$18,500)	
<b>How are my income taxes affected the year I contribute?</b>	Reduced the year you contribute	Not reduced the year you contribute
<b>When are these contributions and their associated investment earnings taxed?</b> <i>See <a href="#">Tax Summary</a> on page 220</i>	When received from the 401(k) Retirement Plan, at the tax rate in effect the year you receive them	Not taxed, if received from the 401(k) Retirement Plan after age 59½, and if the account is more than five years old

	Regular 401(k) (Before-Tax)	Roth 401(k) (After-Tax)
<p><b>Do these contributions qualify for NXP Company Matching Contributions?</b> See <a href="#">Company Matching Contributions</a> on page 206</p>	The first 5% of pay you contribute to the 401(k) Retirement Plan, either a regular (before-tax) or Roth (after-tax) contribution, qualifies for an NXP matching before-tax contribution	
<p><b>Can these contributions be used for catch-up contributions after age 50?</b> See <a href="#">Catch-Up Contributions</a> on page 203</p>	Yes, but the entire catch-up contribution must be either regular (before-tax) or Roth (after-tax), and it cannot be more than the annual IRS limit (the 2018 limit is \$6,000)	
<p><b>May I withdraw these contributions due to a financial hardship?</b> See <a href="#">Hardship Withdrawals</a> on page 215</p>	Yes	Yes
<p><b>May I borrow these contributions and their associated investment earnings from the 401(k) Retirement Plan?</b> See <a href="#">Loans from Your Account</a> on page 214</p>	Yes	Yes
<p><b>Will the contribution escalation feature work with these contributions?</b></p>	Yes	No
<p><b>Will the automatic rebalancing feature work with these contributions and their associated investment earnings?</b> See <a href="#">Automatic Rebalancing</a> on page 209</p>	Yes	Yes
<p><b>May I rollover contributions to this Plan?</b> See <a href="#">Rollovers from Other Plans and IRAs</a> on page 205</p>	Yes, if the contributions being rolled over are before-tax contributions from a tax-qualified plan	Yes, if the contributions being rolled over are Roth contributions from a tax-qualified plan
<p><b>May I roll over these contributions and their associated investment earnings from the 401(k) Retirement Plan if I leave NXP?</b> See <a href="#">Payments That Can and Cannot Be Rolled Over</a> on page 222</p>	Yes, to an IRA or another employer's tax-qualified plan that accepts rollover contributions	Yes, to a Roth IRA or another employer's tax-qualified plan that accepts Roth 401(k) rollover contributions

## Your Contributions

You decide the percentage of your eligible compensation that you would like to contribute to your account. The percentage you choose will be taken from each paycheck and added to your account.

As described previously, if you do not complete your enrollment within 30 days of becoming eligible for the 401(k) Retirement Plan, you are automatically enrolled to make a regular (before-tax) contribution of 5% of pay, usually beginning with your third paycheck after you begin work. You will also be enrolled in a managed account with GuidedChoice. An Auto Enrollment Notice is sent to your home address on file shortly after your hire date. In addition, your contribution rate will automatically increase 1% each January until you are contributing 10% of your pay. If your hire date is within three months of the auto escalation date, your contribution rate will not increase until the following January. You can choose not to participate in the 401(k) Retirement Plan, change the amount or type of contribution you make, or change your auto escalation at any time.

Generally, your contributions are invested in the 401(k) Retirement Plan Trust by each pay date, but no later than as required under applicable law.

### Regular 401(k) Contributions

Your “regular” 401(k) contributions to the 401(k) Retirement Plan are made on a before-tax basis. These contributions come from your eligible compensation before federal (and most state and local) income taxes, but not FICA taxes (Social Security and Medicare).

Regular contributions give you an immediate tax advantage by reducing the amount of pay on which your income taxes are based, so you pay less income tax. You pay taxes on your regular contributions, and on their associated investment earnings, only when you receive them as a benefit from the 401(k) Retirement Plan.

### Roth 401(k) Contributions

Roth contributions come from your eligible compensation on an *after-tax* basis. You do not save on taxes when you make Roth contributions, but under current tax law, if certain requirements are met, Roth contributions and their associated investment earnings are not taxable when you receive them as a qualified distribution. A qualified distribution is generally a distribution that is made after your Roth account is at least five years old and you are age 59½ or older.

### Catch-Up Contributions

If you are age 50 or older, or you will reach age 50 during the 401(k) Retirement Plan (calendar) year, you are eligible to make catch-up contributions each year. You may make catch-up contributions to the 401(k) Retirement Plan in addition to your regular and/or Roth contributions. Catch-up contributions may be made on either a before-tax or Roth (after-tax) basis, but not both, and they have a separate IRS annual limit, described below.

## Contribution Limits

The IRS limits the maximum amount you may contribute to your account each year. This annual limit applies to both regular 401(k) contributions and Roth 401(k) contributions, and there is a separate annual IRS limit that applies to catch-up contributions.

Contributions made by “highly compensated” employees are also subject to certain IRS-required tests that may limit the amount they can contribute for a particular year. The 401(k) Retirement Plan has been designed to meet these tests. You will be notified if the Plan is amended such that testing would be required.

You cannot make contributions based on more than the IRS annual compensation limit, as shown in [Your Eligible Compensation](#), on page 201. The IRS reviews this limit annually.

- **Your Maximum Contribution:** You may contribute up to 75% of your eligible compensation, not to exceed the annual IRS dollar limit. In 2018, the limit is \$18,500; it may change in future years as determined by the IRS.
- **Your Minimum Contribution:** No minimum contribution is required, but you are automatically enrolled if you do not take action within 30 days of becoming eligible, as described in [Automatic Enrollment for Medical and 401\(k\) Plans](#), on page 11.
- **Your Catch-Up Contribution:** The annual maximum catch-up contribution in 2018 is \$6,000; it may change in future years as determined by the IRS.

## If You Contribute to Another Tax-Qualified Plan in the Same Year

Your 401(k) Retirement Plan contributions are limited by the IRS to a dollar amount per calendar year. This amount includes any contributions you make during the year to any tax-qualified plan, such as another employer’s 401(k) plan, Section 408(k) simplified employer pension plan, Section 403(b) annuity contract, or elective employer contributions under Section 408(p)(2)(A)(i) of the Internal Revenue Code.

If you have contributed to another employer’s qualified plan during the same year you contribute to the 401(k) Retirement Plan, you may need to reduce your NXP payroll deductions to your 401(k) Retirement Plan account so that you do not exceed the limit.

You have until April 8 of the following year to notify your former employer or NXP Rewards Customer Service to request a refund of excess contributions. The excess amount, plus any investment gain or loss, will be issued to you no later than April 15. Contact NXP Rewards Customer Service for more information.

## Contribution Escalator

The 401(k) Retirement Plan includes a feature to help you gradually meet your retirement savings goals. The contribution escalator automatically increases your regular (before-tax) contributions to the 401(k) Retirement Plan.

When you use this feature, you choose a target percentage of pay you want to contribute in the future, and the amount by which your contribution will increase each year. Each December you will receive a reminder letter, and in January the contribution escalator will automatically raise the percentage of pay you make as a regular contribution to the 401(k) Retirement Plan. If you are automatically enrolled, your contribution rate will increase 1% per year, until you are contributing 10% of your eligible compensation. The initial automatic escalation will not occur in the first January if you were hired after October 1.

To use the contribution escalator or change your automatic enrollment election, follow the links in the *Savings and Retirement* section of the NXP Rewards website at [NXP.com/rewards](https://nxp.com/rewards).

## Tax Credit for Participant Contributions

You may be entitled to a tax credit for your [Participant Contributions](#) (defined on page 317), in addition to the tax savings on your regular contributions. The tax credit is available only if your “adjusted gross income” for tax purposes is below certain limits that change from year to year. Please refer to IRS Publication 590, *Individual Retirement Arrangements (IRAs)* available online at [IRS.gov](https://irs.gov) for more information.

You may increase or decrease your contribution percentage or change the type of contribution you make, either online at [NXP.com/rewards](https://nxp.com/rewards) or by calling NXP Rewards Customer Service at 888-375-2367.

## Rollovers from Other Plans and IRAs

The 401(k) Retirement Plan accepts rollovers of before-tax and Roth accounts from other companies’ plans (which qualify under Section 401(a) of the Internal Revenue Code) and from conduit Individual Retirement Accounts (IRAs). The 401(k) Retirement Plan also accepts rollovers from Section 403(b) annuities and Section 457 governmental plans. The 401(k) Retirement Plan does not accept stock or other noncash property as part of a rollover. The check must be made payable to “NXP 401(k) Retirement Plan,” and mailed directly to NXP Rewards Customer Service at:

### **NXP Rewards Customer Service**

P.O. Box 1475  
Lincolnshire, Illinois 60069-1475

You must first request a rollover form from NXP Rewards Customer Service, or online at [NXP.com/rewards](https://nxp.com/rewards). The rollover form should be completed by you and the IRA financial institution or by the administrator of your former employer’s qualified plan. If you send the check made payable to “NXP 401(k) Retirement Plan” from the former qualified plan or IRA, your completed rollover form must accompany it.

## Company Matching Contributions

When you contribute to the 401(k) Retirement Plan, NXP will make Company Matching Contributions to the 401(k) Retirement Plan as well. You are eligible for Company Matching Contributions on the first day you join the 401(k) Retirement Plan, as long as you contribute to the 401(k) Retirement Plan. Federal regulations limit the amount of annual additions, including Company Matching Contributions, that can be made to qualified plan accounts in a single year to \$55,000 in 2018, or, if less, 100% of your compensation (as defined for purposes of the Internal Revenue Code). You will be notified if this limit applies to you.

Until NXP determines otherwise, NXP will match up to the first 5% of eligible compensation you contribute as a regular, Roth or catch-up contribution. To be eligible for the maximum Company Matching Contribution, you must contribute at least 5% of your eligible compensation or, if less, the IRS 401(k) limit (\$18,500 in 2018). Although you do not receive a Company Matching Contribution on any amount you contribute above 5% of eligible compensation, every additional percentage you contribute can add up over the years.

**Example:** You contribute 5% (\$3,000) of your \$60,000 pay to your 401(k) Retirement Plan account from January 1 to December 31. With a dollar-for-dollar Company match, the Company Matching Contribution to your account that year would be \$3,000.

Percent of Pay You Contribute	Your Monthly Contribution	Your Annual Contribution	Company Match (discretionary)	Monthly Matching Contribution	Annual Matching Contribution
5%	\$250	\$3,000	\$1 for each \$1	\$250	\$3,000

## True-Up Contributions

NXP makes Company Matching Contributions each pay period, based on your contributions for that pay period. Currently, if, at the end of the year, you have not received the maximum match you could have received on your contributions, NXP will make an additional “true-up” contribution to bring you up to the maximum match based on your actual contributions.

## Vesting in Your Benefit

You are 100% vested in your 401(k) Retirement Plan account. This means you have the right to receive the full value of your account if you leave NXP for any reason. Remember, the value of your account is subject to investment market increases and decreases. There is no guarantee that you will receive an amount equal to or greater than what has been contributed to your account.

## Investing Your 401(k) Retirement Plan Account

You decide how to invest your account balance. Your account balance includes your contributions and any contributions made by NXP, as adjusted for any investment returns or losses on these amounts. You may make changes online at [NXP.com/rewards](https://www.nxp.com/rewards) or by calling NXP Rewards Customer Service at 888-375-2367.

You choose how to invest your account in one or more of the 14 investment funds offered under the 401(k) Retirement Plan, as well as the Self-Directed Brokerage Account. As with any investment you make, there are no guarantees against losses. Each fund is subject to increases and decreases in dollar value as the financial markets respond to economic, social and political conditions.

At any given time, your account balance may have decreased in value rather than increased. In general, the “riskier” funds are more likely to have greater “ups and downs” than less risky funds, but may have a greater potential for higher positive returns over the long term. Monthly and historical investment returns of the funds are available at [NXP.com/rewards](https://www.nxp.com/rewards) (see [Accessing Your Account](#), beginning on page 212).

The 401(k) Retirement Plan is intended to constitute a plan described in Section 404(c) of the Employee Retirement Income Security Act (ERISA) and Section 2550.404c-1 of Title 29 of the Code of Federal Regulations (404(c) Regulations). This means that the 401(k) Retirement Plan fiduciaries are relieved of liability for any losses that are the direct and necessary result of investment decisions made, and investment instructions given, by you as a participant or beneficiary for the investment of the money in your accounts in various 401(k) Retirement Plan funds.

If you elect a partial distribution or installments, the balance of your account (after each payment) remains invested in the funds you have elected. Investment returns may increase or decrease your future payment amounts.

Transfers of balances among investment funds in your account may be made based on a specific percentage from one investment fund to another, or you may realign your entire account. Changes confirmed before the close of the New York Stock Exchange (normally 4 p.m. Eastern time) are normally processed at the end of that day. Changes confirmed after the market closes, on weekends or on market holidays are processed at the end of the next business day. See the [401\(k\) Investment Funds](#) table, beginning on page 210 for a listing of investment funds available.

When a contribution is made to your account, the most recent investment election on file is used. Your most recent investment election is also used to invest Company Matching Contributions made to your account for the pay period.

If you do not make an investment election when you join NXP, 100% of your contributions are automatically invested in a managed account with GuidedChoice, with its associated fees. You may disenroll from GuidedChoice at any time.

## **NXP's Trading Policy for the 401(k) Retirement Plan**

The 401(k) Retirement Plan is designed to help you accumulate the financial resources necessary to sustain your preferred lifestyle after you retire by building your wealth through long-term savings. Market timing or excessive trading is not consistent with the intended Plan purpose and is considered harmful to the long-term strategy of the 401(k) Retirement Plan's investment options. Moreover, excessive trading can be harmful to participants in general by diluting share values, increasing fund transaction costs, interfering with a fund's portfolio management, incurring taxable gains and forcing funds to hold excess levels of cash to maintain sufficient liquidity to accommodate shareholder purchase and sale activity.

To help protect the long-term best interest of the participants in the 401(k) Retirement Plan, NXP has instituted a general trading policy that applies to all funds, except the Stable Value Fund and the Self-Directed Brokerage Account.

Under the trading policy, if you redeem out of a fund, you must wait 30 days before you may re-enter that fund. The record keeper will monitor exchanges and block any purchase that violates this policy. This restriction applies to purchases only; you are always allowed to transfer out of a fund. Any systematic contributions or withdrawals (*i.e.*, regular payroll contributions, loan payments, withdrawals, automatic rebalancing, etc.) are excluded from the 401(k) Retirement Plan's trading monitoring and will be allowed.

Under federal law, investment managers have the right to monitor trade activity to determine if short-term trading practices may be occurring and to restrict or prohibit a participant's transfers if it is believed that the participant is participating in short-term trading, market timing or abusive transfer practices that it believes are detrimental to the investment option and to other investors in the option. All investment managers reserve the right to reject any purchase or exchange transactions at any time as provided for in the fund's prospectuses and other governing documents. To the extent a fund maintains an excess trading policy that is stricter than the 401(k) Retirement Plan's policy described above, the manager of the fund can direct the 401(k) Retirement Plan to apply its excessive trading restrictions to participants' accounts. For more information on the funds' excessive trading policies, please consult each fund's prospectuses.

### **Restrictions on Transfers from the Stable Value Fund to the Self-Directed Brokerage Account**

The 401(k) Retirement Plan does not allow transfers of money directly from the Stable Value Fund to the Self-Directed Brokerage Account. You may transfer money from the Stable Value Fund to any of the 401(k) Retirement Plan's other investment options (the "core funds"), but the value of the funds transferred from the Stable Value Fund must remain in the 401(k) Retirement Plan's core funds for at least 90 days. After 90 days, the restriction on the value of the transferred funds ends.

**Example:** James has \$2,000 invested in the Stable Value Fund, \$5,000 in the Large-Cap Value Fund and \$5,000 in the Fixed Income Bond Fund. On February 1, he liquidates his Stable Value Fund holdings, transferring \$2,000 to the International Growth Fund.

For the next 90 days, or until May 1, James must keep at least \$2,000 invested in the 401(k) Retirement Plan's other core funds (meaning any fund other than the Stable Value Fund or Self-Directed Brokerage Account). On May 1, James' restriction on transfers to the Self-Directed Brokerage Account ends.

The 401(k) Retirement Plan continues to reserve the right to amend its excessive trading and restriction rules in the future.

### **Automatic Rebalancing**

The automatic rebalancing feature in the 401(k) Retirement Plan allows you to use technology to manage the investments of your 401(k) Retirement Plan account, at no cost.

When you enroll in this feature, you determine the percentage of your total 401(k) assets you want each investment fund to represent. As investment gains and losses cause the balance of each fund to rise or fall, your accounts may stray from your original objective.

Four times a year, this feature automatically returns your account to align with your strategy. The 401(k) Retirement Plan buys and sells from your chosen investment funds to rebalance your account and restore your desired investment mix. And if your investment strategy changes, you can update your objectives at any time.

To use the automatic rebalancing feature, visit [NXP.com/rewards](https://www.nxp.com/rewards) and enroll.

**Note:** If you subscribe to GuidedChoice (described below), the automatic rebalancing feature is not available, because a similar process is included in your GuidedChoice services.

### **Using GuidedChoice™**

GuidedChoice, an independent investment advice service provider chosen by NXP, can help you plan for retirement by using an online application, , which is designed to help you make the most of your retirement plan. GuidedChoice is a personalized advisory service that can help you decide how much to save to meet your retirement income goals, and where to invest your retirement assets based on your needs and specific plan choices, for free. You also have the option of selecting the managed account service. With this service, you pay a reasonable fee to have GuidedChoice provide 401(k) account rebalancing every three months, annual 401(k) reallocation based on current information and market conditions and an annual report of how you are doing relative to your goal. Fees of 0.25% of your assets, up to \$100,000, to an annual maximum of \$250 apply if you choose a managed account. Using GuidedChoice for asset allocation at the asset class level or savings guidance is free.

GuidedChoice also provides a retirement income solution service that answers the question of how much you can spend per month in retirement. When you are a year away from retirement or already retired, you can use the GuidedChoice retirement income service to help create a steady stream of retirement income. GuidedChoice provides a tax-efficient withdrawal strategy presented in an easy-to-read Personalized Spending Guide detailing how much to withdraw from savings, which accounts to sell from first and which investments within those accounts to sell. The service also provides a personalized strategy designed to optimize Social Security benefits, allows you to experiment with annuities, the size of a bequest and life expectancy. For more information about fees for the GuidedChoice retirement income service, visit [guidechoice.com/retirement-income-planning](https://guidechoice.com/retirement-income-planning).

GuidedChoice’s advice is based on Modern Portfolio Theory, developed by one of GuidedChoice’s founders, Harry Markowitz, Ph.D., Nobel laureate. Modern Portfolio Theory proposes that there is a “perfect” mix of asset classes (different types of stocks and bonds) that you can invest in at different risk levels that will get you to your maximum return over the long run. Using a proprietary process, GuidedChoice combines economic data and fund style analysis with personal factors (such as your age, salary, savings rate, retirement age, standard mortality tables plus 10 years, etc.) and your retirement income goal to determine your investment mix. The GuidedChoice Retirement Income Service is built on the same foundation as the GuidedChoice Advisory Service. Dr. Markowitz expanded upon Modern Portfolio Theory and developed Financial Guidance Theory to account for the uncertainties of retirement life.

You can access GuidedChoice through the NXP Rewards website at [NXP.com/rewards](https://nxp.com/rewards), from the Savings and Retirement tab. You may also call GuidedChoice Customer Service at 800-242-6182 (Monday – Friday, 10 a.m. – 7 p.m. Central time) for additional information on fees and services offered, including an individual session consisting of a complete walk-through of either service offered by GuidedChoice.

## 401(k) Investment Funds

The following table describes the 401(k) Retirement Plan’s investment funds, and their relative degree of risk to principal.

**Note:** Historical performance of a fund can only give you an idea of the risk level involved, it does not tell you how the fund will perform in the future.

All investments involve some degree of risk. Even if an investment is categorized as “lower risk,” that investment could incur losses at any time, and these losses may exceed the losses incurred during the same period by an investment categorized as “higher risk.”

NXP Fund	Investment Fund Description	Risk
<b>Stable Value</b>	Combination of short-term, fixed-income securities such as U.S. Treasury bills, guaranteed insurance contracts and bank investment contracts. Seeks growth through short-term income.	Lowest 
<b>Intermediate Bond</b>	Combination of U.S. Treasury bills, certificates of deposit, corporate bonds, government bonds, mortgage and asset backed securities. Seeks long-term growth through short- to long-term income.	
<b>Global Bond</b>	Consists of a range of fixed income sectors including global investment grade and high yield corporates, emerging market debt and other global credit spread sectors. Seeks long-term growth through intermediate to longer-term income.	
<b>Balanced Fund</b>	Combination of stocks, bonds and cash equivalents. Seeks long-term growth through capital appreciation and income.	
<b>Large Company Value</b>	Combination of two investment managers investing in large company common stocks, with potential to provide dividend income and some capital appreciation through value-oriented stocks.	
<b>S&amp;P 500 Index</b>	Contains large company domestic common stocks seeking to replicate the S&P 500 Index.	
<b>Large Company Growth</b>	A diversified portfolio of large company common stocks that seeks to provide some capital appreciation through growth-oriented stocks.	
<b>International Value</b>	Equity securities of non-U.S. common stock with potential of providing dividend income and some capital appreciation through value-oriented stocks.	
<b>International Stock Index</b>	Contains equity securities of non-U.S. common stocks seeking to replicate the FTSE All Cap Global ex US Index.	
<b>International Growth</b>	Equity securities of non-U.S. common stock with potential of providing capital appreciation through growth-oriented stocks.	
<b>Small/Mid Company Value</b>	Combination of two investment managers investing in mid and small company common stocks that seek to provide dividend and capital appreciation through value-oriented stocks.	
<b>Small/Mid Company Index</b>	Contains small and mid-sized company domestic stocks seeking to replicate the S&P Completion Index.	
<b>Small/Mid Company Growth</b>	Combination of two investment managers investing in mid and small company common stocks that seeks to provide capital appreciation through growth-oriented stocks.	
<b>Emerging Market Stock</b>	A diversified portfolio of international common stocks solely invested in emerging market countries that seeks to provide capital appreciation through emerging market value-oriented stocks.	Highest 
<b>Self-Directed Brokerage Account</b>	Provides the opportunity to invest in a broad range of investments including individual stocks and access to mutual funds from nearly 300 fund families.	

**Special disclosure regarding the Intermediate Bond Fund:** The Commodity Futures Trading Commission (CFTC) takes the position that this investment option can be considered a commodity pool subject to CFTC regulation. The CFTC regulations contain an exception provided the Plan makes the following disclosure: The Plan is being operated by a person who has claimed an exclusion from the definition of the term “commodity pool operation” under the Act and, therefore, is not subject to registration or regulation as a pool operator under the Act.

## Accessing Your Account

NXP offers two ways to access your 401(k) Retirement Plan account:

- NXP Rewards Customer Service at 888-375-2367; or
- NXP Rewards Website at [NXP.com/rewards](https://nxp.com/rewards).

### NXP Rewards Customer Service

NXP Rewards Customer Service representatives can answer your questions and assist you in performing transactions. Call 888-375-2367 to reach an NXP Rewards Customer Service representative. NXP Rewards Customer Service representatives are available from 8:30 a.m. to 5:30 p.m. Central time.

### NXP Rewards Website

Visit the NXP Rewards website to manage your 401(k) Retirement Plan online 24 hours a day. This easy-to-use site provides you with your balance and benefit information, allowing you to make adjustments when it is most convenient for you.

There are several layers of security built into the NXP Rewards website to protect your personal data. Any information submitted through the site is encoded with Secured Socket Layer encryption. This means that even if the information you submit is somehow intercepted by a third party on its way to our servers, it is scrambled and virtually impossible to decode.

To access the NXP Rewards website, visit [NXP.com/rewards](https://nxp.com/rewards). The first time you visit the NXP Rewards website, click “Are you a new user?” to create your individual user ID and password. If you have already created your individual user ID and password, then you may immediately access the site to review important information about your 401(k) Retirement Plan.

### What You Can Do

Through both NXP Rewards Customer Service and the NXP Rewards website, you may check:

- Your account balance;
- Your investment elections;
- Amount available for full or partial distribution; and
- Fund descriptions and performance.

You may request the following transactions for your account:

- Start, stop or change the amount or type of contributions you make to the 401(k) Retirement Plan;
- Transfer existing account balances among funds or realign your entire account; and
- Request a loan, rollover or distribution, if you are eligible.

### **To Receive Plan Investment Information**

To comply with Section 404(c) of ERISA and the 404(c) Regulations, the 401(k) Retirement Plan names the Retirement Plan Committee as the fiduciary (404(c) Fiduciary) who is responsible for providing 401(k) Retirement Plan investment information upon request of a participant or beneficiary. The address of the party the 404(c) Fiduciary has delegated responsibility for providing Plan investment information is:

#### **NXP Rewards Customer Service**

P.O. Box 1475

Lincolnshire, Illinois 60069-1475

In addition to the material you receive regarding the 401(k) Retirement Plan, you have the right to request additional information to help you decide which investment options to select. The information you may request includes:

- A description of the annual operating expenses of each investment alternative (for example, investment management fees, administrative fees, transaction costs) which reduce your rate of return, and the aggregate amount of expenses expressed as a percentage of average net assets of the investment alternative.
- Copies of any prospectuses, financial statements and reports, and any other materials relating to the investment alternatives, to the extent this information is provided to the 401(k) Retirement Plan.
- For each investment alternative, a list of assets that make up the portfolio, the value of each asset (or the proportion of the investment alternative to which it belongs); and for each asset that is a fixed rate investment contract issued by a bank, savings and loan association or insurance company, the name of the issuer of the contract, the term of and the rate of return on the contract.
- Information concerning the value of shares or units in the investment alternatives, and information about the past and current investment performance, net of expenses, on a reasonable and consistent basis.
- Information concerning the value of shares or units in the investment alternative held in your account.

## Loans from Your Account

Although the primary purpose of the 401(k) Retirement Plan is to help you save for retirement, loans are available to help you meet your financial needs. You may request a loan for any reason, with a minimum loan amount of \$1,000. The maximum amount you can borrow (including any outstanding loan) is the lesser of:

- 50% of your vested account balance; or
- \$50,000 less your highest outstanding loan balance in the preceding 12 months.

The Plan offers general purpose and primary residence loans. You may request a loan by calling 888-375-2367 or by visiting [NXP.com/rewards](https://www.nxp.com/rewards). Generally, only one loan from your account may be outstanding at any given time.

A \$50 fee is charged for each new loan. The loans are taken from your account proportionately from each investment fund. Repayments are withheld from your pay and go directly to your account to be invested based on your investment elections.

## Repayment of Plan Loans

Plan loans are repaid through payroll deductions. A general loan must be paid back to the 401(k) Retirement Plan within five years, and, currently, a residential loan must be paid back to the 401(k) Retirement Plan within 15 years. The interest you pay on your loans goes back into your 401(k) Retirement Plan account. Currently, the interest rate is based on the prime rate plus 0.5%.

If you go on a leave, you are expected to continue making monthly payments. A coupon book for remaining loan payments will be mailed to your address on record. The coupon must be sent with a certified check, cashier's check or money order made payable to "NXP 401(k) Retirement Plan" by the deadline indicated on the coupon. If you miss a payment, your loan may become a defaulted loan and is considered a deemed distribution to you, which, under applicable law, must be reported as taxable income on your U.S. tax return in the year the default occurred. Also, a defaulted loan amount treated as a deemed distribution may not be rolled over to another qualified plan or individual retirement account.

You may repay your loan in full at any time without penalty by calling NXP Rewards Customer Service and requesting an early loan payoff invoice. You may also make a lump sum partial repayment at any time to bring your loan current, but you may not change your required payroll deduction amount or monthly coupon during the term of your loan.

If your employment ends, you cannot continue to make loan payments by payroll deduction. Generally, if you do not repay your loan within 60 days of your termination date, the outstanding loan balance plus accrued interest is automatically considered taxable income.

You should consider repaying your 401(k) Retirement Plan loan before you request a distribution, or within 60 days of your termination date, to avoid taxes if you plan to roll over your 401(k) Retirement Plan benefit. You may repay the loan balance by calling NXP Rewards Customer Service at 888-375-2367, or by following the loan repayment instructions in the separation of employment notice mailed to you by NXP Rewards Customer Service after your employment ends.

If your employment ends and you have an outstanding loan from your 401(k) Retirement Plan account, the Plan Administrator may reduce (or “offset”) your balance in the 401(k) Retirement Plan by the loan amount you have not repaid. Your loan offset amount is treated as a distribution to you at the time of the offset and is taxed unless you roll over an amount equal to your loan offset amount to another eligible plan or a traditional and/or Roth IRA (depending on the account from which you borrowed the funds) within 60 days of the date of the offset.

If your loan offset amount is the only amount you receive or are treated as having received, no amount is withheld from it. If you receive other payments from the 401(k) Retirement Plan, the 20% withholding amount will be based on the entire amount paid to you, including the loan repayment amount. The amount withheld will be limited to the amount of other cash or property paid to you (other than any employer securities).

## **Withdrawals from Your Account**

Withdrawals from your 401(k) Retirement Plan account are allowed only under specific circumstances.

### **Withdrawals of Rollover Amounts**

You may withdraw any portion of your account attributable to rollover contributions. You may not take more than one rollover withdrawal in any six-month period, and the minimum amount you may take is \$200.

### **Hardship Withdrawals**

You may withdraw your own regular and/or Roth contributions from your account to meet a financial hardship. Although you may withdraw earnings credited to your account before January 1, 1989, IRS regulations do not allow you to withdraw earnings credited after that date.

You may not take more than one hardship withdrawal in any calendar year, and the minimum hardship withdrawal you are allowed to take is \$1,000. Approval of the 401(k) Retirement Plan Committee, or its designee, is required.

Hardship withdrawals are not eligible for rollover to another plan or IRA.

#### ***When You May Take a Hardship Withdrawal***

The IRS requires you to meet specific conditions of financial hardship to withdraw funds from your account. You cannot withdraw more than the amount required to meet the financial need, and that need cannot be met by other sources (such as a loan from the 401(k) Retirement Plan or a credit union or bank). Hardship withdrawals are not allowed to alleviate credit card debt or to meet everyday living expenses.

Financial hardship withdrawals are allowed to:

- Pay expenses directly related to the purchase of your principal residence (excluding mortgage payments);
- Prevent eviction from or mortgage foreclosure on your principal residence;
- Pay for qualifying unforeseen repairs of damage to your principal residence;

- Pay medical expenses for you, your spouse, your dependents, or your primary beneficiary;
- Pay tuition, related educational fees and room and board for 12 months of post-secondary education for you, your spouse, your children, your dependents, or your primary beneficiary; or
- Pay burial or funeral expenses for your deceased parent, spouse, child, dependents and/or primary beneficiary.

You must complete a Hardship Withdrawal Application (which can be requested from NXP Rewards Customer Service or you can start the process online at [NXP.com/rewards](https://nxp.com/rewards) and provide the supporting documents requested in the application. **Under IRS regulations, for the six-month period after you receive a hardship withdrawal, you may not make a regular 401(k) contribution, a Roth 401(k) contribution, or a catch-up contribution to the 401(k) Retirement Plan.**

If you withdraw money from your account due to a financial hardship, per IRS regulations, your participation in the Employee Stock Purchase Plan (ESPP) is suspended for six months.

### **Withdrawals After Age 59½**

If you are age 59½ or older, you may withdraw all or a portion of your accounts attributable to your regular and/or Roth contributions and the related earnings. Until your employment ends, Company Matching Contributions are not eligible for withdrawal before age 70½.

You may not make more than one age 59½ withdrawal in any six-month period, and the minimum withdrawal you are allowed to take is \$200.

### **Withdrawals After Age 70½**

If you are age 70½ or older, you may withdraw all or a portion of your 401(k) Retirement Plan account, including Company Matching Contributions.

You may not take more than one age 70½ withdrawal in any six-month period, and the minimum amount you are allowed to take is \$200 (or the remaining balance in your account).

### ***Withdrawals for Legacy NXP Participants***

In addition to the withdrawals listed above, with respect **only** to amounts transferred from the NXP 401(k) Plan to the 401(k) Retirement Plan, you may withdraw all or a portion of your account attributable to amounts transferred from the NXP 401(k) Plan that are after-tax contributions, vested Company Matching Contributions (including vested Roth matching contributions) and, after attaining age 59½, your pre-tax contributions; each as adjusted for earnings and/or losses.

Like other withdrawals under the 401(k) Retirement Plan, you may take only one in-service withdrawal in any six-month period, and the minimum in-service withdrawal is \$200.

## When You Are Eligible for a Distribution

When your employment with NXP (and all related companies) ends for any reason, you are eligible to take a distribution from your account. Transferring from one NXP entity to another NXP entity or related company does not make you eligible to receive a distribution from your account (e.g., if you are an Inpatriate going back to a foreign NXP entity, you will not be able to receive a distribution until you terminate employment with that NXP entity and all other NXP entities). Your termination date is your last day on payroll. If you are on a leave of absence, your termination date is the date your leave is ended by you or by NXP without your returning to work.

You may view your payment options online at [NXP.com/rewards](https://www.nxp.com/rewards) or by calling NXP Rewards Customer Service at 888-375-2367. A Customer Service Representative can assist you with a rollover and other payment options. Distributions are processed as soon as administratively possible.

## Survivor Benefits

If you die, your entire account balance (less any outstanding loan balance) is payable to the beneficiary or beneficiaries you have designated with the 401(k) Retirement Plan. If you are married, your account is paid to your surviving spouse unless you designated another beneficiary and your spouse consented in a notarized writing to that designation.

For tax purposes, the 401(k) Retirement Plan uses federal tax laws to determine who is your spouse. If you are legally married, including a common-law marriage, in a state or country that recognizes same-sex spouses, your same-sex spouse is recognized as your spouse.

You may revoke or change your designation at any time before you die. But, if you are married and you change your designation to name a beneficiary other than your spouse, you must have your spouse's written, notarized consent for the designation to be effective.

You should review your designation of beneficiary if your marital status changes. If you marry after you file a designation of beneficiary, your designation becomes invalid to the extent you need spousal consent but do not have it. If you have designated your spouse as beneficiary and you later are separated or divorced, your designation remains effective unless you change it online or by calling NXP Rewards Customer Service at 888-375-2367.

If there is no beneficiary designation on file, or if it is invalid (for example, you did not complete a new designation when you got married), benefits are paid:

- To your surviving spouse; if none, then
- To your children (in equal shares if more than one); if none, then
- To your parents (in equal shares if both parents survive you); or if none, then
- To your estate.

Except as provided below, if your surviving spouse is your sole beneficiary, he or she may request payment of your account balance immediately, or by December 31 of the year in which you would have turned 70½.

Your spouse may elect to receive his or her survivor benefit in the form of a lump sum distribution or a direct rollover.

If your surviving spouse is not your sole beneficiary, then the beneficiaries may elect a lump-sum distribution, direct rollover or defer the distribution with the entire interest being distributed by December 31 of the calendar year containing the fifth anniversary of your death.

If your account balance is \$1,000 or less at the time of your death (disregarding rollover amounts), the account balance is distributed in a lump sum at the end of the month following the month in which you died.

While your account balance remains in the 401(k) Retirement Plan, your spouse or other beneficiary is entitled to direct how the account is invested, see [Investing Your 401\(k\) Retirement Plan Account](#), beginning on page 207.

## How Your Account Is Paid

### If Your Vested Account Balance Is More than \$1,000

If the value of your account is more than \$1,000, you have a few payment options.

Your Payment Options		
Option	When You Elect this Option	Option Description
<b>Lump Sum</b>	You may choose this option no matter why your employment ends.	Single payment of your account. This option is automatic unless you choose another option.
<b>Direct Rollover</b>	You may choose this option no matter why your employment ends.	Transfer by NXP of all or a portion of your account to another qualified employer plan, traditional IRA, Section 403(b) annuity or Section 457 governmental plan.
<b>Partial Distribution</b>	You may choose this option no matter why your employment ends.	A single payment of part of your account, but at least \$5,000. No more than one partial distribution in any three-month period is allowed.
<b>Combination</b>	You may choose this option no matter why your employment ends.	Various combinations of the options for which you are eligible.

### If You Request a Payment

You receive the payment along with a distribution statement confirming the account value and payment option. Any payment due to you (or your beneficiary) will be paid as soon as administratively possible after:

- Your employment with NXP ends or you are determined to have become totally and permanently disabled; and
- Your request for payment is confirmed at [NXP.com/rewards](http://NXP.com/rewards) or is confirmed after speaking with a Customer Service Representative.

If you elect a partial distribution, the balance of your account (after each payment) remains invested in the funds you have elected. Investment returns may increase or decrease your future payment amounts.

### ***If You Do Not Request a Payment***

Your balance is held in the 401(k) Retirement Plan until you request a method of payment. Once you reach age 70½ and have terminated employment with NXP, the Internal Revenue Code requires that you begin taking distributions by April 1 of the following year. You have the same payment options described above, but you must take a minimum distribution each year as required by the Internal Revenue Code. Information regarding your options is sent to your last address on file in January following the year in which you turn age 70½. If you do not take a minimum distribution when it is required to be paid, the amount of the required distribution may be subject to a 50% excise tax.

### **If Your Vested Account Balance Is \$1,000 or Less**

If the value of your 401(k) Retirement Plan account is \$1,000 or less (determined without regard to any amount in your rollover account) at the time of your termination, you automatically receive it as a lump sum. You may take the total amount in cash, or you may roll it over into a traditional Individual Retirement Account (IRA) or another eligible plan.

If you do not elect to receive a payment or a rollover, NXP mails to your last known address a lump-sum payment of the total amount due to you shortly after 60 days from your termination date. A distribution statement is sent documenting the distribution and the taxation. If you prefer to roll over your 401(k) Retirement Plan distribution, your request must be confirmed by NXP Rewards Customer Service within 60 days of your termination date; otherwise, you will receive a lump-sum payment shortly after 60 days from your termination date.

Whether your account balance is greater or less than \$1,000 is determined without regard to any amounts in your rollover account.

You can request a payment option by calling NXP Rewards Customer Service, or online at [NXP.com/rewards](https://www.nxp.com/rewards). A Customer Service Representative can assist you with a rollover and other payment options.

### **Starting Rollover IRAs Is Easy**

When you leave NXP, you may leave your account in the 401(k) Retirement Plan (if the balance is more than \$1,000) or you may transfer it to a Rollover IRA and/or Rollover Roth IRA. Alight Solutions, the 401(k) Retirement Plan's third-party administrator, sends you a simplified Rollover IRA/Rollover Roth IRA Kit when your employment ends. This kit explains the process for setting up a Rollover IRA and/or Rollover Roth IRA with a number of leading providers, using their secure website.

### **Taxes and Penalties**

You are liable for payment of U.S. income taxes on a 401(k) Retirement Plan withdrawal. A 10% penalty also may apply to withdrawals made before you are age 59½.

## ***Important U.S. Tax Information***

Under current tax laws, your Roth 401(k) contributions, which you make on an after-tax basis, and their associated investment earnings are not taxable when you receive them as a qualifying 401(k) Retirement Plan benefit. To qualify for this favorable tax treatment, you must meet these criteria at the time you receive your Roth funds from the 401(k) Retirement Plan:

- Your Roth account in the 401(k) Retirement Plan must be at least five years old (this requirement also applies to distributions due to death or disability); *and*
- You must be age 59½ or older.

Any Company Matching Contributions made on Roth 401(k) contributions are accounted separately in your 401(k) Retirement Plan account; they are not considered to be Roth funds in the 401(k) Retirement Plan.

## ***Tax Summary***

In addition to describing the U.S. federal tax treatment of distributions, this section explains how you can continue to defer U.S. federal income tax on your retirement savings in the 401(k) Retirement Plan. All or part of any payments you receive from before-tax funds in the 401(k) Retirement Plan (regular, before-tax catch-up and Company Matching Contributions and their associated investment earnings) may be eligible for rollover to a traditional IRA, Roth IRA or another eligible plan. Those funds cannot be rolled over to a SIMPLE IRA or a Coverdell Education Savings Account (formerly known as an education IRA). Payments you receive from Roth funds (Roth 401(k) contributions and their associated investment earnings) may be rolled over to a Roth IRA or another employer's eligible plan that accepts Roth rollover contributions.

Remember, this information is only a summary. More information is available from the IRS and professional tax advisors.

An “eligible plan” (or “tax-qualified plan”) includes a plan qualified under Section 401(a) of the Internal Revenue Code, including a 401(k) plan, profit-sharing plan, defined benefit plan, stock bonus plan, employee stock purchase plan, a money purchase plan, a Section 403(a) annuity plan, a Section 403(b) tax-sheltered annuity and an eligible Section 457(b) plan maintained by a governmental employer (a “governmental 457 plan”).

An eligible plan is not legally required to accept a rollover. Before you decide to roll over your payment to another tax-qualified plan, you should find out whether the plan accepts rollovers, and if so, the types of distributions it accepts as a rollover. You should also find out about any documents that are required to be completed before the receiving plan will accept a rollover.

Even if a plan accepts rollovers, it might not accept rollovers of certain types of distributions, such as after-tax amounts and Roth contributions. If this is the case, and your distribution includes after-tax amounts from a predecessor plan or Roth amounts, you may want instead to roll your distribution over to a traditional IRA and/or Roth IRA, or to split your rollover amount between the tax-qualified plan in which you will participate and a traditional or Roth IRA. If a tax-qualified plan accepts your rollover, the plan may restrict subsequent distributions of the rollover amount or may require your spouse's consent for any subsequent distribution. A subsequent distribution from the plan that accepts your rollover may also be subject to different tax treatment than distributions from the 401(k) Retirement Plan. Check with the plan administrator that is to receive your rollover before making the rollover.

A payment from the 401(k) Retirement Plan that is eligible for “rollover” can be taken in two ways. You can have all or any portion of your payment either:

- Paid in a “direct rollover” to a traditional and/or Roth IRA or, if you choose, to another eligible plan that will accept it; or
- Paid to you.

If you choose a direct rollover:

- If rolled over to a traditional IRA or another tax-qualified plan, your payment received from before-tax funds is not taxed in the current year, and no income tax is withheld.
- If rolled over to a Roth IRA, your payment received from before-tax funds in the 401(k) Retirement Plan will be taxed, but income tax is not required to be withheld and the 10% additional tax on early distributions will not apply (unless you take the amount rolled over out of the Roth IRA within five years, counting from January 1 of the year of the rollover);
- Your payment received from Roth funds in the 401(k) Retirement Plan is not taxed and no income tax is withheld;
- Your payment is made directly to your traditional and/or Roth IRA or, if you choose, to another tax-qualified plan that accepts your rollover.
- Your benefit cannot be rolled over to a SIMPLE IRA or Coverdell Education Savings Account.
- With a traditional IRA or other eligible plan, your payment is taxed later when you take it from the plan. Depending on the type of plan, the later distribution may be subject to different tax treatment than it would be if you received a taxable distribution from the 401(k) Retirement Plan.
- Under current tax law, your Roth payment is not taxed when you take it out of the Roth IRA, if you meet the Roth IRA distribution rules described in IRS Publication 590, *Individual Retirement Arrangements (IRAs)*, IRS Publication 590-A, *Contributions to Individual Retirement Arrangements (IRAs)* and IRS Publication 590-B, *Distributions from Individual Retirement Arrangements (IRAs)*, as applicable, after Publications 590-A and 590-B are issued.

If you choose to have a taxable 401(k) Retirement Plan payment that is eligible for rollover paid to you:

- You receive only 80% of the payment, because the 401(k) Retirement Plan is required to withhold 20% of the taxable amount of the payment and send it to the IRS as income tax withholding to be credited against your taxes.
- Your payment is taxed in the current year unless you roll it over. You may be able to use special tax rules that could reduce the tax you owe. However, if you receive the payment before age 59½ you may also have to pay an additional 10% tax.
- You can roll over the payment by paying it to your traditional and/or Roth IRA or to another tax-qualified plan that accepts your rollover within 60 days of receiving the payment. The amount rolled over is not taxed until you take it out of the traditional IRA or employer plan.

- If you want to roll over 100% of the payment to a traditional and/or Roth IRA or an eligible plan, you must find other money to replace the 20% that was withheld. If you roll over only the 80% that you received, you are taxed on the 20% that is not rolled over.
- If the distribution of your Roth funds meets IRS regulations, no taxes are withheld from your Roth funds.

To speak with a Customer Service Representative, call NXP Rewards Customer Service at 888-375-2367.

## Payments That Can and Cannot Be Rolled Over

### *Non-Taxable Payments*

After-tax employee contributions, other than Roth 401(k) contributions, generally are contributions you make from your own pay that are already taxed. The 401(k) Retirement Plan does not allow non-Roth, after-tax contributions today, but they may have been allowed under a predecessor plan or rolled over to the 401(k) Retirement Plan. Distributions that include non-Roth, after-tax contributions may be rolled directly into an IRA or into another employer plan qualified under Section 401(a) or 403(a) that accepts after-tax contributions and separately accounts for them. You may roll over to another employer plan all of a payment that includes after-tax contributions, but only through a direct rollover. You can do a 60-day rollover to an employer plan of part of a payment that includes after-tax contributions, but only up to the payment amount that would be taxable if not rolled over. Also, you cannot first roll over non-Roth, after-tax contributions to a traditional IRA and then roll over that amount into an employer's tax-qualified plan. You also cannot roll over non-Roth, after-tax contributions to a governmental 457 plan.

NXP Rewards Customer Service should be able to tell you how much of your payment is the taxable portion and how much (if any) is the non-Roth, after-tax employee contribution portion. It is your obligation to keep track of the non-Roth, after-tax contributions you roll over to a traditional IRA and report them to the IRS on the applicable forms. This will make it possible to determine the nontaxable amount of any future distributions from the traditional IRA.

The following types of payment cannot be rolled over:

- **Required Minimum Payments:** Beginning in the year you reach age 70½ or retire, whichever is later, a certain portion of your payment cannot be rolled over because it is a "required minimum payment" that must be paid to you.
- **Corrective Distributions:** A distribution that is made to correct a failed nondiscrimination test or because legal limits on certain contributions were exceeded cannot be rolled over.
- **Loans Treated as Distributions:** The amount of a qualified plan loan that becomes a taxable deemed distribution because of a default cannot be rolled over. However, a loan offset amount is eligible for rollover, as described in [Repayment of Plan Loans](#), beginning on page 214. Call NXP Rewards Customer Service to ask if distribution of your loan qualifies for rollover treatment.
- **Hardship Distributions:** A hardship distribution from a qualified plan is not eligible for rollover.

## **Rollovers of Distributions**

### ***Direct Rollovers***

You can choose a direct rollover of all or any portion of your payment that is an eligible rollover distribution, as described above. In a direct rollover, the eligible rollover distribution is paid directly from the 401(k) Retirement Plan to a traditional or Roth IRA or other eligible employer plan that accepts rollovers. If you choose a direct rollover, you are not taxed on a payment until you later take it out of the IRA or the other eligible employer plan. Remember, no federal income tax withholding is required for any portion of your 401(k) Retirement Plan benefits for which you choose a direct rollover.

### ***Direct Rollover to an IRA***

You can open IRAs to receive a direct rollover: a traditional IRA for regular 401(k) funds and a Roth IRA for Roth 401(k) funds. If you choose to have your payment made directly to an IRA, contact an IRA sponsor (usually a financial institution) to find out how to have your payment made in a direct rollover to an IRA at that institution. In choosing a traditional or Roth IRA, you may want to consider whether the IRA you choose will allow you to move all or part of your payment to another tax-qualified plan or IRA at a later date without penalties or other limitations.

### ***Direct Rollover to an Employer's Tax-Qualified Plan***

If your new employer has an eligible (tax-qualified) plan, including Section 403(b) annuities and Section 457 government plans, and you want to make a direct rollover to that plan, ask the administrator of that plan whether it will accept a rollover and the type of rollovers it will accept.

An employer plan is not legally required to accept a rollover. If your new employer's plan does not accept a rollover, you can choose a direct rollover to a traditional and/or Roth IRA.

If the employer plan accepts your rollover, the plan may provide restrictions on the circumstances under which you may later receive a distribution of the rollover amount or may require spousal consent to any subsequent distribution. Check with the administrator of that plan before making your decision.

### ***Change in Tax Treatment Resulting from a Direct Rollover***

The tax treatment of any payment from the eligible employer plan or traditional IRA receiving your direct rollover might be different than if you received your benefit in a taxable distribution directly from the 401(k) Retirement Plan. However, if you have your benefit rolled over to a Section 403(b) annuity, governmental 457 plan or traditional IRA in a direct rollover, your benefit will no longer be eligible for that special treatment (see [\*\*Additional 10% Tax If You Are Under Age 59½\*\*](#) on page 225).

## **Taxes on a Payment Made to You**

If you have the payment made to you, it is subject to 20% income tax withholding. The payment is taxed in the year you receive it unless, within 60 days, you roll it over to a traditional and/or Roth IRA or another eligible plan that accepts rollovers. If you do not roll it over, special tax rules may apply.

Taxes are not withheld on qualifying distributions of Roth contributions and their associated investment earnings.

### ***Mandatory Income Tax Withholding***

If any portion of the payment to you is an eligible rollover distribution, and you do not elect a direct rollover, the 401(k) Retirement Plan is required by law to withhold 20% of the taxable amount. This amount is sent to the IRS as federal income tax withholding.

### ***Voluntary Income Tax Withholding***

If any portion of your payment is not an eligible rollover distribution but is taxable, the mandatory withholding rules described above do not apply. In this case, you may choose not to have withholding apply to that portion. NXP Rewards Customer Service can provide you the appropriate election form.

See IRS Form 5329 for more information on the additional 10% tax.

### ***60-Day Rollover Option***

If you have an eligible rollover distribution paid to you, you can still decide to roll over all or part of it to a traditional and/or Roth IRA or another eligible plan that accepts rollovers. If you decide to roll over, you must contribute the payment amount you received to a traditional and/or Roth IRA or another eligible plan within 60 days after you receive the payment. The portion of your payment that is rolled over will not be taxed until you take it out of the IRA or the other eligible plan.

You can roll over up to 100% of the eligible rollover distribution, including an amount equal to the 20% that was withheld. If you choose to roll over 100%, you must find other money within the 60-day period to contribute to the traditional and/or Roth IRA or the other eligible plan to replace the 20% that was withheld. On the other hand, if you roll over only the 80% that you received, you will be taxed on the 20% that was withheld.

**Example:** If your eligible rollover distribution is \$10,000, only \$8,000 will be paid to you because the 401(k) Retirement Plan must withhold \$2,000 as income tax. However, when you prepare your income tax return for the year, you will report the full \$10,000 as a payment from the 401(k) Retirement Plan. You will report the \$2,000 as tax withheld, and it will be credited against any income tax you owe for that year.

**Example:** Your eligible rollover distribution is \$10,000 and you choose to have it paid to you. You will receive \$8,000 and \$2,000 will be sent to the IRS as income tax withholding. Within 60 days after receiving the \$8,000 you may roll over the entire \$10,000 to a traditional IRA or eligible plan.

To do this, you roll over the \$8,000 you received from the 401(k) Retirement Plan, and you will have to find \$2,000 from other sources (your savings, a loan, etc.). In this case, the entire \$10,000 is not taxed until you take it out of the IRA or eligible plan.

If you roll over the entire \$10,000, when you file your income tax return you may get a refund of part or all of the \$2,000 withheld. If, on the other hand, you roll over only \$8,000, the \$2,000 you did not roll over is taxed in the year it was withheld. When you file your income tax return, you may get a refund of part of the \$2,000 withheld. (However, any refund is likely to be larger if you roll over the entire \$10,000.)

### ***Additional 10% Tax If You Are Under Age 59½***

If you receive a payment before you reach age 59½ and you do not roll it over, then, in addition to the regular income tax, you may have to pay an extra tax equal to 10% of the taxable portion of the payment. The additional 10% tax generally does not apply to your payment if it is:

- Paid to you because you separate from NXP during or after the year you reach age 55;
- Paid because you retire due to disability;
- Paid to you as equal (or almost equal) payments over your life or life expectancy (or your life expectancy and your beneficiary's life expectancy);
- Used to pay certain deductible medical expenses;
- Paid directly to the government to satisfy a federal tax levy;
- Paid to you during a period of at least 180 days of active duty military service on or after December 31, 2007; or
- Paid to an alternate payee under a Qualified Domestic Relations Order.

The additional 10% tax will normally not apply to distributions from a governmental 457 plan, except to the extent the distribution is attributable to an amount you rolled over to that plan (adjusted for investment returns) from the 401(k) Retirement Plan. Any amount rolled over from a governmental 457 plan to the 401(k) Retirement Plan will become subject to the additional 10% tax if it is distributed to you before you reach age 59½, unless one of the exceptions applies.

## Surviving Spouses, Alternate Payees and Other Beneficiaries

In general, the rules summarized in this section that apply to NXP employees also apply to payments to surviving spouses or former spouses who are “alternate payees” under a Qualified Domestic Relations Order (QDRO), which is an order issued by a court, usually in connection with a divorce or legal separation that has been determined by the Plan Administrator as meeting the requirements of a QDRO. Some of these rules also apply to a deceased NXP employee’s beneficiary who is not a spouse. However, there are some exceptions for payments to surviving spouses, alternate payees and other beneficiaries that should be mentioned.

### ***If You Are a Surviving Spouse, Alternate Payee or Another Beneficiary***

You may choose to have an eligible rollover distribution paid in a direct rollover to a traditional and/or Roth IRA or another eligible plan, or paid to you. If you have it paid to you, you can keep it or roll it over yourself to a traditional and/or Roth IRA or to another eligible employer plan that accepts rollovers.

Your payment is generally not subject to the additional 10% tax, even if you are younger than age 59½ (see [Additional 10% Tax If You Are Under Age 59½](#) on page 225).

You may be able to use the special tax treatment for lump-sum distributions. If you receive a payment because of the employee’s death, you may be able to treat the payment as a lump-sum distribution if the employee met the appropriate age requirements, even if the employee did not have five years of participation in the 401(k) Retirement Plan.

### ***Where to Go for More Information***

This notice summarizes only the U.S. federal (not state or local) tax rules that may apply to your payment. The rules described in this section are complex and contain many conditions and exceptions that are not included in this SPD. Therefore, you should consult a professional tax advisor before you take a payment of your benefits from the 401(k) Retirement Plan.

You can find more specific information on the tax treatment of payments from qualified retirement plans in IRS Publication 575: *Pension and Annuity Income*, and IRS Publication 590: *Individual Retirement Arrangements*. These publications are available from your local IRS office, on the IRS’s website at [IRS.gov](https://www.irs.gov), or by calling 800-829-3676 (within the U.S.).

## **Additional Information**

### **Leave of Absence for Military Service**

Under the Heroes Earnings Assistance and Relief Tax (HEART) Act of 2008, if you are called to active duty in the U.S. armed forces for 30 days or more, the 401(k) Retirement Plan will allow you to receive a distribution from your account on the same basis as if your NXP employment terminated. If you receive such a distribution, you must wait six months from the date of the distribution to again contribute to the 401(k) Retirement Plan.

If you receive differential pay while on Uniformed Service, you may elect to make participant contributions to the 401(k) Retirement Plan and NXP will make Company Matching Contributions to your account based on your contributions. If you are re-employed by NXP following Uniformed Service, you are treated as not having a break in service for the 401(k) Retirement Plan. Uniformed Service leaves may not exceed five years in the aggregate, and you must return to employment at NXP within the time provided by law.

Beginning on your date of re-employment, you have a period equal to three times your period of Uniformed Service (not to exceed five years) to make up participant contributions to the 401(k) Retirement Plan. The amount you may contribute may not be more than the maximum amount you would have been allowed to contribute if you had not gone into Uniformed Service, and you may choose to make your contributions as regular or Roth contributions, or as catch-up contributions (if you are eligible to make them).

Your eligible compensation for this calculation is the eligible compensation you would have received had you continued working for NXP during the period of your Uniformed Service. If your eligible compensation is not reasonably certain, then the average eligible compensation during the 12-month period immediately preceding your Uniformed Service will be used. If you worked less than 12 months, your actual period of employment is used.

If you make up your participant contributions, NXP will make Company Matching Contributions to your account equal to the amount NXP would have contributed if you had made your participant contributions during your period of Uniformed Service. However, you are not credited with any investment earnings for made-up contributions for your time in Uniformed Service; investment earnings begin when the contributions are actually put into your account.

### **Other Former Employees Who Terminate Employment and Return**

If you leave NXP and later return, your 401(k) Retirement Plan status depends on several things, including whether you were a participant when you left, whether you had a “break in service,” and whether you received a distribution upon your earlier termination. You should check with NXP Rewards Customer Service about your status if you are rehired.

## Qualified Domestic Relations Order (QDRO)

A Qualified Domestic Relations Order is a court order, judgment or decree in connection with alimony, marital property rights or child support requirements. If a Domestic Relations Order complies with the Retirement Equity Act of 1984, as amended, NXP recognizes it as a Qualified Domestic Relations Order and makes payments to the alternate payee (your spouse, former spouse, child or other dependent) as specified in the Qualified Domestic Relations Order.

NXP Rewards Customer Service has established a special process for requesting information about QDROs. You may:

- Visit the Qualified Order website at [QOCenter.com](https://www.QOCenter.com);
- Email your questions to [QOCenter@aonhewitt.com](mailto:QOCenter@aonhewitt.com); or
- Call NXP Rewards Customer Service at 888-375-2367 and ask to speak with a QDRO specialist.

A \$400 processing fee applies to each QDRO. The QDRO processing fee will be applied to your and/or your alternate payee's account.

## Keeping Your Records Current

It is very important that you keep your 401(k) Retirement Plan contact details up to date. Your mailing address and beneficiary designation in particular need to be on file in case benefit payments need to be sent to you or your beneficiary.

## Work/Life Programs and Life Events

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*This section provides information on how to take advantage of your benefits as your situation changes. Specific sections include:*

- **Work/Life Programs**, including:
  - **Adoption Assistance Program** (beginning on page 231);
  - **Resource & Referral Program** (beginning on page 236);
  - **Travel Assistance** (beginning on page 239); and
- **Life events** (some of which are qualified status changes) *and how these events affect your benefits (beginning on page 244).*

See **Participation**, beginning on page 5, for information on who is eligible, how to enroll, when coverage begins, when changes can be made and when coverage ends.

The NXP Rewards package is designed to support you through the different stages and events of your life. The charts and other information in this section highlight the information you need to take full advantage of your health and wellness benefits as your situation changes.

**Note:** If your work schedule changes (for example, you begin working less than 20 hours per week), this change may affect the benefits for which you are eligible. Contact NXP Rewards Customer Service at 888-375-2367 to find out exactly how your benefits may be affected.

## Work/Life Programs

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### Balancing Your Work and Your Personal Life

From time to time, we can all use a little assistance in balancing our work and personal responsibilities. NXP's Work/Life benefits provide you with information, resources, financial assistance and benefit programs that can ease some of the challenges you face in managing your daily life.

NXP offers a wide range of solutions and resources to help meet your needs, regardless of your stage of life, whether you need a child care center, a nursing home facility for a loved one, or scholarship resources for your college-bound child. The chart below gives an overview of the various Work/Life programs offered to NXP employees and a description of who may be eligible for them.

Please note that to participate in these programs, you must meet the eligibility requirements as detailed in this SPD. Some of the programs require you to enroll for participation, while others are automatic.

Work/Life Program	What It Is	Who Is Eligible
<a href="#">Adoption Assistance Program</a>	Offers financial assistance to help with some of the expenses associated with adopting a child.	You
<a href="#">Resources for Living Program</a>	A resource and referral program that offers a range of tools and information to help you manage your work and personal life, such as child care, elder care and convenience services like landscaping, home maintenance, car repair, etc. It also offers a variety of discounted products and services.	You, members of your household and your adult children up to the age of 26
International SOS <a href="#">Travel Assistance Program</a>	Travel assistance program that provides a comprehensive resource for domestic and international travel information services including medical and security assistance.	You (and family members if you are on a U.S. Expatriate or U.S. Inpatriate assignment)

### To Find Out More

Use the following resources when looking for more details on your Work/Life programs:

- NXP Intranet under the Benefits section; or
- [NXP.com/rewards](https://www.nxp.com/rewards); or
- NXP Rewards Customer Service: Call 888-375-2367.

## Adoption Assistance Program

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If you are adopting a child, NXP can help. The Adoption Assistance Program offers you financial assistance for some of the expenses associated with domestic and international adoptions. You may be reimbursed for up to \$8,000 per child for eligible adoption expenses. If both you and your spouse/domestic partner are NXP employees, your family is only eligible for up to \$8,000 per child.

### How the Program Works

You may receive reimbursement for many eligible expenses associated with adopting or attempting to adopt a child, such as legal and medical fees. You simply submit the appropriate documentation and paid receipts to NXP Rewards Customer Service.

#### ***Adoption Assistance***

NXP reimburses up to \$8,000 in eligible adoption expenses. You can file for reimbursement once a child is placed in your home for adoption, once the adoption becomes finalized or when your attempts to adopt a child end unsuccessfully.

### Filing for Reimbursement

Once a child has been placed in your home for adoption, the adoption is finalized or your attempts to adopt a child end unsuccessfully, you can file for reimbursement of eligible expenses.

Expenses must be:

- Incurred while you are an eligible NXP employee; and
- Submitted for reimbursement by the earlier of the date you terminate, or the following applicable date:
  - For eligible expenses incurred on or before the date of the initial placement of the child in your home, one year from the date of the initial placement.
  - During the period after the initial placement of the child in your home but before the final (or failed) adoption, you may submit one or more requests for reimbursement for eligible expenses incurred following the initial placement of the child in your home but before the date of the final (or failed) adoption; or
  - For all eligible expenses associated with a final (or failed) adoption, one year from the later of (a) the date of the final (or failed) adoption, or (b) the date the eligible expense was incurred.

For reimbursement, use the Adoption Assistance Reimbursement Request form, available online at [nxp.com/benefits](https://nxp.com/benefits) under Adoption Assistance Program. Complete the form and send all relevant documents (translated to English, if they are originated in a non-English language) including:

- A copy of the adoption court order or a notarized letter from an attorney or agency granting preliminary placement or documenting a failed adoption attempt; and
- Paid itemized receipts for eligible adoption expenses, sent to the address listed on the form.

Be sure to sign and include your NXP Workday identification number on each document, including receipts (in case any paperwork gets separated).

Mail all documentation to:

**NXP Rewards Customer Service**  
100 Half Day Road  
Lincolnshire, Illinois 60069-1475

## Documents Needing Translation

More parents are adopting children from locations around the world. In many of these cases, adoption documents or receipts will not be in English. Therefore, you must have these documents translated to English.

For a smooth adoption reimbursement process:

- Locate someone who is proficient in the language of the documents and in English to translate the documents;
- Submit a signed, notarized letter or affidavit from the translator that:
  - Attests that they are proficient in the English language and the language they have translated;
  - Attests that their translation is accurate as to what the original documents contain;
  - Provides a list of each document translated;
  - Provides the native currency amount of each receipt and the translated dollar equivalent; and
  - Contains the legible, printed name of translator.

Documents that have been translated to English should be accompanied by a notarized letter or affidavit from the translator, noting each of the documents he or she has translated.

## Adoption Assistance Eligible Expenses

- Public or private adoption agency fees (includes home study fees where required);
- Foreign and international adoption fees;
- Legal fees associated with the adoption or with a legal guardianship, if the legal guardianship is an integral part of a final (or failed) adoption, except for legal retainer fees;
- Court fees associated with the adoption;
- Medical expenses (adopting parent(s)' physical exam, and in the case of a private adoption, the medical and professional counseling expenses of the biological mother and child);
- Agency or legal fees associated with temporary foster care charges;
- Reasonable travel expenses, including auto, airfare, hotel and meals, if such expenses are directly related to and necessary for an adoption or a bona fide attempt to adopt; and
- Fees associated with the translation of documents written in a language other than English.

If you have any questions about the Adoption Assistance program, call NXP Rewards Customer Service at 888-375-2367.

## Expenses Not Eligible

- Donations to adoption organizations;
- Legal fees for legal guardianship unless legal guardianship is an integral part of a final (or failed) adoption;
- Cost of adoption when you, your spouse/domestic partner is the biological parent of the child;
- Costs to have a child through a surrogate parent or adopt a child born to a surrogate parent;
- Expenses covered by any other plan, policy or program offered by NXP or otherwise;
- Legal retainer fees paid to an attorney;
- Independent adoption networking fees and associated services;
- Advertisement and soliciting fees;
- Any service or expenses incurred before the date you became eligible to participate in the Program;
- Expenses incurred or submitted for reimbursement after your Program participation ends; and
- Any expenses not listed as eligible.

## Key Terms

- **Eligible expenses** are those costs that are associated with the placement or adoption of a child, such as adoption agency fees, legal fees, court fees and in some circumstances, medical and travel expenses.
- **Failed adoption expenses** are eligible costs incurred in the legal attempt to adopt a child, when the adoption has been terminated due to unforeseen circumstances.
- **Temporary foster care expenses** are agency and legal fees associated with temporary foster care that results in a final (or failed) adoption.

## Some Things to Consider

- **Before Adopting:** NXP's Resources for Living Program, managed by Aetna, can assist you if you need help with additional resources or information about adoption. Call 866-702-7435, 24 hours a day, or visit [resourcesforliving.com](https://resourcesforliving.com) (Username: NXP; Password: member) for more information on this.

Certain expenses may have special tax advantages. Please consult your tax advisor for details.

- **After Adopting:** As soon as the placement or adoption of the child is complete, you will want to consider the following options:
  - File for any remaining Adoption Assistance program reimbursement: complete an Adoption Assistance Reimbursement Request form and send it to NXP Rewards Customer Service (see [Filing for Reimbursement](#) beginning on page 231 for details);
  - Add your child to your medical, dental and/or vision coverage within 30 days of adoption by calling NXP Rewards Customer Service at 888-375-2367;
  - Enroll your new child, if eligible, in Child(ren) Life Insurance;
  - Establish or change a Health Care Flexible Spending Account;
  - Establish or change a Dependent Care Flexible Spending Account;
  - Change your beneficiary designations for your life insurance and/or your 401(k) Retirement Plan; and
  - Find out about child care options in your area by contacting NXP's Resources for Living at [resourcesforliving.com](https://resourcesforliving.com) (Username: NXP; Password: member), or by calling 866-702-7435.

## When Adoption Assistance Program Coverage Ends

Your coverage under the Adoption Assistance Program ends on the earliest of the following events:

- The date on which your NXP employment ends;
- The date you no longer meet the Adoption Assistance Program eligibility requirements other than due to a leave of absence under the NXP Parental Leave Policy or a paid leave of absence;
- The last day of the month in which you receive military service pay under the NXP Military Service Pay Policy, provided that your coverage as a participant who returns to active employment within 31 days of ending military service as described in the Uniformed Services Employment and Reemployment Rights Act is not terminated due to the absence;
- 90 days after the Adoption Assistance Program requests repayment from you or your covered dependent of amounts subject to reimbursement, overpayments or mistaken payments from any NXP welfare plan, if you fail to repay or set up an acceptable repayment schedule; or
- The day the Adoption Assistance Program ends, or the effective date of an amendment eliminating such coverage.

## Important Tax Information

The Adoption Assistance Program's reimbursements are considered taxable income. Any reimbursements you receive are paid directly to you with applicable tax withholding already deducted. Reimbursements are not eligible for the adoption assistance income exclusion under Internal Revenue Code Section 137. Therefore, any reimbursements you receive are reported as wages in box 1 of your Form W-2.

You may be able to take a tax credit, allowed by Section 23 of the Internal Revenue Code, for qualified adoption expenses that are not reimbursed under this Plan. Depending on your financial situation, it may be to your advantage to have only certain eligible expenses reimbursed by the Adoption Assistance Program, or to use the Program only after you have received the full tax credit. For information on the adoption tax credit, talk to your accountant or financial advisor or review information online at [IRS.gov](https://www.irs.gov).

## Resources for Living Program

The Resources for Living Program is your Employee Assistance Program (EAP). It is managed by Aetna and offers you a wide range of tools, resources and information to help you better manage your work and personal life. A simple toll-free call connects you with a trained specialist who can provide assistance with child care and elder care services, education or caring for yourself or your home.

To contact Resources for Living, call 866-702-7435 or visit [resourcesforliving.com](https://resourcesforliving.com) (Username: NXP; Password: member).

This program is available to you, members of your household and your adult children up to the age of 26 at no cost. However, you are responsible for any costs associated with any services or products you may purchase.

By calling Resources for Living at 866-702-7435 or visiting [resourcesforliving.com](https://resourcesforliving.com) (Username: NXP; Password: member), you can get practical advice, useful materials and referrals to address a wide range of work or personal issues, such as those listed in the chart below.

Family	Health and Wellness	Education	Legal/Financial/Identity Theft	Daily Life
Adoption	Children's Health	College	Will Development	Automotive Services
Aging Loved Ones	Diet and Nutrition	Elementary Education	Legal Support and Representation	Consumer Information
Child Care	Emotional Health	Financial Aid	Identity Theft Breach or Prevention	Home Improvement
Funeral Planning	Fitness/Exercise	Gifted and Talented	Credit and Debt	Moving/Relocation
Grandparenting	General Health	Middle/High School	Insurance	Pet Care
Parenting	Men's Health	Pre-K/Kindergarten	Medicare/Medicaid	Travel
Prenatal	Safety	Preschool/Nursery School	Personal Finance	Utilities/Home Services
Special Needs	Women's Health	Special Education	Real Estate and Loans	
Summer Programs	Senior Health		Retirement Planning	
Work and Family			Social Security	

## Program Resources

You can access program services for information and materials through a variety of formats, all of which are easy to use.

- Trained specialists offer supportive, individualized consultation, referrals and educational materials to identify programs and services that best meet your needs. One specialist works with you from start to finish.
- Even if you don't have a need for a specialist, you can request educational materials on an array of family and personal issues supported by the program. Resources include:
  - Educational Guides;
  - Helpful articles and checklists; and
  - Online tools, including health encyclopedias, online workshops, a Discount Center and more.

To access services, go to [resourcesforliving.com](https://resourcesforliving.com) (Username: NXP; Password: member). If you need help, you can call a trained Resources for Living Program specialist any time, day or night, at 866-702-7435.

## Child Care Assistance

NXP offers assistance with identifying and screening a network of national child care providers as well as helping you with tips on how to evaluate the quality of the programs you may be considering. Call Resources for Living at 866-702-7435 and speak with a worklife consultant for more information. The participating child care centers or programs are not endorsed or recommended by NXP. It's up to you to visit participating centers and decide which is best for your child.

You are responsible for any fees and child care costs at the service provider you choose. A participating child care center does not automatically guarantee a space for your child or any priority in enrollment.

Resources for Living, your EAP, can also help you find before- and after-school programs, summer camps and other local programs for school-age children. Call 866-702-7435 or visit [resourcesforliving.com](https://resourcesforliving.com) (Username: NXP; Password: member).

## Back-Up/Drop-In Care Programs

When your regular child care arrangements fall through, you may need to consider back-up care arrangements. Since not all child care centers offer back-up or drop-in care service, you may consider contacting Resources for Living's worklife program at 866-702-7435 for help with investigating options in your community. Because back-up or drop-in care is usually due to late notice situations, space availability will vary. It is always recommended to call a child care center as soon as you find that your regular care arrangements have fallen through. You are responsible for the cost of care.

To use back-up or drop-in care at any child care center, you are typically required to register your child in advance with the center where you want to receive care. This ensures that the center has information on file about your child's specific needs such as medical conditions or food allergies.

Contact the center director to receive information about hours, programs offered and availability; and complete any applicable registration forms and submit them to the center.

For more information regarding child care solutions, call or visit:

### **Resources for Living**

866-702-7435

[resourcesforliving.com](http://resourcesforliving.com) (Username: NXP; Password: member)

### **School's Out Program**

One of the toughest problems faced by many working parents is what to do when their children's schools are closed for vacations, holidays and other events. NXP offers programs at several locations to provide care for children ages 6 through 12 at times when schools are closed. Call Resources for Living at 866-702-7435 for a referral to a program near you.

To learn more about programs for school-age children that are available in your area, call Resources for Living at 866-702-7435 or visit [resourcesforliving.com](http://resourcesforliving.com) (Username: NXP; Password: member).

## Travel Assistance

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The Travel Assistance Program is administered by International SOS Assistance Inc. (Intl. SOS), the world's largest provider of international assistance services, and it is available to you 24 hours a day. Travel Assistance is a program that provides you a comprehensive source for domestic and international travel information and services. One phone call connects you to a network of multilingual specialists for immediate help in an emergency. These services are designed to help you with medical, personal, travel, security and legal problems when away from home. Contact the Travel Assistance Program at any time to speak with a physician or security specialist about simple or critical matters.

Other travel assistance benefits, covering both international and domestic travel, are available with Basic Life Insurance coverage (see [Travel Services](#), beginning on page 240, for details).

For more information on the Travel Assistance Program, go online [internationalsos.com/member-zone](https://internationalsos.com/member-zone) to login or contact an International SOS Assistance Center at 800-523-6586 (from abroad, call collect 215-942-8226).

The NXP corporate membership number: **11BCPA000145**

### Who Is Eligible

The Travel Assistance Program is available to all NXP employees who are traveling domestically and abroad on NXP business, including those on an assignment as determined by NXP Global Mobility.

### Benefit Summary

This is not a health insurance program; however this program offers you a wide array of pre-trip and in-transit travel services while you are traveling abroad on NXP business, including:

#### Medical Services

- Immunization information;
- 24-hour emergency and routine medical advice;
- Medical and dental referrals;
- Access to International SOS medical clinics;
- Emergency medical care;
- Emergency evacuation or medically-supervised repatriation and companion ticket;
- Additional travel and accommodation arrangements after medical evacuation;
- Pre-trip information on travel health issues (Country Guides);
- Claims assistance; and
- Dispatch of medication and medical supplies.

## Travel Services

- Travel advice;
- Legal referrals;
- Emergency message transmission;
- Translations and interpreters;
- Lost document advice; and
- Emergency personal cash advances.

## Security Services

- Up-to-date travel security alerts;
- Security evacuation assistance;
- Online travel security information; and
- Access to security crisis center.

The Travel Assistance Program is administered by International SOS Assistance Inc. (Intl. SOS), the world's largest provider of international assistance services, and it is available to you 24 hours a day.

This means that when traveling on NXP business anywhere in the world, you have the assurance, security and convenience of a “one stop shop” for any and all health, safety and travel concerns.

## Emergency Assistance and Your SOS Card

Carry the International SOS membership card with you at all times. It includes the telephone numbers of the three major worldwide International SOS Alarm Centers. In an emergency, call one of the emergency phone numbers listed on the card. (You may call collect, reverse charges, if necessary.) You may print a copy of it by logging in to the website at [internationalsos.com/member-zone](https://internationalsos.com/member-zone) (NXP corporate membership number: **11BCPA000145**).

To ensure a prompt response when calling, you should be prepared to provide the following:

- Your name, location, age, gender and nationality;
- The NXP corporate membership number: **11BCPA000145**;
- The telephone number from which you are calling (in case you are disconnected);
- Your relationship to the NXP employee (if the person calling is not the employee); and
- Name, location and telephone number of the hospital, clinic or treating doctor (when applicable).

International SOS provides help with a wide variety of problems while you are abroad, including medical, personal, legal, travel and security issues.

For more information on available services, log in at [internationalsos.com/member-zone](https://internationalsos.com/member-zone) (NXP corporate membership number: **11BCPA000145**).

## ***Download the International SOS App***

You get immediate access to a medical, security or logistical expert in time of need or for routine advice. You also get up-to-date medical and security advice and real-time alerts for the locations where you are traveling. The App is supported on all leading smart phones, including Blackberry, iPhone and Android.

To download, open your smart phone's browser and go to [app.internationalsos.com](http://app.internationalsos.com). Once downloaded, you will need the membership number, which is **11BCPA000145**, to log in.

## **Medical Services**

### **Immunization Services**

Because there is always the risk that you may be exposed to potentially dangerous diseases while traveling internationally, it is important that you ensure that you meet certain minimum immunization standards. This minimum standard strongly suggests that you should be up to date for the following “primary” immunizations: diphtheria, rubella, tetanus, hepatitis A, measles, polio and mumps. Other primary or secondary immunizations may be required.

Immunization information is available online by logging in at [internationalsos.com/member-zone](http://internationalsos.com/member-zone) (NXP corporate membership number: **11BCPA000145**). If you do not meet the stated minimum immunization standard or if you are not sure of your immunization history, you should contact your personal physician or the travel-medicine clinic nearest you (see below) to arrange for an immunization screening and/or any required immunizations.

### **Steps to Follow**

- Contact an International SOS Assistance Center at 800-523-6586 (from abroad, call collect 215-942-8226) or visit [internationalsos.com/member-zone](http://internationalsos.com/member-zone) (log in with NXP corporate membership number: **11BCPA000145**) to find out if you are properly immunized. International SOS will provide you with a list of necessary and recommended immunizations.
- If you need immunizations, International SOS provides you the name and location of travel-medicine physician nearest you. You can also find this information online at [internationalsos.com/member-zone](http://internationalsos.com/member-zone) (log in with NXP corporate membership number: **11BCPA000145**).
- If you decide to receive the suggested immunizations from your personal physician, contact International SOS for the appropriate Immunization Update form before making an appointment. Your physician should then forward a record of the immunization(s) to International SOS to ensure that your international immunization records remain current.

Contact International SOS at 800-523-6586 for guidance on whether you need additional immunizations. From abroad, call collect: 215-942-8226.

## Medical Advice and Referral Information

There is always the chance you might experience some form of minor illness or injury while you are abroad that you would not consider an “emergency.” However, you may still require medical consultation. In these cases, International SOS provides you with the following services:

- **24-Hour Medical Advice:** Telephone consultation with a physician and information on recommended treatment practices; and
- **Medical and Dental Referrals:** From a database of over 3,000 dentist, physician and hospital referrals worldwide, International SOS can arrange for you to see an English-speaking physician or dentist locally.

Regardless of the reason or severity, you are encouraged to contact International SOS for any medical issue you may have, whether a toothache or a potentially life-threatening situation.

Travel Assistance is administered by a third party; therefore all medical and immunization records are securely maintained and managed to ensure the highest level of confidentiality.

Your privacy is assured since all information is secure. It can only be accessed by you, your physician or an International SOS health care professional in case of emergency.

## Travel Services

The Travel Assistance Program can give you peace of mind, knowing that no matter where you are traveling, you are just a simple phone call away from assistance. The program offers help for a wide array of circumstances, providing such things as travel advice, legal referrals, emergency message transmission, translations and interpreters, lost document advice and emergency personal cash advances.

Whether your passport is lost, your wallet stolen, or your travel plans go awry and you find yourself in a foreign country and unable to communicate in the native language, the an International SOS Assistance Center can help. Just call one of the numbers of the three Worldwide Alarm Centers listed on your International SOS Card, and provide them with the NXP membership number, which is **11BCPA000145**.

## Country Guides

Before you depart, go to the International SOS website [internationalsos.com/member-zone](https://internationalsos.com/member-zone) (log in with NXP corporate membership number: **11BCPA000145**) to view the Country Guide for the country(ies) you will visit. These comprehensive guides provide both medical and general travel advice, such as information on the standard of health care, how to pay for medical care, the availability of medications, safety of the blood supply, embassy/visa information, dialing code information, cultural etiquette and financial and voltage/plug information.

## Security Services

Before leaving on any international trip, you should familiarize yourself with potential health and/or safety risks of the country or countries to which you will be traveling.

International SOS provides a number of features to help you prepare for your trip and to assure your safety while you are traveling internationally on NXP business. Remember, it is important for you to always carry your International SOS card with you, so you will have immediate access to all the program features whenever you need them.

### 24-Hour Travel Security Alerts

To receive country-specific travel advisory information, contact International SOS (available 24 hours a day). You will receive (via fax or email) timely information regarding potential health concerns in the area to which you are traveling, as well as specific recommendations on how to avoid or minimize risk to you and your family. You request travel advisories at [internationalsos.com/member-zone](https://internationalsos.com/member-zone) (log in with NXP corporate membership number: **11BCPA000145**).

### E-Mail Alerts

You have the option to sign up for email alerts. You can choose to sign up for medical and/or security alerts. Medical Alerts are issued when there is an unusual health risk that, in the opinion of the International SOS medical staff, may negatively affect travelers or expatriates visiting a country. Security Alerts are issued when International SOS security professionals have identified a security risk in a specific country.

### Security Evacuation Assistance and Coordination

The International SOS Security Division will assist you in a threatening situation, such as civil and/or political unrest, insurrection, revolution or similar situations, by providing information, guidance and resources if personal safety and security can no longer be assured.

## Life Events

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During your employment with NXP, you may experience life events such as the birth of a child, marriage or divorce. While these types of events may be demanding times in your life, they are also times when you need to consider how your benefits are affected. This section includes charts summarizing the actions you can take and some considerations when the following events occur:

- [When you are a new employee;](#)
- [If you marry or establish a domestic partnership;](#)
- [Adding an eligible dependent child;](#)
- [If you divorce or end a domestic partnership;](#)
- [If your child no longer qualifies as a dependent;](#)
- [If you take a leave of absence;](#)
- [If you retire;](#)
- [If you die;](#)
- [If your spouse/domestic partner or child dies;](#)
- [If you terminate employment;](#) and
- [When you reach age 65.](#)

This list is not all inclusive and other qualified status changes may apply due to other events. For example, if your work schedule changes (such as you begin working less than 20 hours per week), this change may affect the benefits for which you are eligible. Contact NXP Rewards Customer Service for more information.

Most events require that you make changes **within 30 days** of the event. However, if you are making a change due to the loss of CHIP or Medicaid coverage or because you became eligible for contribution subsidies from Medicaid or CHIP, you may make changes within **60 days** of the event.

Any change you make must be consistent with the event allowing the change. For example, if a dependent child is no longer eligible due to reaching age 26, you may drop that child from coverage; you may not enroll yourself in coverage.

No Flexible Spending Account changes are allowed for any reason between November 1 and December 31.

We recommend you carefully review any changes to your Health Savings Account before processing them since they can significantly impact your paycheck, especially large HSA elections or changes late in the plan year.

Any change will be implemented as soon as administratively possible. If you do not take action when allowed within the time required (30 days), you must wait until the next annual enrollment, unless you experience another qualified status change that is reported within the time required (30 days).

## When You Are a New Employee

See [Participation](#), beginning on page 1, for more detailed information.

Benefit Program	Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>Enroll and choose coverage option for yourself, your spouse/domestic partner and/or eligible children</li> <li><b>If no action is taken</b>, you will be automatically enrolled with employee-only coverage in the Choice Plan coverage option, and the applicable contributions will be deducted from your pre-tax earnings</li> <li>If you enroll in the Medical Savings Plan with HSA coverage option, a Health Savings Account will be established in your name and you will receive a pro-rated amount of NXP's annual contribution based on when you are hired</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>Enroll and choose coverage option for yourself, your spouse/domestic partner and/or eligible children</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>Enroll and choose coverage option for yourself, your spouse/domestic partner and/or eligible children</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Enroll and consider the pay amount you want to contribute</li> <li>If you enroll in the Medical Savings Plan with HSA coverage option, you can only enroll in the Limited Use Health Care Flexible Spending Account</li> <li><b>If hired after November 1</b>, participation begins January 1</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Enroll and consider the pay amount you want to contribute</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>No enrollment required; coverage is automatic</li> <li>Coverage begins on the first day of the month after 90 days of continuous service</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>Enroll and elect coverage</li> <li><b>If enrolled within 30 days of hire</b>, coverage begins on the first day of the month following 90 days of continuous service</li> </ul>

Benefit Program	Action and/or Consideration
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>No enrollment required; coverage is automatic</li> <li>Coverage begins on the first day of the month after 90 days of continuous service</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>No enrollment required; coverage is automatic</li> <li>Designate beneficiary(ies)</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>Enroll and choose level of coverage</li> <li>Designate beneficiary(ies)</li> </ul>
<b>Dependent Life Insurance (Spouse/Domestic Partner and/or Children)</b>	<ul style="list-style-type: none"> <li>Enroll and choose level of coverage for spouse/domestic partner and/or eligible children</li> </ul>
<b>Accidental Death and Dismemberment Insurance*</b>	<ul style="list-style-type: none"> <li>No enrollment required; coverage is automatic</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>No enrollment required; coverage is automatic</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>Enroll and elect percentage to contribute</li> <li>Elect investments</li> <li>Designate beneficiary(ies)</li> <li><b>If no action is taken</b>, you will be automatically enrolled to contribute 5% of eligible compensation to be invested in the managed accounts service provided by GuidedChoice, usually beginning with the third paycheck</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>Available on your first day of active employment</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>Available on your first day of active employment</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>Enroll and choose coverage. If no action is taken, you will be enrolled in no coverage.</li> </ul>

## If You Marry or Establish a Domestic Partnership

Benefit Program	Allowed Action and/or Consideration
Medical, including pharmacy and behavioral health	<ul style="list-style-type: none"> <li>Enroll your spouse/domestic partner (and your spouse's/domestic partner's eligible children)</li> <li><b>HSA:</b> If you are enrolled in the Medical Savings Plan coverage option and are changing to family coverage, the amount you may contribute to your HSA may increase (no additional contribution will be made by NXP)</li> </ul>
Dental	<ul style="list-style-type: none"> <li>Enroll your spouse/domestic partner (and your spouse's/domestic partner's eligible children)</li> </ul>
Vision	<ul style="list-style-type: none"> <li>Enroll your spouse/domestic partner (and your spouse's/domestic partner's eligible children)</li> </ul>
Health Care/Limited Use Health Care Flexible Spending Account	<ul style="list-style-type: none"> <li>Consider your contribution amount</li> </ul>
Dependent Care Flexible Spending Account	<ul style="list-style-type: none"> <li>Enroll or consider your contribution amount</li> </ul>
Short-Term Disability	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
Short-Term Disability Buy-Up	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
Long-Term Disability	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
Basic Life Insurance	<ul style="list-style-type: none"> <li>Consider updating your beneficiary designation</li> </ul>
Supplemental Life Insurance	<ul style="list-style-type: none"> <li>Consider amount of coverage and updating your beneficiary designation</li> </ul>
Spouse/Domestic Partner and Child(ren) Life Insurance	<ul style="list-style-type: none"> <li>Enroll your spouse/domestic partner</li> </ul>
Business Travel Accident Insurance	<ul style="list-style-type: none"> <li>Consider updating you beneficiary designation</li> </ul>
Accidental Death and Dismemberment Insurance	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
401(k) Retirement Plan	<ul style="list-style-type: none"> <li>Update your beneficiary designation</li> </ul>
Adoption Assistance	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
Resources for Living	<ul style="list-style-type: none"> <li>Available immediately to spouse/domestic partner</li> </ul>
Legal Services Plan	<ul style="list-style-type: none"> <li>No changes allowed</li> </ul>

## Adding an Eligible Dependent Child

Newborns (or any new dependents) are **not** automatically enrolled in coverage. You must report the birth of the child and add the child to coverage by calling NXP Rewards Customer Service at 888-375-2367. If you do not add the child within 30 days, he or she cannot be enrolled for coverage until the next annual enrollment, unless you experience another qualified status change that is reported within 30 days.

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>If you already have medical coverage, enroll child in coverage</li> <li><b>HSA:</b> If you are enrolled in the Medical Savings Plan coverage option and are changing to family coverage, the amount you may contribute to your HSA may increase (no additional contribution will be made by NXP)</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>If you already have dental coverage, enroll child in coverage</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>If you already have vision coverage, enroll child in coverage</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Consider contribution amount</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Enroll or consider contribution amount</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>Contact Occupational Health Resources and Prudential before childbirth</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>Contact Occupational Health Resources and Prudential before childbirth</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>Consider updating beneficiary designation</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>Consider amount of coverage and updating beneficiary designation</li> </ul>
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>Enroll child for coverage</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>Consider updating you beneficiary designation</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>Consider updating beneficiary designation</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>Benefit is available when child is placed in your home for adoption, the adoption is finalized or your attempt to adopt ends unsuccessfully</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>No changes allowed</li> </ul>

## If You Divorce or End a Domestic Partnership

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>• Drop spouse/domestic partner and any ineligible children from coverage</li> <li>• <b>HSA:</b> If you are enrolled in the Medical Savings Plan coverage option and are changing to employee-only coverage, the amount NXP contributed to your HSA will not change; however, this may mean the amount you may contribute to your Health Savings Account may be less</li> <li>• <b>HSA:</b> If you have an HSA, money in your HSA may be considered part of your assets when going through divorce proceedings. Therefore, these accounts may be subject to division under the terms of the divorce or a Qualified Domestic Relations Order</li> <li>• <b>COBRA:</b> Spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>• Drop spouse/domestic partner and any ineligible children from coverage</li> <li>• <b>COBRA:</b> Spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>• Drop spouse/domestic partner and any ineligible children from coverage</li> <li>• <b>COBRA:</b> Spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• Consider contribution amount</li> <li>• <b>COBRA:</b> Health Care Flexible Spending Account coverage may be extended to the end of the calendar year</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• Enroll or consider contribution amount</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>• No action necessary</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>• No action necessary</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>• No action necessary</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>• Consider updating beneficiary designation</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>• Consider updating beneficiary designation</li> </ul>
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>• Drop spouse/domestic partner and any ineligible children from coverage</li> <li>• Your spouse/domestic partner may elect to convert or port coverage</li> </ul>

Benefit Program	Allowed Action and/or Consideration
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>Consider updating your beneficiary designation</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>Update your beneficiary designation; divorce or legal separation does not automatically change an existing designation</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>Spouse's/domestic partner's eligibility ends on date of divorce or termination of domestic partnership</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>No changes allowed</li> </ul>

## If Your Covered Child No Longer Qualifies as a Dependent

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>Coverage ends on the last day of the month</li> <li><b>HSA:</b> Only the child's eligible expenses incurred before the date the child no longer qualifies are eligible</li> <li><b>COBRA:</b> Child is eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>Coverage ends on the last day of the month</li> <li><b>COBRA:</b> Child is eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>Coverage ends on the last day of the month</li> <li><b>COBRA:</b> Child is eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Only the child's eligible expenses incurred before the date the child no longer qualifies will be reimbursed</li> <li><b>COBRA:</b> Health Care Flexible Spending Account coverage may be extended to the end of the calendar year</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Consider contribution amount</li> <li>Only the child's eligible expenses incurred before the child no longer qualifies will be reimbursed</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>Dependent can apply to convert or port coverage</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>No changes allowed</li> </ul>

## If You Take a Leave of Absence

Under certain conditions, you can continue your NXP health care coverage and life insurance coverage (and dependent coverage), if you are on an approved leave of absence. You must continue to pay the monthly contributions required for each type of coverage.

In addition to a paid leave due to disability (as detailed in [Disability Income Benefits](#) on page 152), NXP provides five types of leaves of absence:

- **Medical Leave:** For your own serious health condition or due to a workplace injury or illness or for the illness or qualifying serious health condition of a family member;
- **Parental Leave:** To care for a child after the birth, foster care placement or adoption of the child;
- **Leave under the Family and Medical Leave Act:**
  - For the birth of a son or daughter and to care for such son or daughter;
  - For the placement of a child with you for adoption or foster care;
  - To care for a spouse, child or parent with a serious health condition; or
  - For your own serious health condition that makes you unable to perform the functions of your position;
- **Personal Leave:** To attend to personal matters; and
- **Military Service Leave:** If you are called to active duty or temporary active duty by the U.S. armed forces or you are on temporary training duty with the U.S. armed services.

## If You Are on a Personal (Non-Disability) Leave of Absence

Benefit Program	Allowed Action and/or Consideration
<p><b>Medical, including pharmacy and behavioral health</b></p>	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service,</b> your coverage ends on the last day of the month in which the leave occurs</li> <li>• <b>If you have six or more months of service,</b> your coverage may continue for up to six months if monthly contributions are paid</li> <li>• <b>If you are on a military service leave,</b> your coverage will continue until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> <li>• <b>HSA:</b> You may continue to use your HSA; you can make contributions until coverage under an eligible HDHP ends</li> <li>• <b>COBRA:</b> You may continue coverage under COBRA for up to 18 months with paid contributions</li> </ul>
<p><b>Dental</b></p>	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service,</b> your coverage ends on the last day of the month in which the leave occurs</li> <li>• <b>If you have six or more months of service,</b> your coverage may continue for up to six months if monthly contributions are paid</li> <li>• <b>If you are on a military service leave,</b> your coverage will continue until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> <li>• <b>COBRA:</b> You may continue coverage under COBRA for up to 18 months with paid contributions</li> </ul>
<p><b>Vision</b></p>	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service,</b> your coverage ends on the last day of the month in which the leave occurs</li> <li>• <b>If you have six or more months of service,</b> your coverage may continue for up to six months if monthly contributions are paid</li> <li>• <b>If you are on a military service leave,</b> your coverage will continue until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> <li>• <b>COBRA:</b> You may continue coverage under COBRA for up to 18 months with paid contributions</li> </ul>

Benefit Program	Allowed Action and/or Consideration
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service</b>, your participation ends on the last day of the month in which your leave begins</li> <li>• <b>If you have six or more months of service</b>, your participation may continue for up to six months if monthly contributions are paid (contributions will be paid on an after tax basis); you may stop contributions at the end of the month in which your leave occurs</li> <li>• You have until March 31 of the following year to submit claims for eligible expenses incurred through the date your contributions ended</li> <li>• <b>COBRA:</b> You may extend coverage under COBRA to the end of the calendar year</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• <b>If you are on an unpaid leave of absence</b>, your participation ends on the last day of active employment before your leave</li> <li>• <b>If you are on a paid leave of absence</b>, you may continue contributions or change or stop contributions within 30 days of beginning your leave</li> <li>• You can request reimbursement from any remaining account balance through March 31 for the following year for expenses incurred through the end of the calendar year</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>• Your coverage ends on date your leave begins</li> <li>• If your leave is due to a medical condition and within the first six months of your leave you are determined to be disabled under the Disability Income Plan, you will be reinstated to the Plan, retroactive to the date the leave began</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>• Your coverage ends on date your leave begins</li> <li>• If your leave is due to a medical condition and within the first six months of your leave you are determined to be disabled under the Disability Income Plan, you will be reinstated to the Plan, retroactive to the date the leave began</li> </ul>

Benefit Program	Allowed Action and/or Consideration
<p><b>Long-Term Disability</b></p>	<ul style="list-style-type: none"> <li>• Your coverage ends on date your leave begins</li> <li>• If your leave is due to a medical condition and within the first six months of your leave you are determined to be disabled under the Disability Income Plan, you will be reinstated to the Plan, retroactive to the date the leave began</li> </ul>
<p><b>Basic Life Insurance</b></p>	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service</b>, your coverage ends on the last day of the month in which your leave begins</li> <li>• <b>If you have six or more months of service</b>, your coverage continues at no cost to you for up to six months from the last day of the month in which your leave began</li> <li>• <b>If you are on a military service leave</b>, your coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> <li>• When your coverage ends, you may elect to convert or port coverage</li> </ul>
<p><b>Supplemental Life Insurance</b></p>	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service</b>, your coverage ends on the last day of the month in which your leave begins</li> <li>• <b>If you have six or more months of service</b>, your coverage may continue for up to six months from the last day of the month in which your leave began if contributions are paid</li> <li>• <b>If you are on a military service leave</b>, your coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> <li>• When your coverage ends, you may elect to convert or port coverage</li> </ul>

Benefit Program	Allowed Action and/or Consideration
Spouse/Domestic Partner and Child(ren) Life Insurance	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service</b>, coverage ends on the last day of the month in which your leave begins</li> <li>• <b>If you have six or more months of service</b>, coverage may continue for up to six months from the last day of the month in which your leave began if contributions are paid</li> <li>• <b>If you are on a military service leave</b>, coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> <li>• When coverage ends, your dependents may elect to convert or port coverage</li> </ul>
Business Travel Accident Insurance	<ul style="list-style-type: none"> <li>• Your coverage ends on date your leave begins</li> </ul>
Accidental Death and Dismemberment Insurance	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service</b>, your coverage ends on the last day of the month in which your leave begins</li> <li>• <b>If you have six or more months of service</b>, your coverage continues at no cost to you for up to six months from the last day of the month in which your leave began</li> <li>• <b>If you are on a military service leave</b>, your coverage continues until the last day of the last month in which you receive military service pay under the NXP Military Service Pay Policy</li> </ul>
401(k) Retirement Plan	<ul style="list-style-type: none"> <li>• Your contributions stop when you go on an unpaid leave</li> <li>• You cannot receive a distribution until you terminate employment; however, you may request a loan or withdrawal, if eligible</li> <li>• You must continue to make any outstanding loan payments; contact NXP Rewards Customer Service for a coupon book</li> </ul>
Adoption Assistance	<ul style="list-style-type: none"> <li>• Benefit is only available when you are actively at work</li> </ul>
Resources for Living	<ul style="list-style-type: none"> <li>• Benefit is available during your leave</li> </ul>
Legal Services Plan	<ul style="list-style-type: none"> <li>• Benefit is available during your leave</li> </ul>

## If You Are on a Disability Leave of Absence

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>Your coverage continues as long as you remain employed and eligible for Long-Term Disability Plan benefits if monthly contributions are paid</li> <li><b>HSA:</b> You may continue to use your HSA; you can make contributions until coverage under an eligible HDHP ends</li> <li><b>COBRA:</b> COBRA continuation coverage is not available during long-term disability leave</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>Your coverage continues as long as you remain employed and eligible for Long-Term Disability Plan benefits if monthly contributions are paid</li> <li><b>COBRA:</b> COBRA continuation coverage is not available during long-term disability leave</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>Your coverage continues as long as you remain employed and eligible for Long-Term Disability Plan benefits if monthly contributions are paid</li> <li><b>COBRA:</b> COBRA continuation coverage is not available during long-term disability leave</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Your participation continues as long as you remain employed and disabled if monthly contributions are paid</li> <li>You may change or stop your contributions at the end of the month in which your leave occurs</li> <li>You have until March 31 of the following year to submit claims for eligible expenses incurred through the date your contributions ended</li> <li>Your participation ends on the day you become eligible for the Post-Employment Benefits Plan</li> <li><b>COBRA:</b> COBRA continuation coverage is not available during long-term disability leave</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>You may continue contributions or change or stop contributions within 30 days of beginning your leave</li> <li>Your participation may continue until termination of employment under the Medical Leave Policy if monthly contributions are paid</li> <li>You can request reimbursement from your remaining account balance through March 31 for the following year for expenses incurred through the end of the calendar year</li> </ul>

Benefit Program	Allowed Action and/or Consideration
Short-Term Disability	<ul style="list-style-type: none"> <li>• Benefits are paid for up to 180 days</li> <li>• Contact Occupational Health Resources and Prudential</li> </ul>
Short-Term Disability Buy-Up	<ul style="list-style-type: none"> <li>• Your contributions are waived while you are receiving benefits</li> </ul>
Long-Term Disability	<ul style="list-style-type: none"> <li>• Benefits begin after 180 days of short-term disability</li> </ul>
Basic Life Insurance	<ul style="list-style-type: none"> <li>• <b>If you have six or more months of service</b>, your coverage continues for up to 12 months.</li> <li>• <b>If you remain totally disabled at 12 months</b>, your coverage may continue for the duration of your disability, up to age 65 if you were disabled before age 60 or up to the earlier of age 70 or five years from onset of disability if you were disabled after age 60.</li> </ul>
Supplemental Life Insurance	<ul style="list-style-type: none"> <li>• <b>If you have six or more months of service</b>, your coverage may continue for up to 12 months if contributions are paid.</li> <li>• <b>If you remain totally disabled at 12 months</b>, your coverage may continue for duration of your approved disability, up to age 65 if you were disabled before age 60 or up to the earlier of age 70 or five years from the onset of disability if you were disabled after age 60.</li> </ul>
Spouse/Domestic Partner and Child(ren) Life Insurance	<ul style="list-style-type: none"> <li>• Coverage may continue if contributions are paid</li> </ul>
Business Travel Accident Insurance	<ul style="list-style-type: none"> <li>• Coverage ends on the date your leave begins</li> </ul>
Accidental Death and Dismemberment Insurance	<ul style="list-style-type: none"> <li>• <b>If you have less than six months of service</b>, your coverage ends on the last day of the month in which your disability leave of absence begins</li> <li>• <b>If you have six or more months of service</b>, your coverage continues for up to 12 months</li> </ul>
401(k) Retirement Plan	<ul style="list-style-type: none"> <li>• Your contributions stop</li> <li>• You cannot receive a distribution until you terminate employment; however, you may request a loan or withdrawal, if eligible</li> <li>• You must continue to make any outstanding loan payments; contact NXP Rewards Customer Service for a coupon book</li> </ul>
Adoption Assistance	<ul style="list-style-type: none"> <li>• Benefit is only available when you are actively at work</li> </ul>
Resources for Living	<ul style="list-style-type: none"> <li>• Benefit is available during your leave</li> </ul>
Legal Services Plan	<ul style="list-style-type: none"> <li>• Benefit is available during your leave</li> </ul>

## When You Return from a Leave of Absence

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>• If you were previously covered, your coverage resumes on first day of reinstatement</li> <li>• <b>HSA:</b> There is no change</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>• If you were previously covered, your coverage resumes on first day of reinstatement</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>• If you were previously covered, your coverage resumes on first day of reinstatement</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• If you were previously participating, your participation is reinstated at your last election choice</li> <li>• You may elect to make up missed contributions</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• If you were previously participating, your participation is reinstated at your last election choice</li> <li>• You may change your contribution amount if you had a qualified status change</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>• Your coverage resumes on your first day of reinstatement</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>• If you were previously enrolled, your coverage resumes on your first day of reinstatement</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>• Your coverage resumes on your first day of reinstatement</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>• Your coverage resumes on your first day of reinstatement</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>• If you were previously enrolled, your coverage resumes on your first day of reinstatement</li> </ul>
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>• If previously enrolled, coverage resumes on your first day of reinstatement</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>• Your coverage resumes on your first day of reinstatement</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>• Your coverage resumes on your first day of reinstatement</li> </ul>

Benefit Program	Allowed Action and/or Consideration
401(k) Retirement Plan	<ul style="list-style-type: none"> <li>• <b>If you are a full-time employee or part-time employee and have at least one year of service</b>, your participation is automatically reinstated on the date your employment is reinstated</li> <li>• Consider enrolling and electing a percentage of pay to contribute; Contributions may begin with your first paycheck</li> <li>• <b>If you are returning from a uniformed service leave of absence</b>, you can choose if you would like to make up any missed contributions.</li> </ul>
Adoption Assistance	<ul style="list-style-type: none"> <li>• Available on your first day of reinstatement</li> </ul>
Resources for Living	<ul style="list-style-type: none"> <li>• Available on your first day of reinstatement</li> </ul>
Legal Services Plan	<ul style="list-style-type: none"> <li>• If you were previously covered, your coverage resumes on first day of reinstatement</li> </ul>

## If You Retire

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>• Coverage for you and your dependents ends on the last day of the month in which your employment ends</li> <li>• <b>If eligible</b>, coverage may be provided under the Post-Employment Benefits Plan (see the Post-Employment Benefits Plan SPD)</li> <li>• <b>HSA:</b> NXP contributions are only made while you are an active employee covered under the Plan. However, since you own the account, you may continue to use your account for eligible expenses; if your account is with the HSA bank, the HSA bank will send you a new card and account numbers</li> <li>• <b>COBRA:</b> You and your dependents are eligible for COBRA for up to 18 months with paid contributions</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>• Coverage for you and your dependents ends on the last day of the month in which your employment ends</li> <li>• <b>If eligible</b>, coverage may be provided under the Post-Employment Benefits Plan (see the Post-Employment Benefits Plan SPD)</li> <li>• <b>COBRA:</b> You and your dependents are eligible for COBRA for up to 18 months with paid contributions</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>• Coverage for you and your dependents ends on the last day of the month in which your employment ends</li> <li>• <b>If eligible</b>, coverage may be provided under the Post-Employment Benefits Plan (see the Post-Employment Benefits Plan SPD)</li> <li>• <b>COBRA:</b> You and your dependents are eligible for COBRA for up to 18 months with paid contributions</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• Your contributions end on the last day of the month in which your employment ends</li> <li>• <b>COBRA:</b> Your Health Care Flexible Spending Account participation may be extended to the end of the calendar year</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>• Your contributions end with the last pay period before your last day of employment</li> <li>• You can request reimbursement from your remaining account balance through March 31 of the following year for expenses incurred through the end of the calendar year</li> </ul>

Benefit Program	Allowed Action and/or Consideration
Short-Term Disability	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends</li> </ul>
Short-Term Disability Buy-Up	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends</li> </ul>
Long-Term Disability	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends</li> </ul>
Basic Life Insurance	<ul style="list-style-type: none"> <li>Your coverage ends on the last day of the month in which your employment ends</li> <li>You may apply to convert or port coverage</li> </ul>
Supplemental Life Insurance	<ul style="list-style-type: none"> <li>Your coverage ends on the last day of the month in which your employment ends</li> <li>You may apply to convert or port coverage</li> </ul>
Spouse/Domestic Partner and Child(ren) Life Insurance	<ul style="list-style-type: none"> <li>Coverage ends on the last day of the month in which your employment ends</li> <li>Dependents may apply to convert or port coverage</li> </ul>
Business Travel Accident Insurance	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends</li> </ul>
Accidental Death and Dismemberment Insurance	<ul style="list-style-type: none"> <li>Your coverage ends on the last day of the month in which your employment ends</li> <li>You may apply to port coverage</li> </ul>
401(k) Retirement Plan	<ul style="list-style-type: none"> <li>Contact NXP Rewards Customer Service to initiate the payment process; this process is optional until age 70½</li> <li><b>If the value of your benefit is \$1,000 or less and you are entitled to a distribution, you will automatically receive a lump-sum payment.</b></li> </ul>
Adoption Assistance	<ul style="list-style-type: none"> <li>Benefit ends when your employment ends</li> </ul>
Resources for Living	<ul style="list-style-type: none"> <li>Benefit ends when your employment ends</li> </ul>
Legal Services Plan	<ul style="list-style-type: none"> <li>Benefit ends when your employment ends, but the Plan will cover legal fees for covered services that were opened and pending during your employment</li> </ul>

## If You Die

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>Your dependent's coverage ends on the last day of the month in which you die</li> <li><b>HSA:</b> If you have an HSA when you die, the account may be transferred to your designated beneficiary. The account will continue to be considered an HSA for your spouse. However, if you designate another beneficiary (other than your spouse), it will no longer be considered an HSA and your beneficiary will be required to pay taxes on the account</li> <li><b>COBRA:</b> Your spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>Your dependent's coverage ends on the last day of the month in which you die</li> <li><b>COBRA:</b> Your spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>Your dependent's coverage ends on the last day of the month in which you die</li> <li><b>COBRA:</b> Your spouse/domestic partner and dependents are eligible for COBRA for up to 36 months with paid contributions</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Participation ends on the last day of the month in which you die</li> <li><b>COBRA:</b> Your Health Care Flexible Spending Account participation may be extended to the end of the calendar year</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Contributions end with your last pay period before your last day of employment</li> <li>Survivors can request reimbursement from your remaining account balance through the end of the calendar year</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>Your coverage ends on date of your death</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>Your coverage ends on date of your death</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>Your coverage ends on date of your death</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>Full benefit is payable to your beneficiary(ies)</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>If enrolled, full benefit is payable to your beneficiary(ies)</li> </ul>

Benefit Program	Allowed Action and/or Consideration
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>• Coverage ends on the last day of the month in which you die</li> <li>• Dependents may apply to convert or port coverage</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>• If applicable, full benefit is payable to your beneficiary(ies)</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>• If applicable, full benefit is payable to your beneficiary(ies)</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>• <b>If you die before retirement or termination of your employment</b>, your beneficiary will receive payment according to the option chosen</li> <li>• <b>If you die after retirement or termination of employment</b>, no action necessary if you received payment before your death; otherwise, your beneficiary will receive payment according to the option chosen</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>• Benefit ends on date of your death</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>• Benefit ends on date of your death</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>• Benefit ends on date of your death</li> </ul>

## If Your Covered Spouse/Domestic Partner or Child Dies

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>Coverage for that person ends on the date of his or her death</li> <li><b>HSA:</b> If you are enrolled in the Medical Savings Plan coverage option and are changing to individual coverage, the amount NXP contributed will not change; however, this may mean the amount you are eligible to contribute to your Health Savings Account may be less</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>Coverage for that person ends on the date of his or her death</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>Coverage for that person ends on the date of his or her death</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Consider contribution amount</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Consider contribution amount</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>Consider updating your beneficiary designation</li> </ul>
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>Consider amount of coverage and updating your beneficiary designation</li> </ul>
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>If dependent was enrolled for coverage, full benefit is payable to you</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>Consider updating your beneficiary designation</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>Update your beneficiary designation, as needed</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>No action necessary</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>No changes allowed</li> </ul>

## If You Terminate Employment

Benefit Program	Allowed Action and/or Consideration
<b>Medical, including pharmacy and behavioral health</b>	<ul style="list-style-type: none"> <li>Coverage for you and your dependents ends on the last day of the month in which your employment ends</li> <li><b>HSA:</b> NXP contributions will end; however, you own this account, so you may continue to use the account for eligible expenses</li> <li><b>COBRA:</b> You and your dependents may be eligible for COBRA for up to 18 months with paid contributions</li> </ul>
<b>Dental</b>	<ul style="list-style-type: none"> <li>Coverage for you and your dependents ends on the last day of the month in which your employment ends</li> <li><b>COBRA:</b> You and your dependents may be eligible for COBRA for up to 18 months with paid contributions</li> </ul>
<b>Vision</b>	<ul style="list-style-type: none"> <li>Coverage for you and your dependents ends on the last day of the month in which your employment ends</li> <li><b>COBRA:</b> You and your dependents may be eligible for COBRA for up to 18 months with paid contributions</li> </ul>
<b>Health Care/Limited Use Health Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Your contributions end on the last day of the month in which your employment ends</li> <li><b>COBRA:</b> Your Health Care Flexible Spending Account participation may be extended to the end of the calendar year</li> </ul>
<b>Dependent Care Flexible Spending Account</b>	<ul style="list-style-type: none"> <li>Your contributions end with the last pay period before your last day of employment</li> <li>You can request reimbursement from your remaining account balance through March 31 for the following year for expenses incurred through the date your employment ended</li> </ul>
<b>Short-Term Disability</b>	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends</li> </ul>
<b>Short-Term Disability Buy-Up</b>	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends</li> </ul>
<b>Long-Term Disability</b>	<ul style="list-style-type: none"> <li>Your coverage ends on the date your employment ends unless you are disabled and terminated under the Medical Leave Policy and your coverage continues as a Terminated Disabled Participant (TDP)</li> </ul>
<b>Basic Life Insurance</b>	<ul style="list-style-type: none"> <li>Your coverage ends on the last day of the month in which your employment ends</li> <li>You may apply to convert or port coverage</li> </ul>

Benefit Program	Allowed Action and/or Consideration
<b>Supplemental Life Insurance</b>	<ul style="list-style-type: none"> <li>• If enrolled, your coverage ends on the last day of the month in which your employment ends</li> <li>• You may apply to convert or port coverage</li> </ul>
<b>Spouse/Domestic Partner and Child(ren) Life Insurance</b>	<ul style="list-style-type: none"> <li>• If enrolled, your dependent's coverage ends on the last day of the month in which your employment ends</li> <li>• Your dependents may apply to convert or port coverage</li> </ul>
<b>Business Travel Accident Insurance</b>	<ul style="list-style-type: none"> <li>• Your coverage ends on the date your employment ends</li> </ul>
<b>Accidental Death and Dismemberment Insurance</b>	<ul style="list-style-type: none"> <li>• Your coverage ends on the last day of the month in which your employment ends</li> <li>• You may apply to port coverage</li> </ul>
<b>401(k) Retirement Plan</b>	<ul style="list-style-type: none"> <li>• Contact NXP Rewards Customer Service to initiate the payment process; this process is optional up to age 70½</li> <li>• If the value of your benefit is \$1,000 or less, and you are entitled to a distribution, you will automatically receive a lump-sum payment.</li> </ul>
<b>Adoption Assistance</b>	<ul style="list-style-type: none"> <li>• Benefit ends when your employment ends</li> </ul>
<b>Resources for Living</b>	<ul style="list-style-type: none"> <li>• Benefit ends 90 days after your employment ends</li> </ul>
<b>Legal Services Plan</b>	<ul style="list-style-type: none"> <li>• Benefit ends when your employment ends, but the Plan will cover legal fees for covered services that were opened and pending during your employment</li> </ul>

## When You Reach Age 65

Many Americans become eligible for Medicare at age 65. If you continue working at NXP when you reach age 65, the Social Security Administration may allow you to defer your Medicare coverage without penalty until you retire. This section includes information about the Medicare enrollment process.

If you continue to work beyond age 65, are enrolled in the Medical Savings Plan with HSA coverage option and do not enroll in Medicare, NXP will continue to make contributions to your HSA. If you enroll in Medicare, no contributions are allowed to your HSA; however, you may use your HSA for eligible expenses.

### Medicare and Social Security

During the 3-4 months before your 65th birthday, you should contact your local Social Security Administration office. You will have to provide proof of your eligibility for both Medicare and Social Security (though it is not necessary to actually receive Social Security retirement benefits to qualify for Medicare). Documents you may need include:

- Your Social Security card (or a record of your number);
- Your birth certificate;
- Proof of U.S. citizenship or lawful alien status if you were not born in the U.S.;
- Military discharge papers; and/or
- Last year's Form W-2 or tax return.

Original Medicare, Medicare Parts A and B, is a fee-for-service medical plan offered by the federal government. Medicare Part A is provided at no cost to most people who are eligible for Medicare (known as Medicare beneficiaries). Medicare Part B requires a monthly premium. When you enroll, you have a number of options for making payment, including automatic withdrawal from your Social Security benefits.

For many, Original Medicare coverage may begin on the first day of the month before their 65th birthday. If your birthday falls on the first day of the month, your Medicare coverage may begin on the first day of the month before your birthday. For example:

- If your 65th birthday is May 10, your Medicare coverage may begin on May 1.
- If your 65th birthday is August 1, your Medicare coverage may begin on July 1.

You may start the Medicare enrollment process up to 120 days before the date you want your Medicare coverage to begin. If you are already age 65 or older when you enroll, you may arrange to start your Original Medicare coverage on the day that your NXP active plan coverage ends.

If you need help completing any Social Security Administration (SSA) Form contact NXP Rewards Customer Service at 888-375-2367.

Contact the nearest Social Security Administration office or visit [SocialSecurity.gov](https://www.SocialSecurity.gov) or [Medicare.gov](https://www.Medicare.gov) for more information.

## Medicare and Your NXP Retiree Health Coverage

If you are eligible for the Post-Employment Benefits Plan, it is important that you take steps to enroll in Medicare before you reach age 65, or before you retire if you continue working beyond your 65th birthday. **You must be enrolled in both Medicare Parts A and B to be covered by an NXP Age 65+ medical option.** This also applies to your covered spouse/domestic partner.

## Claims and Appeals

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*This section provides information on:*

- How to **file claims** (beginning on page 271);
- The **appeals** process (beginning on page 277);
- How your benefits are **coordinated** with other plans (beginning on page 283); and
- Your **privacy** rights (beginning on page 286).

## 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 NXP Rewards Customer Service, as shown in this chart. If you wait any longer than the indicated deadlines, you are not eligible for Plan benefits relating to those expenses.

Since the Health Savings Account belongs to you; you do not need to submit claims, therefore there are no claims or appeals procedures relating to your Health Savings Account.

Filing for Your Benefits			
Plan/Program	Information Needed and Deadline	Claims Administrator	Initial Decision
<b>NXP Medical Plan (including Behavioral Health Program)</b>	<p><b>Network Care:</b> You are not required to file a claim when using a network provider</p> <p><b>Non-Network Care*:</b> If your provider does not submit the claim for you, you must submit an itemized bill that includes:</p> <ul style="list-style-type: none"> <li>• Date of service</li> <li>• Description of service, with CPT code if applicable</li> <li>• Dollar amount</li> <li>• Diagnosis</li> <li>• Name and address of provider</li> <li>• Patient's name</li> </ul> <p>Write the NXP employee's identification number on the statement</p> <p><b>Deadline:</b> One year from date service is provided</p>	<p><b>NXP Medical Plan</b></p> <p><b>Aetna</b> PO Box 385018 Birmingham, AL 35238-0518</p>	<p><b>Urgent Care Claim:</b> Within 72 hours after claim is received</p> <p><b>Concurrent Care Claim:</b> Within 72 hours after claim is received</p> <p><b>Pre-Service Claim</b> (not urgent): Within 15 days** after claim is received</p> <p><b>Post-Service Claim:</b> Within 30 days** after claim is received</p>

## Filing for Your Benefits

Plan/Program	Information Needed and Deadline	Claims Administrator	Initial Decision
<p><b>Prescription Drug</b></p>	<p>If your provider does not submit the claim for you, you must submit an itemized bill that includes:</p> <ul style="list-style-type: none"> <li>• Date of service</li> <li>• Description of service</li> <li>• Dollar amount</li> <li>• Name and address of provider</li> <li>• Patient's name</li> </ul> <p>Write the NXP employee's identification number on the statement</p> <p><b>Deadline:</b> One year from date service is provided</p>	<p><b>NXP Medical Plan</b>  <b>CVS Caremark</b>            P.O. Box 52136            Phoenix, Arizona            85072-2116</p>	<p>Within 30 days** after claim is received</p>
<p><b>Dental Plan</b></p>	<p>If your provider does not submit the claim for you, you must submit an itemized bill that includes:</p> <ul style="list-style-type: none"> <li>• Date of service</li> <li>• Description of service</li> <li>• Dollar amount</li> <li>• Name and address of provider</li> <li>• Patient's name</li> </ul> <p>Write the NXP employee's identification number on the statement</p> <p><b>Deadline:</b> One year from date service is provided</p>	<p><b>MetLife Dental Claims</b>            P.O. Box 981282            El Paso, TX            79998-1282            800-275-4638            Fax: 859-389-6505</p>	<p><b>Urgent Care Claim:</b>            Within 72 hours after claim is received</p> <p><b>Pre-Service Claim</b> (not urgent): Within 15 days** after claim is received.</p> <p><b>Post-Service Claim:</b>            Within 30 days** after claim is received</p>

Filing for Your Benefits			
Plan/Program	Information Needed and Deadline	Claims Administrator	Initial Decision
<b>Vision Plan</b>	<p>If your provider does not submit the claim for you, you must submit an itemized bill that includes:</p> <ul style="list-style-type: none"> <li>• Date of service</li> <li>• Description of service</li> <li>• Dollar amount</li> <li>• Name and address of provider</li> <li>• Patient's name</li> </ul> <p>On the statement, write the NXP employee's name and either birth date or the last four digits of his/her Social Security number</p> <p><b>Deadline:</b> One year from date service is provided</p>	<p><b>VSP</b>  P.O. Box 997105  Sacramento, California  95899-7105</p>	<p>Within 30 days** after claim is received</p>
<b>Flexible Spending Accounts</b>	<p>Completed Health Care Flexible Spending Account/Dependent Care Flexible Spending Account claim either by mail or online, and all supporting documentation, such as receipts or Explanation of Benefits</p> <p><b>Deadline:</b> By March 31 of the following year</p>	<p><b>Your Spending Account</b>  P.O. Box 785040  Orlando, Florida  32878-5040  Fax: 888-211-9900</p>	<p>Within 30 days** after the claim is received</p>
<b>Disability Income Plan</b>	<p>See <a href="#">Filing a Claim — Notifying NXP of Your Disability</a> (beginning on page 166)</p>		
<b>Life and Accidental Death and Dismemberment Insurance</b>	<p>Contact NXP Rewards Customer Service</p> <p>An original death certificate for death claims (photocopies cannot be accepted)</p> <p><b>Deadline:</b> Within 90 days after the covered loss (180 days for disability claims)</p>	<p><b>NXP Rewards Customer Service</b>  P.O. Box 1475  Lincolnshire, Illinois  60069-1475</p>	<p>Within 90 days after claim is filed (45 days for disability claims)  Plus extension of up to 90 days (30 for disability claims) in special circumstances</p>

Filing for Your Benefits			
Plan/Program	Information Needed and Deadline	Claims Administrator	Initial Decision
<b>401(k) Retirement Plan</b>	Contact NXP Rewards Customer Service to initiate payment <b>Deadline:</b> Varies based on the benefit being requested; see <a href="#">How Your Account Is Paid</a> (beginning on page 218)	<b>NXP Rewards Customer Service</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475	Varies based on the benefit being requested

\* Includes care received abroad by eligible plan members.

\*\* Plus extension of up to 15 days in special circumstances.

## Group Health Plans

As identified in the preceding charts, the following special rules apply to expedite claims under the NXP group health plans (i.e., the Medical Plan, Dental Plan, Vision Plan and Health Care Flexible Spending Accounts), depending on the type of claim involved. Any reference in this section to “you” includes your authorized representative (see page 303). The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

### Urgent Care Claim

An urgent care claim is any claim for medical care for which the applicable periods for the Plan to make non-urgent care determinations could:

- Seriously jeopardize your life or health or your ability to regain maximum function;
- In the case of a pregnant woman, cause serious jeopardy to the health of the fetus; or
- In the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment.

If you provide insufficient information for the Plan to decide an urgent care claim, the Plan will notify you of the deficiency and the necessary information to complete the claim within 24 hours after its receipt of your claim. You must provide the requested information within a reasonable period, but not more than 48 hours after the Plan notifies you of the deficiency. The Plan will then notify you of its decision within 48 hours of the earlier of its receipt of the requested information or the end of the period within which you were to provide the requested information.

## **Pre-Service Claim**

A pre-service claim is any claim for a Plan benefit where the Plan requires you to get approval of the benefit in advance of receiving the care. If your claim is incomplete, the Plan will notify you of the Plan's procedures for a pre-service claim, and your failure to follow them within five days after its receipt of your deficient claim if your attempt at filing:

- Is communicated by you or your authorized representative to NXP Rewards Customer Service; and
- Names your specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

If your claim is incomplete but does not meet to the above, you will be treated as not having filed the required claim for benefits.

## **Post-Service Claim**

A post-service claim is any claim for a benefit for care already provided.

## **Concurrent Care Claims**

At times, your Aetna Personal Health Advocate may approve an ongoing course of treatment to be provided over a period of time or number of treatments.

If the Plan later reduces or no longer covers a previously approved course of treatment before the end of the approved period of time or number of treatments, the Plan will notify you of the adverse benefit determination sufficiently in advance of the reduction or elimination to allow you to appeal and request a determination before the benefit is reduced or eliminated.

If you want to extend a course of treatment and the claim is an urgent care claim, you should contact your Aetna Personal Health Advocate at least 24 hours before the expiration of the prescribed period of time or number of treatments to request extended coverage. If you meet this timing, the Plan will notify you of its decision within 24 hours of its receipt of your claim. Otherwise, a decision will be made according to the category your claim falls into at the time it is made (i.e., urgent care, pre-service or post-service). If your claim is denied, you may appeal the decision as described below.

## **Claim Decision**

You will receive a decision in writing. If your request for benefits is denied, the written notice contains:

- The specific reasons for the denial;
- The specific Plan provisions upon which the denial is based;
- A description of any additional material or information necessary for you to perfect the claim for benefits and an explanation of why such material or information is necessary; and
- An explanation of how you may appeal the denial, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.

For disability and health benefits, the written denial notice also informs you of:

- Any specific rule, guideline or protocol that was relied upon or a statement that the rule, guideline or protocol was relied upon and that you may request a copy of it free of charge;
- If the adverse determination is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment or a statement that you may request such explanation free of charge; and
- For an urgent care claim, a description of the expedited review process.

You have the right to request and receive reasonable access to and copies of relevant documents, records and other information in NXP's possession free of charge. Relevant documents, records and other information are those that:

- Were relied upon in making the benefit determination;
- Were submitted, considered or generated in the course of making the benefit determination;
- Demonstrate compliance with the Plan's administrative processes or safeguards; or
- For disability and health benefits, constitute a statement of the Plan's policy or guideline regarding the benefit for your diagnosis, whether relied upon or not.

## Your Right to Appeal

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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 NXP Rewards Customer Service 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 NXP Rewards Customer Service at 888-375-2367 to request a *Claim Initiation Notice*.

For all claims (excluding disability claims and health benefit claims), the applicable decision makers consider your request for review and notify you in writing of their decision within 60 days of receiving your request. If, because of special circumstances, they cannot make a decision within the initial review period, the review period may be extended up to an additional 60 days. If an extension is necessary, you are notified before the end of the initial review period.

For a disability claim, the applicable decision makers consider your appeal and notify you in writing of their decision within 45 days of receiving your request. If, because of special circumstances, they cannot make a decision within the initial review period, the review period may be extended up to an additional 45 days. If an extension is necessary, you are notified before the end of the initial review period.

For health benefit claims, the applicable decision makers consider your request for review and notify you of their decision within the following periods:

- **Urgent Care Claims:** 36 hours of receipt of your appeal (72 hours for MetLife Dental under the Dental Plan).
- **Pre-Service Claims:** 15 days of receipt of your appeal (30 days of receipt of your appeal to MetLife Dental under the Dental Plan).
- **Post-Service Claims:** 30 days of receipt of your appeal (60 days of receipt of your appeal to MetLife Dental under the Dental Plan).

For a 401(k) Retirement Plan or Life Insurance Plan claim, the applicable decision makers consider your request for review and notify you in writing of their decision within 60 days of receiving your request. If, because of special circumstances, they cannot make a decision within the initial review period, the review period may be extended up to an additional 60 days. If an extension is necessary, you are notified before the end of the initial review period.

You will receive a decision on appeal in writing as detailed in [Claim Decision](#), beginning on page 275.

<b>Where to Send Appeals</b>		
<b>Type of Appeal</b>	<b>Send Written Appeals to:</b>	<b>Deadline for Submitting Written Appeals</b>
<b>Eligibility and Enrollment</b> (all Plans and Programs, including any rescission or retroactive termination of coverage)	<b>NXP Benefits Determination Review Team</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475	180 days from notification of denial
<b>Medical Plan</b> (including Behavioral Health Program)	<b>Aetna Appeals</b> P.O. Box 14463 Lexington, Kentucky 40512	180 days from notification of denial <b>Urgent Care:</b> 72 hours from receipt of denial
<b>Prescription Drug Program</b>	<b>CVS Caremark</b> Appeals Department Mail Code 109 P.O. Box 52084 Phoenix, Arizona 85072-2084	180 days from notification of denial <b>Urgent Care:</b> 72 hours from receipt of denial
<b>Aetna Global Medical Plan</b> For U.S. Inpatriates and U.S. Expatriates	<b>Aetna Global Benefits/Aetna</b> P.O. Box 981543 El Paso, Texas 79998-1543 USA	180 days from notification of denial <b>Urgent Care:</b> 72 hours from receipt of denial
<b>Dental Plan</b>	<b>MetLife Dental Claims</b> P.O. Box 981282 El Paso, TX 79998-1282	180 days from notification of denial
<b>Vision Plan</b>	<b>VSP</b> P.O. Box 2350 Rancho Cordova, California 95741-2350	180 days from notification of denial
<b>Flexible Spending Account Plan</b>	<b>NXP Benefits Determination Review Team</b> P.O. Box 1475 Lincolnshire, Illinois 6006901475	180 days from notification of denial
<b>Disability Income Plan</b>	<b>Prudential Appeals</b> 80 Livingston Avenue Roseland, NJ 07068	180 days from notification of denial
<b>Life and Accidental Death and Dismemberment Insurance Plans</b>	<b>MetLife Group Life Claims</b> P.O. Box 6100 Scranton, PA 18505-6100	60 days from notification of denial
<b>Business Travel Accident Insurance Plan</b>	<b>ACE International Claims</b> Accident & Health P.O. Box 5124 Scranton, PA 18505-0556	180 days from notification of denial

Where to Send Appeals		
Type of Appeal	Send Written Appeals to:	Deadline for Submitting Written Appeals
Adoption Assistance Program	<b>NXP Benefits Determination Review Team</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475	60 days from notification of denial
401(k) Retirement Plan	<b>401(k) Retirement Plan Committee</b> 6501 William Cannon Drive West Mail Drop OE331 Austin, Texas 78735	60 days from notification of denial

## Second Level Appeals

Under the **Medical Plan** (including behavioral health and prescription drug) and the **Disability Income Plans**, if your appeal is denied, you may submit a second level appeal of that denial. *Note that this second level of review does not apply to claims for any other benefits.* Your written second level appeal, issues and comments should be sent to different locations, depending on the plan/program. There is no second level review for any claim for benefits other than what is listed below.

Second Level Appeals			
Type of Appeal	Send Written Appeals to:	Deadline for Submitting Written Request for Review	Decision on Appeal
<b>Medical Plan</b> (including Behavioral Health Program)	<b>Aetna Appeals</b> P.O. Box 14463 Lexington, Kentucky 40512	60 days from notification of denial	<b>Urgent Care:</b> 36 hours of receipt of your appeal <b>Pre-Service Care:</b> 15 days of receipt of your appeal <b>Post-Service Care:</b> 30 days of receipt of your appeal
<b>Prescription Drug Program</b> (included in Medical Plan)	<b>CVS Caremark Prescription Drug Appeals</b> Mail Code 109 P.O. Box 52084 Phoenix, Arizona 85072-2084	180 days from notification of denial	<b>Urgent Care:</b> 72 hours from receipt of your appeal <b>All Others:</b> 15 days from receipt of your appeal
<b>Disability Income Plan</b>	<b>Prudential Appeals</b> 80 Livingston Avenue Roseland, NJ 07068	60 days from notification of denial	45 days of receipt of your written appeal (plus extension of up to 45 days in special circumstances)

## Special Rule When Decision Is Based on Medical Judgment

When a denial on appeal is based on a medical judgment, the Plan consults with a health care professional with appropriate training, who will be identified upon request. Such health care professional will be someone who was neither consulted in connection with the initial denial of a claim that is the subject of the appeal, nor the subordinate of any such individual.

The final decision on appeal is sent to you in writing and will inform you of the specific reasons for the decision and the specific Plan provision upon which the decision is based. Except as required by law, the decisions are final and binding on all parties. You or your covered dependents must exhaust all the internal administrative remedies described above before bringing an action for Plan benefits under Section 502(a) of ERISA.

## External Reviews — Medical Claims

You must complete all of the levels of standard appeal process described in the previous sections before you can request an external review. Your authorized representative may act on your behalf for an external review.

The notice of adverse benefit determination you receive from Aetna will describe the process to follow if you want to request an external review and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the adverse benefit determination notice from Aetna. If the last filing date falls on a Saturday, Sunday or federal holiday, the date is extended to the next day that is not a Saturday, Sunday or federal holiday. You must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary external review request, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other Plan benefits. However, the appeal is voluntary and you are not required to file a request before pursuing legal action.

## Request for External Review

You are eligible to request an external review if the claim decision involves medical judgment and:

- Aetna, the Plan or its designee does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations);
- The standard levels of appeal have been exhausted; or
- The appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An adverse benefit determination based on eligibility is not eligible for external review.

If a coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

### **Preliminary Review**

Within five business days after the date of receipt of the request, Aetna will provide a preliminary review determining if you are eligible for an external review, which will evaluate if:

- You were covered under the Plan at the time the service was requested or provided;
- The determination does not relate to eligibility;
- You have exhausted the internal appeals process; and
- You have provided all paperwork necessary to complete the external review.

Within one business day after completion of the preliminary review, Aetna will issue written notification. If your request is complete but not eligible for an external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If the request is not complete, the notification will describe the information or materials needed to make the request complete and Aetna will allow you to perfect the request for an external review within the 123 calendar days filing period or within the 48-hour period following the receipt of the notification, whichever is later.

### **Referral to External Review Organization (ERO)**

Aetna will assign an ERO accredited as required under federal law, to conduct the external review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for external review and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information for the ERO to consider when conducting the external review. Within one business day after making the decision, the ERO will notify you, Aetna and the Plan of the decision.

The ERO will review all information and documents timely received. In reaching a decision, the assigned ERO will review the claim and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
- Plan terms to ensure that the ERO's decision is not contrary to Plan terms, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;

- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with Plan terms or applicable law; and
- The opinion of the ERO's clinical reviewer(s) after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The assigned ERO will provide written notice of the external review decision within 45 days after the ERO receives the request for an external review. The ERO will deliver the notice to you, Aetna and the Plan.

After a final external review decision, the ERO will maintain records of all claims and notices associated with the external review process for six years. The ERO will make the records available for examination by you, the Plan or state or federal oversight agencies upon request, except where disclosure would violate state or federal privacy laws.

Upon receipt of a decision reversing the adverse benefit determination, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

### **Expedited External Review**

The Plan allows you to request an expedited external review if you receive an adverse benefit determination:

- That involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- If you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or it concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, Aetna will determine if the request meets the reviewability requirements described above for standard external review. Aetna will immediately send you a notice of its eligibility determination.

### ***Referral of Expedited Review to ERO***

Upon a determination that a request is eligible for external review following preliminary review, Aetna will assign an ERO. The ERO will make a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO will provide written confirmation of the decision to you, Aetna and the Plan.

## Coordination of Benefits

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If you have medical and/or dental coverage under a group health plan, automobile no-fault/PIP or medical payment coverage or Medicare in addition to your NXP health care benefit, National Association of Insurance Commissioners (NAIC) rules indicate which plan pays first. These rules prioritize how benefit payments are coordinated, to avoid duplication of benefits.

The primary plan pays before a secondary plan. The NXP Plan is always secondary to:

- Any medical payment, PIP or no-fault coverage under any automobile policy available to you; and
- Any plan or program that is required by law.

Review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

When the NXP Plan is the secondary plan, it pays benefits only if the primary plan pays less of the allowable expenses than the NXP Plan would have paid if it had been primary. When your NXP Plan is the secondary plan, any allowable expenses that would have counted toward satisfying your deductible and/or annual out-of-pocket maximum are applied to the NXP Plan.

**Medicare Exception:** There is an exception for Medicare beneficiaries whose Medicare coverage is secondary by law. If you are a Medicare beneficiary, see [Coordination of Benefits for Participants Eligible for Medicare](#), beginning on page 284, or call NXP Rewards Customer Service for more information.

Following is a summary of the NAIC rules. The first rule that applies determines which plan is primary and which is secondary.

- **Rule 1: No Coordination of Benefits Provisions.** If one plan does not have a coordination of benefits provision that is consistent with these rules, then it is the primary plan, while the plan with the coordination provision is the secondary plan.
- **Rule 2: Dependent/Non-dependent.** The plan that covers the person as a non-dependent (for example, because the person is an employee or retiree) is primary over a plan that covers that person as a dependent.
- **Rule 3: Child of Parents *Not* Separated or Divorced.** In this case, the “birthday rule” applies. Under the birthday rule, benefits are paid first by the plan of the parent whose birthday is earlier in the year. If by chance both parents have the same birth date, then the plan of the parent who has been covered longer pays first.

### **Example**

If Mom was born on March 21 and Dad was born on May 10, then Mom’s plan is considered primary, regardless of the actual years in which they were born.

- **Rule 4: *Child of Separated or Divorced Parents.*** If a court order specifies that one of the parents is responsible for the child's health coverage, the plan of that parent is primary.

If the court decree awards joint custody without allocating responsibility for the child's health coverage, the birthday rule determines which parent's plan is primary.

If no court order allocates responsibility for the child's health coverage, the plan of the custodial parent pays first, the plan of the spouse of the custodial parent (if any) pays second, the plan of the non-custodial parent pays next, and the plan of the spouse of the non-custodial parent (if any) pays last.

- **Rule 5: *Active or Inactive Employee.*** A plan that covers the person as a former employee (or dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee). If the other plan does not have this rule, and the plans do not agree on the order of benefits, then this rule does not apply.
- **Rule 6: *Continuation Coverage.*** COBRA coverage is secondary to the plan covering the person as an employee or retiree. **Note:** This rule applies only when both plans provide either non-dependent coverage or dependent coverage to the person. However, if one plan provides dependent coverage and the other non-dependent coverage, Rule 2 applies.
- **Rule 7: *Longer or Shorter Length of Coverage.*** If none of the above rules determines the order of payment, then the plan that has covered the person longer pays before the plan that has covered the person for the shorter period.
- **Rule 8: *Other Rules Do Not Apply.*** If none of the above rules determines which plan is primary, then the expenses are shared equally between the plans.

If you or your spouse/domestic partner or other dependent has health care coverage under a government-sponsored program in another country based on citizenship in that country, and you or your dependent are also covered under this Plan, the NAIC rules do not apply, and the NXP Plan is secondary.

You must notify NXP Rewards Customer Service anytime you gain or lose other health coverage. If you or a covered dependent has primary coverage under another medical or dental plan, you must file a claim for benefits under that coverage before your NXP claim is processed.

## Coordination of Benefits for Participants Eligible for Medicare

If you or any of your dependents are eligible for Medicare, the coordination of your benefits works differently from the NAIC rules. Congress established rules to determine whether Medicare or another plan pays first. Please note that those who are "eligible for Medicare" includes those who **are not** covered by Medicare because they refused, dropped or did not properly request it.

Medicare is primary (and the NXP Plan is secondary) for your surviving dependent age 65 or older who is eligible for Medicare and covered under the Plan due to a survivor benefits provision. In this case, the Plan pays secondary **regardless of whether your dependent has enrolled in Medicare.**

Medicare is secondary (and the NXP Plan is primary) if you or any of your dependents are entitled to Medicare and entitled to Social Security disability benefits, but only while NXP Plan coverage is due to your “current employment status” under Medicare rules (generally while you are employed and during the first six months you are receiving disability benefits from an employer). If NXP Plan coverage is other than because of your “current employment status” (after your employment terminates or after the sixth month that you receive disability benefits), Medicare is primary.

A different rule applies if you have End-Stage Renal Disease (ESRD). If you have ESRD and are eligible for Medicare because of ESRD, the NXP Plan is primary up to the first 30 months of your ESRD treatment. The 30-month period begins with the month in which you become eligible for Medicare benefits for ESRD. Thereafter, Medicare is primary, the NXP Plan pays secondary ***regardless of whether you or your dependent (whoever is eligible) has enrolled in Medicare.***

When the NXP Plan is secondary, NXP may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total reimbursable expenses under the NXP Plan.

In general, total benefits under this Plan (the amount that would be paid if there were no Medicare benefits) will be calculated. If the amount calculated is more than the amount Medicare provides for these expenses, this Plan will pay the difference. Otherwise, this Plan will pay no benefits.

# NXP HIPAA Notice of Privacy Practices for Protected Health Information

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The NXP Health Plans are required by federal law (specifically, the Health Insurance Portability and Accountability Act, known as HIPAA) to protect the privacy of your personal health information.

This notice explains:

- How your personal health information (called Protected Health Information) may be used, and
- What rights you have regarding this information.

## How The Group Health Plans May Use Your Information

We are permitted by law to use and disclose your Protected Health Information in certain ways without your authorization:

- **For treatment.** We may use and disclose your Protected Health Information to coordinate or manage health care services you receive from providers.
- **For payment.** We may use and disclose your Protected Health Information to determine plan eligibility and responsibility for coverage and benefits. For example, to make sure that you receive the correct benefits and claims are paid accurately, we may use your information when we confer with other health plans to resolve a coordination of benefits issue. We may also use your Protected Health Information for utilization review activities.
- **For health care operations.** We may use your Protected Health Information in several ways, including Plan administration, quality assessment and improvement, and vendor review. Your information could be used to ensure quality and efficient plan operations, for example, to assist in the evaluation of a vendor who supports us. We also may contact you to provide information about treatment alternatives or other health-related benefits and services available under the Plan.

We may also disclose your Protected Health Information to NXP (the plan sponsor) in connection with these activities or for purposes related to your enrollment or disenrollment in the Plan.

## Other Permitted Uses and Disclosures

Federal regulations allow us to use and disclose your Protected Health Information, without your authorization, for several additional purposes, in accordance with law:

- Public health--We may disclose your Protected Health Information to public health authorities that need the information to prevent or control disease, injury, or disability.
- Reporting and notification of abuse, neglect or domestic violence--We may disclose Protected Health Information to appropriate authorities if we have reason to believe that a person has been a victim of abuse, neglect, or domestic violence.
- Oversight activities of a health oversight agency--We may disclose Protected Health Information so that government agencies can monitor or oversee the health care system and government benefit programs and be sure that certain health care entities are following regulatory programs or civil rights laws like they should.
- Judicial and administrative proceedings--We may disclose Protected Health Information in a court or other type of legal proceeding if it is requested through a legal process, such as a court order or a subpoena.
- To law enforcement officials--We may disclose Protected Health Information to law enforcement if it is required by law; if needed to help identify or locate a suspect, fugitive, material witness, or missing person; if it is about an individual who is or is suspected to be the victim of a crime; or if we think that a death may have resulted from criminal conduct.
- To a coroner or medical examiner--We may disclose Protected Health Information to coroners, medical examiners or funeral directors so that they can carry out their responsibilities.
- To certain organ, eye or tissue donation programs--We may disclose Protected Health Information to organizations involved in organ donation or organ transplants.
- To avert a serious threat to health or safety--We may use or disclose your Protected Health Information to appropriate persons or authorities if we have reason to believe it is needed to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- Specialized government functions (e.g., military and veterans' activities, national security and intelligence, federal protective services, medical suitability determinations, correctional institutions and other law enforcement custodial situations)--We may use or disclose Protected Health Information to the federal government for military purposes and activities, national security and intelligence, or so it can provide protective services to the U.S. President or other official persons.
- Research, as long as certain privacy-related standards are satisfied--We may use or disclose Protected Health Information for research purposes if the privacy of the information will be protected in the research.

- Workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness--We may use or disclose Protected Health Information to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illness without regard to fault.
- Other purposes required by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law--We may use or disclose Protected Health Information as may be required by and as may be enforceable in a court of law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.

## **In Special Situations**

We may disclose your Protected Health Information to a family member, relative, close personal friend or any other person whom you identify, when that information is directly relevant to the person's involvement with your care or payment related to your care.

We also may use your Protected Health Information to notify a family member, your personal representative, another person responsible for your care, or certain disaster relief agencies of your location, general condition or death. If you are incapacitated, there is an emergency, or you otherwise do not have the opportunity to agree to or object to this use or disclosure, we will do what in our judgment is in your best interest regarding such disclosure and will disclose only information that is directly relevant to the person's involvement with your health care.

*For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, we are required to have your written authorization. We must obtain your authorization for all treatment and health care operations communications where we receive financial remuneration for making communications from a third party whose product or service is being marketed. We must obtain an authorization for any disclosure which is a sale of protected health information. Such authorization must state that the disclosure will result in remuneration to the Plan. Finally, communications of Protected Health Information containing psychotherapy notes generally require your authorization, except for use by the originator of the psychotherapy notes for treatment, 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
  - Disclosures we make to you about your own health information or that you authorized in writing

### Right to Request Restrictions

You may ask us to restrict how we use and disclose your Protected Health Information as the Plan carries out payment, treatment or health care operations. You may also ask the Plan to restrict disclosures to your family members, relatives, friends or other persons you identify who are involved in your care or payment for your care. However, we are not required to agree to these requests, except that we must agree to a request to restrict disclosure of Protected Health Information if the disclosure is for the purpose of carrying out payment or health care operations, is not otherwise required by law, and the Protected Health Information pertains solely to a health care item or service for which you, or someone on your behalf, has paid in full.

## **Right to Request Confidential Communications**

You may request to receive your Protected Health Information by alternative means or at an alternative location if you reasonably believe that other disclosure could pose a danger to you. For example, you may only want to have Protected Health Information sent by mail or to an address other than your home.

*For more information about exercising these rights, contact the office below.*

## **Right to Notice of Breach of Unsecured Protected Health Information**

You have the right to receive notice in the event that unsecured Protected Health Information identifying you has been or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner.

## **Complaints**

If you believe that your privacy rights have been violated, you may file a written complaint without fear of reprisal. Direct your complaint to the office listed below under “Contacting Us” or to the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201.

## **About this Notice**

We are required to provide you this notice regarding our privacy policies and procedures, and to abide by the terms of this notice, as it may be updated from time to time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all Protected Health Information we maintain. If we 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 USA, Inc.**

Human Resources Department –HIPAA Privacy Inquiries  
6501 William Cannon Drive West, OE 331  
Austin, Texas 78735

## **Subrogation and Right of Recovery Provisions**

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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 NXP Rewards Customer Service 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.

The Plan's subrogation and right of recovery provisions apply to all current and former Plan participants, including parents, guardians and other representatives of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) applies to the personal representative of your estate, your decedents, minors and incompetent or disabled persons. You or your includes anyone on whose behalf the Plan pays benefits. No adult may assign any rights he or she may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of that adult without the prior express written Plan consent.

Throughout this Subrogation and Right of Recovery Provisions section, "you" or "your" refers to you and/or your covered dependent(s).

The Plan's right of subrogation or reimbursement extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims, including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage.

This Plan is always secondary to automobile no-fault coverage, personal injury protection coverage and medical payments coverage.

No disbursement, including but not limited to the payment of attorney's fees, of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interests are fully satisfied.

### **Subrogation**

The right of subrogation means the Plan is entitled to pursue any claims that you or your covered dependent(s) may have to recover benefits paid by the Plan. Immediately upon paying or providing any Plan benefit, the Plan is subrogated to (stands in the place of) all rights of recovery for any claim or potential claim against any party due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your or your dependent's name and take appropriate action to assert its subrogation claim, with or without your or your dependent's consent. The Plan is not required to pay you or your covered dependent part of any recovery it may obtain, even if it files suit in your name.

### **Reimbursement**

If you receive any payment due to an injury, illness or condition, you agree to reimburse the Plan first from that payment for all amounts the Plan has paid and will pay due to that injury, illness or condition, from such payment, up to and including the full amount of the recovery.

## **Constructive Trust**

By accepting benefits (whether payment is made to you or made on your behalf to any provider), you agree that if you receive any payment due to an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold the funds in trust will be deemed a breach of your fiduciary duty to NXP or the Plan. No disbursement, including but not limited to the payment of attorney's fees, of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interests are fully satisfied.

## **Lien Rights**

The Plan automatically has a lien to the extent of benefits paid by NXP or the Plan for treatment of an illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which NXP or the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by NXP or the Plan including, but not limited to, you, your representative or agent and/or any other source possessing funds representing benefit amounts paid by NXP or the Plan.

## **Assignment**

To secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

## **First-Priority Claim**

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be paid to the Plan before you and your attorney receive any recovery for your damages. The Plan is entitled to full reimbursement on a first-dollar basis from any payments, even if the payment to the Plan results in a recovery that is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

## **Applicability to All Settlements and Judgments**

The Plan's subrogation and right of recovery provision terms apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of the settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

## **Cooperation**

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or receive compensation due to your injury, illness or condition. You and your agents agree to provide the Plan or its representatives with notice of any recovery you or your agents obtain before receipt of the recovery funds or within five days if no notice was given before receipt. Further, you and your agents agree to provide notice before any disbursement of settlement or any other recovery funds obtained. You and your agents must provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, to assist the Plan in pursuit of its subrogation rights or to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in full, termination of Plan benefits or the institution of court proceedings against you.

You must do nothing to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of this provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery before fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that NXP and the Plan have the right to conduct an investigation regarding the injury, illness or condition to identify potential sources of recovery. NXP and the Plan reserve the right to notify all parties and their agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right, according to the Health Insurance Portability and Accountability Act (HIPAA) to share your personal health information in exercising its subrogation and reimbursement rights.

## **Interpretation**

If any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan's Claims Administrator has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

## **Jurisdiction**

By accepting benefits from the Plan, you agree that any court proceeding about this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting benefits, you hereby submit to each jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this provision.

## Plan Information

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*This section includes important administrative information, as well as your [ERISA rights](#) (see page 299).*

## Administrative Information

<b>Employer and Plan Sponsor</b>	<b>NXP USA, Inc.</b> 6501 William Cannon Drive West Austin, Texas 78735
<b>Employer Identification Number</b>	20-0443182
<b>Agent for Legal Service</b>	NXP USA, Inc. c/o Corporation Service Company 251 Little Falls Drive Wilmington, DE 19808
<b>Plan Year</b>	January 1 through December 31

<b>Plan Name and Type</b>	<b>Number</b>	<b>Funding Administration</b>	<b>Plan Administrator</b>	<b>Effective Date</b>
<b>NXP Employee Medical Plan</b> (including pharmacy and behavioral health)	501	Self-insured by NXP and claims administered by: <b>Aetna Life Insurance Company</b> 151 Farmington Ave. Hartford, Connecticut 06156	NXP USA, Inc.	January 1, 2016
<b>NXP Employee Dental Plan</b>	501	Self-insured by NXP and claims administered by: <b>MetLife Dental</b> P.O. Box 981282 El Paso, TX 79998-1282	NXP USA, Inc.	January 1, 2016
<b>NXP Employee Vision Plan</b>	501	Self-insured by NXP and claims administered by: <b>VSP</b> 3333 Quality Drive Rancho Cordova, California 95670	NXP USA, Inc.	January 1, 2016
<b>NXP Health Care Flexible Spending Account Plan</b>	501	Self-insured by NXP and claims administered by: <b>Alight Solutions</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475	NXP USA, Inc.	January 1, 2016
<b>NXP Dependent Care Flexible Spending Account Plan</b>	501	Self-insured by NXP and claims administered by: <b>Alight Solutions</b> P.O. Box 785040, Orlando, Florida 32878-5040	NXP USA, Inc.	January 1, 2016

Plan Name and Type	Number	Funding Administration	Plan Administrator	Effective Date
<b>NXP Disability Income Plan</b>	501	Self-insured by NXP and claims administered by: <b>Prudential</b> 80 Livingston Avenue Roseland, NJ 07068	NXP USA, Inc.	January 1, 2016
<b>NXP Group Life Insurance Benefit Plan</b> (Life, Accidental Death and Dismemberment)	501	Insurance contract with Claims Administrator: <b>MetLife</b> P.O. Box 6100 Scranton, PA 18505-6100	NXP USA, Inc.	January 1, 2016
<b>NXP Business Travel Accident Insurance Plan</b>	501	Insurance contract with Claims Administrator: <b>ACE American Insurance Company</b> 436 Walnut Street Philadelphia, PA 19106	NXP USA, Inc.	January 1, 2016
<b>MetLaw® Legal Services Plan</b>	926/0025	Contract with Hyatt Legal Plans and administered by: <b>Hyatt Legal Plans, Inc.</b> 1111 Superior Avenue Cleveland, Ohio 44114-2407	NXP USA, Inc.	January 1, 2016
<b>NXP Adoption Assistance Program</b>	501	Self-insured by NXP and claims administered by: <b>Alight Solutions</b> P.O. Box 785040 Orlando, Florida 32878-5040	NXP USA, Inc.	January 1, 2016
<b>401(k) Retirement Plan</b>	001	Plan assets are held in trust by the Trustee: <b>The Northern Trust Company</b> 50 South LaSalle Street Chicago, Illinois 60690 The Plan Administrator has engaged Alight Solutions as a third-party administrator.	401(k) Retirement Plan Committee	Amended and restated effective January 1, 2016
<b>Health Savings Account</b>	Not applicable	Assets are held in individual accounts with <b>UMB Bank</b> (or as otherwise established)	Alight Solutions	January 1, 2016

## **Plan Administration**

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe Plan terms, including the making of factual determinations. The Plan Administrator has the discretionary authority to grant or deny Plan benefits. Plan benefits will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator's decisions are final and conclusive for all questions relating to the Plans.

No final action, finding, interpretation, ruling or decision is subject to de novo review in any judicial proceeding. No Plan Administrator's final action, finding, interpretation, ruling or decision may be set aside unless it is held to have been arbitrary and capricious by a final judgment of a court having jurisdiction over the issue.

The Plan Administrator may delegate to other persons responsibilities for performing certain Plan Administrator duties under Plan terms and may seek expert advice as the Plan Administrator deems reasonably necessary under the Plans. The Plan Administrator is entitled to rely upon the information and advice provided by the delegates and experts, unless actually knowing such information and advice to be inaccurate or unlawful.

The Plan Administrator may adopt uniform rules for Plan administration from time to time, as it deems necessary or appropriate.

## **Amendment and Termination**

NXP reserves the sole discretionary right to modify, amend or terminate any of the NXP benefit plans, in any respect, at any time and from time to time, retroactively or otherwise, by a written instrument adopted by its Board of Directors or its designee. In addition, the Retirement Plan Committee has been designated to approve any amendment of the 401(k) Retirement Plan.

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.

No amendment of the 401(k) Retirement Plan can divest any participant of his or her accrued benefit, except according to 401(k) Retirement Plan terms and as permitted under ERISA. Except for the 401(k) Retirement Plan, no person covered under any of the Plans has any vested right, at any time, to receive benefits. If a Plan is terminated, benefits may be paid for covered expenses incurred or vested benefits as of the date of Plan termination.

## **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) are primarily funded by NXP and paid from NXP's general assets. Other portions of the Plan (e.g., life insurance) is funded through insurance contracts.

The 401(k) Retirement Plan is funded through employee contributions and NXP contributions. The Northern Trust Company holds in trust the assets of the 401(k) Retirement Plan.

## **No Assignment**

To the extent allowed by law, and except as specified under Plan terms, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. However, some Plan benefits may be subject to a Qualified Medical Child Support Order or a Qualified Domestic Relations Order, and you may assign your benefits under the NXP Group Life Insurance Plan.

## **Recovery of Payments Made by Mistake**

You are required to return to NXP any benefits, or portion thereof, paid under any of the Plans by a mistake of fact or law.

## **No Contract of Employment**

Your participation in the Plans does not assure you of continued employment with NXP or rights to benefits except as specified under Plan terms. Nothing in the Plans or in this SPD confers any right of continued employment to any employee.

## **Severability**

If a court of competent jurisdiction finds, holds or deems any provision of a Plan described in this SPD to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan continues in full force and effect.

## **Applicable Law**

The Plans described in this SPD are governed and construed according to the laws of the State of Texas, to the extent not pre-empted by the laws of the United States.

## Statement of ERISA Rights

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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, Texas 78735, and major Human Resources Offices of NXP, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA), such as annual financial reports (Form 5500 Series).
- Get copies of documents governing Plan operations, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive summaries of the Plan's annual financial reports. These reports are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to provide each participant a copy of the summary annual report.

### Continue Group Health Plan Coverage

- Under a group health plan, continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the group health plan due to a qualifying event. You or your dependents may have to pay for such coverage.
- Review this Summary Plan Description and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for Plan operations. The people who operate the Plans, called fiduciaries, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer or any other person, may discharge you or otherwise discriminate against you in any way to prevent you from getting a benefit or exercising your rights under ERISA.

## Enforce Your Rights

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reasons for the denial. You have the right to know why this was done, to get copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials about a Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the Plan Administrator to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

## Assistance with Your Questions

If you have any questions about the Plans, you should contact NXP Rewards Customer Service. If you have any questions about this Statement or about your rights under ERISA, or if you need assistance in getting documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or you may write:

### **Employee Benefits Security Administration**

Division of Technical Assistance and Inquiries

200 Constitution Avenue, N.W.

Washington, DC 20210

866-444-3272

[DOL.gov/EBSA](https://www.dol.gov/EBSA)

You may also get certain publications about your rights and responsibilities under ERISA by contacting the Employee Benefits Security Administration.

## Definitions

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*This section includes definitions of terms and phrases used throughout this SPD that have special meanings for the Plans described in this SPD.*

### **401(a)(17) Limit**

Annual amount established by the IRS under Section 401(a)(17) of the Internal Revenue Code limiting compensation that may be considered in calculating employee and employer contributions to the 401(k) Retirement Plan. For 2018, the limit is \$275,000. This limit may change annually, based on cost-of-living increases.

### **401(k) Elective Deferral Limit**

Annual amount established by the IRS that limits the amount you can contribute to 401(k) plans. For 2018, this limit is \$18,500. The limit may change annually, based on cost-of-living increases.

### **401(k) Retirement Plan**

Tax-qualified plan maintained by NXP for eligible employees that allows you to actively contribute to your financial security.

### **Accident**

An unexpected, unintentional and unforeseen traumatic experience that is caused by an outside force and that happens at a specific time and place.

For the Disability Income Plan, “accident” further means that such experience results in your inability to return to work with NXP for a period of at least eight consecutive calendar days beginning within 30 days of the experience and does not include a strain or injury caused by over-exertion of the body or pregnancy.

For Accidental Death and Dismemberment Insurance, “accident” means a sudden, unexpected and unintended event, independent of sickness and all other causes. Accident does not include sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, bacterial or viral infection, regardless of how contracted. Accident does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

### **Accidental Injury**

For the Dental Plan, accidental injury means damage to the mouth, teeth and supporting tissue, due directly to an accident and independent of all other causes. Accidental injury does not include damage to the teeth appliances or prosthetic devices that results from chewing or biting food or other substances.

### **Accidental Death and Dismemberment (AD&D) Insurance**

Insurance coverage that provides benefits due to loss of life, limb(s), eyesight, speech or hearing as the result of an accident.

***Actively at Work***

You currently perform the essential functions of your job at your assigned place of employment during assigned working hours.

***Adoption Assistance***

A benefit program that reimburses employees up to \$8,000 (on a taxable basis) for eligible expenses related to adoption.

***Aetna***

Medical, behavioral health and disability administrator responsible for claims processing, customer service and appeals.

***Aetna Global Medical***

Medical, behavioral health, prescription drug and dental benefits administrator responsible for claims processing, customer service and appeals. This plan is for U.S. Inpatriates and U.S. Expatriates. The benefit details for this plan is not included in this Summary Plan Description.

***Aetna Personal Health Advocate***

A service that Aetna maintains to provide precertification, disease management, case management, utilization review, network information and other services to NXP Medical Plan participants. Reach your Aetna Personal Health Advocate by calling Aetna Member Services at 800-626-1987.

***Aggregate Lifetime Maximum Benefit***

The sum of all benefits a plan pays over a person's lifetime. For example, if during your employment with NXP and Motorola you participated in the NXP Medical Plan and the former Basic Medical Plan, the sum of benefits paid under the NXP Medical Plan and the former Basic Medical Plan is your aggregate lifetime maximum benefit under any NXP health plan. The NXP Medical Plan does not have an aggregate lifetime maximum benefit.

***Allowable Medical Expense***

Expenses for medical care provided to a participant for which the Claims Administrator has determined a benefit is payable under the Employee Medical Plan.

***Ancillary Services***

Services performed by laboratories, therapists, dietitians, nutritionists, pathologists, assistant surgeons, anesthesiologists and radiologists.

### ***Annual Enrollment***

Period each year in which eligible participants may enroll themselves and their eligible dependents in medical, dental and/or vision coverage and enroll in the Short-Term Disability Buy-Up option. Eligible participants may also establish a Health Care Flexible Spending Account and a Dependent Care Flexible Spending Account for the next calendar year. Eligible participants may make enrollment changes during annual enrollment without a qualified status change.

### ***Annual Out-of-Pocket Maximum***

The maximum amount of eligible expenses (including any deductibles) that you have to pay in a calendar year. Once you or your family members meet the annual out-of-pocket maximum, covered services for you or all covered family members, as applicable, are paid at 100% coinsurance for the remainder of the calendar year.

### ***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.

### ***Any Reasonable Occupation***

For Short-Term and Long-Term Disability Plan benefits, this is any gainful activity for which you are, or may reasonably become, fitted by education, training or experience that results in, or can be expected to result in, an income of more than 60% of your adjusted pre-disability earnings.

### ***Audiologist***

A person skilled in the science of hearing, particularly the study of impaired hearing that cannot be improved by medication or surgical means.

### ***Authorized Representative***

For filing claims under the group health plans (Medical Plan, Dental Plan, Vision Plan, Health Savings Account and Health Care Flexible Spending Account), your authorized representative is a person you authorize in writing to act on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may act as your authorized representative.

### ***Automatic Contribution***

The rate (5%) at which new hires begin contributing to the 401(k) Retirement Plan on a before-tax basis unless they affirmatively elect otherwise. Automatic contributions normally begin by your third paycheck. Unless you elect otherwise, your automatic contributions are invested in a managed account with GuidedChoice, with its associated fees, and your contribution rate will increase 1% each year until you are contributing 10%.

### ***Balance Billing***

Balance billing, also called extra billing, is the practice where a healthcare provider, usually an **ancillary services** provider, physician, facility or hospital, bills a patient for the difference between what the patient's health insurance reimburses and what the provider charges. In cases where you use a network provider or the services were an **emergency** and are asked to pay an extra amount, over the network amount Aetna reimburses, call Aetna Member Services at 800-626-1987 for assistance. If the services were performed out of network you are responsible for any amount over the **recognized charge** Aetna reimburses.

### ***Basic Life Insurance***

An NXP-funded program that provides a benefit to your beneficiary (or beneficiaries) if you die.

### ***Behavioral Health Program***

Program available to all NXP Medical Plan participants for the treatment of psychiatric, emotional and/or chemical dependency disorders.

### ***Beneficiary***

- **Primary Beneficiary:** The person, trust or estate you choose to receive the proceeds from your life insurance, business travel accident insurance and/or the 401(k) Retirement Plan account following your death.
- **Contingent Beneficiary:** Designated to receive the benefit if no primary beneficiary is living at the time the benefit becomes payable.

You may not designate your will as your beneficiary.

For the Dental Plan, beneficiary means you and your covered dependent(s), or legal representative of either, and anyone to whom the rights of you or your covered dependent(s) may pass.

### ***Biofeedback***

A treatment method that uses monitoring instruments to feedback physiological information to patients, enabling them to learn to adjust their thinking and other mental processes to control bodily processes such as blood pressure, temperature, gastrointestinal functioning and brain wave activity.

### ***Board Certification***

A national test for physicians indicating that they are certified to practice the specialty for which the test is taken.

### ***Brand Name Drug***

The trademark name of a prescription drug.

### ***Business Travel Accident Insurance***

Insurance coverage that provides benefits if you have an accident while traveling on NXP business and that accident results in the loss of life, limb(s), eyesight, speech or hearing.

### ***Care Management***

See [Precertification](#), beginning on page 61.

### ***Case Management***

Medical case management assistance that the Aetna Personal Health Advocate provides to NXP Medical Plan participants. Reach Case Management through your Aetna Personal Health Advocate by calling Aetna Member Services at 800-626-1987.

### ***Castlight***

When you enroll in an NXP Aetna medical plan, you and your covered family members have access to Castlight. Castlight is a personalized online tool that empowers you to make informed healthcare choices with a clear understanding of costs and likely outcomes. Castlight lets you compare doctors and other medical services based on quality, convenience and estimated cost. See [Castlight](#), on page 60 for more information.

### ***Catch-Up Contribution (401(k))***

An additional contribution you are allowed to make to the 401(k) Retirement Plan, if you have attained age 50 or will turn 50 during the year. For 2018, the catch-up contribution limit is \$6,000.

### ***Child and Children***

Your children by birth, adoption or pending adoption or legal guardianship; stepchildren who live with you; foster children legally placed by a licensed agency and grandchildren you legally adopt or for whom you are the court-appointed guardian. The term also includes the children of your domestic partner. See [Section 152 Dependent](#), on page 321, for information on IRS Section 152 and dependents.

### ***Child(ren) Life Insurance***

Optional life insurance for which you make contributions. Child(ren) life insurance pays benefits for the loss of life of a dependent child.

### ***Claim***

Request for a Plan benefit made according to the Plan's reasonable procedure for filing benefit claims. All claims except urgent care claims must be in writing and contain the information described in [Filing Claims](#), beginning on page 270. 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 271 for the contact information for the Claims Administrator for specific benefits under the Plan.

### ***COBRA***

Consolidated Omnibus Budget Reconciliation Act of 1985, a federal law that extends group medical, dental and vision plan coverage to eligible employees, former employees, and their qualifying spouses and dependent children, and Health Care Flexible Spending Account participation to you, in certain circumstances. COBRA requires employers to offer covered individuals 18, 29 or 36 months (for the Health Care Flexible Spending Account, through end of calendar year) of continued coverage (offset, in some cases, by periods of coverage already provided) for a contribution based on the cost of the coverage plus a 2% administration fee (or a 50% administration fee for a qualifying 11-month disability extension).

### ***Coinsurance***

A plan's benefit, expressed as a percentage of covered expenses; e.g., a medical plan pays 90% of covered expenses as coinsurance, and you pay the other 10%. Coinsurance is sometimes referred to as "benefit level."

### ***Company Matching Contributions***

Before-tax contributions NXP may make to your 401(k) Retirement Plan account. Company Matching Contributions are made based on your contributions and invested based on your elections for your own contributions.

### ***Copayment***

An amount you pay directly to the provider for covered expenses at the time you receive services. Copayments are not included in the annual deductible or out-of-pocket maximum.

### ***Cosmetic Dentistry***

Those services provided by dentists solely for the purpose of improving the appearance when form and function are satisfactory and no pathologic conditions exist.

### ***Covered Dependent***

An eligible dependent whom an employee has enrolled in medical, pharmacy, dental, vision and/or spouse/domestic partner and/or child(ren) life insurance coverage.

### ***Covered Expense***

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

For the Dental Plan, covered expense means the reasonable and customary charge or predetermined charge for a dentally necessary covered service incurred by you or your covered dependent(s).

### ***Covered Pay***

For the Disability Income Plan, see [Your Covered Pay Determines Your Benefits](#), beginning on page 154.

### ***Custodial Care***

For the Medical Plan, custodial care means services and supplies that are primarily intended to help you meet personal needs. Examples include changing dressings, respite care, and help with daily living activities (i.e., walking, grooming, bathing), and services that a person without medical or paramedical training could be trained to perform.

### ***Deductible***

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

### ***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 extent of care and treatment that is the generally accepted, proven and established practice by most dentists with similar experience and training where the service is provided. To determine dental necessity, MetLife Dental may require preoperative dental X-rays and any other pertinent information to help determine if benefits are payable for the service submitted for consideration.

### ***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.

### ***Dependent Care Flexible Spending Account (DCFSA)***

An account to which you can contribute before-tax dollars that are later used to reimburse you for eligible dependent care expenses.

### ***Diagnostic Testing***

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

### ***Direct Rollover***

A direct payment of your 401(k) Retirement Plan benefits to a traditional or Roth individual retirement account, 403(b) annuity, Section 457 governmental plan or other eligible (tax-qualified) plan.

### ***Disability Management Program***

A program designed to effectively manage short-term disabilities and return NXP employees to work as soon as they are able.

### ***Domestic Partner***

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

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

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

An affidavit can be requested from the NXP Customer Service Center or downloaded from [NXP.com/files/benefits/CommonLaw\\_Affidavit.pdf](https://nxp.com/files/benefits/CommonLaw_Affidavit.pdf).

### ***Eligible Compensation***

Eligible compensation for life, accidental death and dismemberment and business travel accident insurance benefits includes your annual base salary, prior year Sales Incentive Plan payments, prior quarter shift differential and lump sum merit awards. It does not include overtime, bonuses, Incentive Plan payments, moving allowances, educational allowances, noncash payments or overseas allowances.

For 401(k) Retirement Plan purposes, “eligible compensation” refers to your regular earnings, Sales Incentive Plan payments, annual bonuses, shift differentials, overtime and lump-sum pay, up to the 401(a)(17) limit before you make any before-tax contributions for your NXP Rewards benefits. All other awards and individual spot bonuses, and any severance payments, moving allowances, educational allowances, noncash payments, cost of living adjustments, overseas allowances and other termination payments are excluded.

### ***Eligible Plan***

The kind of plans to which an eligible distribution can be rolled over from the 401(k) Retirement Plan. This includes, in addition to a traditional individual retirement account or annuity, a Roth IRA (for Roth 401(k) funds only), an employer retirement plan qualified under Section 401(a) or 403(a) of the Internal Revenue Code, a Section 403(b) annuity contract or a Section 457(b) plan maintained by a state or other U.S. governmental entity that agrees to account separately for rollovers.

### ***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 the Claims Administrator in its sole and complete discretion. Examples include heart attack, loss of breathing, unconsciousness, poisoning, severe bleeding and broken bones.

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

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

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

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

For the Dental Plan, emergency means the necessary procedures for treatment of pain and/or injury. Services include emergency procedures for treatment to the teeth and supporting structures.

### ***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.

### ***Expense Incurred Date***

For the Dental Plan, the date on which:

- The teeth are prepared for fixed bridges, crowns, inlays or onlays;
- The final impression is made for dentures or partials;
- The pulp chamber of a tooth is opened for root canal therapy;
- Periodontal surgery is performed; or
- The service is performed for covered expenses not listed above.

### ***Experimental or Investigational Care***

For the Medical Plan (including behavioral health, but not prescription drug), except as provided for under **Clinical Trials** on page 79, a drug, a device, a procedure, or treatment will be determined by the Claims Administrator to be experimental or investigational if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;
- Approval required by the FDA has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational or for research purposes;
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of phases indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment. It also includes the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment that states that it is experimental or investigational or for research purposes.

### ***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.

### ***Financial Hardship***

When you need to make a withdrawal from your 401(k) Retirement Plan account because of an unforeseen immediate and heavy financial need, and your need cannot be met by other sources (such as a loan from the Plan or a credit union or bank).

### ***Generic Drug***

A chemical copy of a brand name prescription drug.

### ***Health Care Flexible Spending Account (HCFSA)***

An account to which you can contribute before-tax dollars that are later used to reimburse you for eligible medical, dental or vision expenses that you and your eligible dependents incur. If you are eligible, you may participate in the Health Care Flexible Spending Account regardless of whether you enroll in medical, dental or vision coverage through NXP.

### ***Health Savings Account (HSA)***

A tax-advantaged savings account, available with a corresponding High Deductible Health Plan, used to accumulate funds to pay for eligible expenses for you and your eligible dependents.

### ***High Deductible Health Plan (HDHP)***

A health plan that meets federal requirements about minimum deductible and maximum out-of-pocket costs.

### ***Home Health Care***

Care provided in the home as an alternative to extended hospitalization. Services must be prescribed by a physician, provided by a licensed agency and pre-approved by your Aetna Personal Health Advocate.

### ***Home Health Care Provider***

A registered nurse (RN), a licensed practical nurse (LPN), a licensed vocational nurse (LVN), a home health care aide or a medical social worker.

### ***Home Nursing Care***

Nursing services prescribed in writing by a physician and provided by a graduate licensed registered nurse, or by a licensed practical nurse if the services are the same as those provided by a registered nurse. Home nursing care cannot be provided by someone who ordinarily resides in your home. Custodial care expenses are not included in home nursing care.

### ***Hospice***

An organization or facility that cares for the terminally ill. Hospice programs deal with the physical and psychological aspects of the illness.

### ***Hospital***

An institution supervised by a staff of physicians, with 24-hour R.N. service, primarily engaged in providing inpatient medical, surgical and diagnostic services. It must meet local licensing requirements and be accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations. It is not a convalescent nursing home or facility, skilled nursing facility, or residential treatment facility for behavioral health treatment. You may contact the Claims Administrator to determine if a facility you are considering for care qualifies as a hospital under the Plan.

### ***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.

### ***Ineligible Providers***

Providers whose services are not covered by the NXP Medical Plan, including but not limited to:

- Acupuncturist (except when provided by a physician if performed as a form of anesthesia in connection with a covered surgical procedure and to treat an illness, injury or to alleviate chronic pain);
- Certified Doula;
- Certified Herbalist;
- Certified Holistic Health Practitioner;
- Certified Massage Therapist/Practitioner;
- Certified Operating Room Technician;
- Certified Oral Facial Myologist;
- Certified Surgical Technologist;
- Christian Science Practitioner;
- Doctor of Oriental Medicine;
- Emergency Medical Technician;
- Holistic Nurse;
- Homeopathic Doctor;
- Hypnotherapist;
- Myotherapist;
- Naturopathic Doctor;
- Non-Nurse Midwife; and
- Registered Kinesiotherapist.

### ***Infertility or Infertile***

The condition of a presumably healthy covered person who is unable to conceive or produce conception as outlined in the [Infertility section](#) of this SPD.

### ***Investment Funds***

Funds in the 401(k) Retirement Plan in which you may invest your contributions and Company Matching Contributions. The funds have varying risk and return potential.

### ***Kaiser Permanente***

NXP employees are eligible for a Health Maintenance Organization (HMO) available through either Kaiser Permanente of Northern California or Southern California, depending on location. The HMO is a fully-insured medical option and is not described in this SPD. For more information on the Kaiser HMO, contact Kaiser Member Services at 800-464-4000.

### ***Leave of Absence***

There are five types of leaves of absence available to eligible NXP employees:

- **Medical Leave:** For your own serious health condition or as necessitated by a workplace injury or illness, or for the illness or qualifying serious health condition of a family member;
- **Parental Leave:** To care for a child after the birth, foster care placement or adoption of the child;
- **Leave under the Family and Medical Leave Act:**
  - For the birth of a son or daughter and to care for such son or daughter;
  - For the placement of a child with you for adoption or foster care;
  - To care for a spouse, child or parent with a serious health condition; or
  - For your own serious health condition that makes you unable to perform the functions of your position.
- **Personal Leave:** To attend to personal matters; and
- **Military Service Leave:** If you are called to active duty or temporary active duty by the U.S. armed forces or you are on temporary training duty with the U.S. armed services.

### ***Life Insurance***

Death benefit protection that provides benefits to your beneficiary following your death or to you following the death of a covered dependent. Life insurance benefits include Basic Life, Supplemental Life, Accidental Death and Dismemberment, Business Travel Accident, Spouse/Domestic Partner and Child(ren) Life Insurance.

### ***Limited Use Health Care Flexible Spending Account***

An account to which you can contribute before-tax dollars that are later used to reimburse you for eligible dental and vision expenses that you and your eligible dependents incur. This account is only available if you are enrolled in the Medical Savings Plan with HSA.

### ***Long-Term Disability Plan Benefit***

Percentage of base salary paid to an eligible employee who is under a doctor's care, continuously unable to engage in your *own* or *any* reasonable occupation due to a medically determinable physical or mental impairment, and satisfies the other requirements under the Disability Income Plan. Benefits begin after you qualify for and receive payment of 180 days of Short-Term Disability Plan benefits. Duration of benefits depends on the employee's age when he or she became disabled, how long he or she continues to be disabled and, in some cases, the primary cause of the disability.

### ***Lump-Sum Distribution***

A payment of your entire balance from the 401(k) Retirement Plan after your service with NXP ends.

### ***Maternity Care Program***

Aetna Personal Health Advocate Service that provides NXP Medical Plan participants with risk screenings, prenatal education and information to help ensure a healthy delivery.

### ***Medically Necessary***

Medical or dental services and supplies that a physician or other health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical or dental practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient, physician or other health care or dental provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Generally accepted standards of medical or dental practice means standards that are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community, or otherwise consistent with physician or dental specialty society recommendations and the views of physicians or dentists practicing in relevant clinical areas and any other relevant factors.

### ***Member Identification Number***

Unique identifier provided to each NXP Plan participant that replaces the Social Security Number.

### ***Mental/Nervous/Alcohol/Drug-Related Condition***

Conditions subject to the 24-month maximum disability benefit under the Disability Income Plan.

### ***MetLife Dental***

Dental benefits administrator responsible for dental claims processing, customer service and appeals.

### ***Negotiated Network Fee***

The amount network providers have agreed to charge NXP Medical Plan participants for services provided. In many cases the negotiated network fee is discounted from the providers' regular rates.

### ***Network Hospitals***

A group of hospitals that have met quality criteria and agree to charge negotiated rates to NXP Medical Plan participants for services.

### ***Network Provider***

A physician, dentist or other health care provider who participates in a network, has met specific quality standards and has agreed to a negotiated fee schedule.

### ***Neuropsychological Testing***

The administration and interpretation of standardized tests to assess an individual's cognitive functioning.

### ***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 Health Plans***

- NXP Employee Medical Plan;
- Post-Employment Benefits Plan Health Plan;
- Post-Employment Benefits Plan Employee Dental Plan; and
- NXP Pre-Tax Contributions and Health Care Flexible Spending Account Plan.

### ***NXP Medical Plan***

An NXP medical benefits plan that features coverage for most medical services, preventive care, a network of physicians and hospitals, well-baby care and more.

### ***NXP Rewards Customer Service***

Benefits administrator responsible for the 401(k) Retirement Plan and NXP Welfare Plan eligibility, appeals and customer service.

### ***NXP Welfare Plans***

NXP Employee Medical Plan, NXP Employee Dental Plan, NXP Employee Vision Plan, NXP Disability Income Plan, NXP Pre-Tax Contributions and Health Care Flexible Spending Account Plan, NXP Adoption/Assistance Program, NXP Dependent Care Flexible Spending Account Plan and Post-Employment Benefits Plan.

### ***Ophthalmologist***

A medical physician who specializes in the diagnosis and medical and surgical treatment of diseases and defects of the eye.

### ***Optometrist***

A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing corrective lenses and other optical aids.

### ***Opt Out***

Electing not to enroll in medical (including behavioral health and prescription drug), dental and/or vision coverage. NXP employees who opt out pay no contributions for coverage.

### ***Orthodontia***

A dental specialty that involves the correction of abnormally positioned teeth.

### ***Out-of-Area***

A term that describes participants who live in, or travel to, an area in the U.S. outside of the designated U.S. network areas.

### ***Out-of-Network Provider***

A physician or other health care provider who is not a part of a network and who has not agreed to charge the negotiated network fee schedule. If you live in a network area and use an out-of-network provider, the Plan pays a reduced (out-of-network) level of benefits, or no benefits.

### ***Own Occupation***

For Short-Term and Long-Term Disability Plan benefits, the occupation that you are routinely performing when your disability period begins. Your occupation will be viewed as it is normally performed in the national economy instead of how it is performed for your specific employer or at your location or worksite, and without required to your specific reporting relationship.

### ***Participant Contributions***

Your contributions to your 401(k) Retirement Plan account. You may contribute up to 75% of your pay, up to the 401(k) Elective Deferral Limit (plus catch-up contributions, if you are eligible). The automatic contribution is a regular (before-tax) contribution of 5% of pay, increasing 1% per year until you are contributing 10% of pay, but you may change your contribution level and type at any time. Regular, Roth and catch-up contributions are all participant contributions. You may invest participant contributions in one or more of the Plan's investment funds.

### ***Physician***

A licensed Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM) or Doctor of Dental Surgery (DDS), to the extent that each provides services within the scope of his or her license.

### ***Post-Service Claim***

Request for a plan benefit for which precertification is not required and payment is being requested for medical care already provided.

### ***Precertification***

Aetna Personal Health Advocate review and approval of a physician's recommendation for certain equipment, treatment, outpatient surgeries, testing, and non-emergency hospital admissions. Getting precertification where indicated for out-of-network care provides the highest level of coverage under the NXP Medical Plan.

### ***Predetermined Charge***

For the Dental Plan, the charge for a covered service negotiated between MetLife Dental and their network providers.

### ***Predetermination of Dental Benefits***

A review by MetLife Dental of a dentist's planned treatment and expected charges, including diagnostic charges, before providing the services. A predetermination of benefits remains effective for 90 days.

### ***Preferred Drug List***

List of medications health care experts have selected to be preferred drugs. The Medical Plan pays a higher level of coinsurance for preferred drugs than non-preferred drugs.

### ***Preferred Drugs***

Drugs clinical experts select to be placed on the Preferred Drug List. Drugs on the PDL cost participants less than non-preferred drugs. Preferred drugs have met rigorous clinical and therapeutic criteria.

### ***Prescription Drugs***

Brand name and generic drugs prescribed by a physician and dispensed by a pharmacist in a retail pharmacy or through a mail order service.

### ***Pre-Service Claim***

Request for a plan benefit for which the Plan requires the claimant to get approval of the benefit in advance of receiving the care.

### ***Pretreatment Estimate***

Itemized description from a dentist that describes the recommended dental procedure and how much it costs. Pretreatment estimates remain effective for 90 days.

### ***Primary Residence***

The place you primarily reside, as reported to the Plan Administrator.

### ***Primary Provider***

The following are generally considered NXP Medical Plan network primary providers:

- Family practitioner;
- General practitioner;
- Internist;
- Nurse practitioner, but only when billed by a primary physician's office;
- Obstetrician/gynecologist; and
- Pediatrician.

### ***Principal Sum***

Your business travel accident and accidental death and dismemberment insurance coverage amount is known as the “principal sum.”

### ***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.

### ***Provider***

Any person or facility that provides covered health care services under one of NXP’s Plans. Providers may include hospitals, physicians, counselors or technicians.

### ***Provider Network***

A group of U.S. hospitals, physicians, specialists, ancillary providers, etc., that meet specific criteria and that agree to provide services at negotiated rates to participants covered by NXP Medical Plans that include the network.

### ***Psychological Testing***

The administration and interpretation of standardized tests to assess an individual’s psychological/personality functioning.

### ***Qualified Domestic Relations Order (QDRO)***

A court order, approved by the Plan and meeting the requirements of ERISA, that requires all or a portion of the benefits payable from the 401(k) Retirement Plan or the Life Insurance Plan to be paid to someone else, usually a spouse or child for whom the participant has financial responsibility.

### ***Qualified Medical Child Support Order (QMCSO)***

A court order, approved by the Plan, that provides for health care coverage and allocation of responsibility for payment of costs for health care coverage for a child of the employee.

### ***Reasonable and Customary (R&C) Charge***

For the Dental Plan, the reasonable and customary (R&C) charge refers to the charge that is based on the lowest of:

- The dentist’s actual charge;
- The dentist’s usual charge for the same or similar services; or
- The charge of most dentists in the same geographic area for the same or similar services as determined by dental Claims Administrator.

### ***Recognized Charge***

The covered expense is only that part of a charge that is the recognized charge.

For medical expenses, the recognized charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For inpatient and outpatient hospitals and other facilities charges, 140% of the Medicare allowable rate for the geographic area where the service is provided; or
- For professional services and other services or supplies not mentioned above, 105% of the Medicare allowable rate for the geographic area where the service is provided.

### ***Residential Treatment Center***

A facility with 24-hours-a-day, voluntary, short-term supervised level of care provided to children, adolescents or adults with behavioral health illnesses previously not responsive to short-term interventions and/or those requiring crisis stabilization as an alternative to inpatient hospitalization. For treatment of alcoholism and substance use disorder, the facility must provide detoxification services and licensed behavioral health provider and/or substance use disorder professionals onsite 24-hours-a-day.

### ***Resource & Referral Program***

A service designed to provide NXP employees with information, resources and referrals on work and personal issues, as well as child care and elder care referral. Sometimes referred to as the NXP EAP program.

### ***Rh Factor***

A risk factor screened for in the Maternity Care Program. If the mother's blood type is Rh negative and the father's blood type is Rh positive, then the mother may produce antibodies to the fetus's red blood cells, which may cause complications. Hence, it is important to know the mother's and father's blood type, whether Rh negative or positive.

### ***Rollover***

A distribution from an eligible plan that you deposit in another eligible (tax-qualified) retirement plan, traditional individual retirement account (IRA), Roth IRA or other eligible plan.

### ***Routine Office Visit***

Visits with a physician or other provider covered under the medical plan in the physician's or provider's office or outpatient facility.

### ***Section 152 Dependent***

Under the provisions of Section 152 of the Internal Revenue Code that would apply under Plan terms, an individual is your “Section 152 dependent” if he or she is a “qualifying child” or a “qualifying relative.”

Generally, a “qualifying child” is a person who:

- Is your child or legal ward;
- Has the same principal place of abode as you for more than one-half of the taxable year;
- Either has not attained age 19 at the close of the taxable year or is a student who has not attained age 24 at the close of the year; and
- Does not provide more than 50% of his or her own support in the calendar year.

To be a “qualifying child,” the child must be your son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister, or a descendant of any such individual. An eligible foster child is treated as your child (an “eligible foster child” means a person who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction).

Generally, a “qualifying relative” is a person:

- Who is either your child or a person who has the same principal abode as you and who is a member of your household;
- Whose gross income for the calendar year is less than the exemption amount for the year;
- For whom you provide over 50% of his or her support in the calendar year; and
- Who is not a qualifying child of yours or any other person for the year.

### ***Short-Term Disability Benefit***

Percentage of base salary paid for up to 180 calendar days to an eligible employee who is under a physician’s care and continuously unable to perform the essential duties of his or her usual occupation due to a medically determinable physical or mental impairment.

### ***Short-Term Disability Buy-Up***

A program that enables you to increase your benefit coverage under the Short-Term Disability Plan by an additional 15%. You pay for this increased level of coverage through before-tax payroll deductions.

### ***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.

### ***Spouse/Domestic Partner Life Insurance***

Optional life insurance for which you make contributions. Spouse/domestic partner life insurance pays benefits for the loss of life of a spouse/domestic partner. Your after-tax contribution amount to pay for this benefit depends on the level of coverage selected, your spouse/domestic partner's age and their tobacco use status.

### ***Social Security Offset***

Any Social Security benefit paid to you for the same period that you receive benefits under the Disability Income Plan. This amount is offset from your Disability Plan benefit.

### ***Specialty Provider***

For the NXP Medical Plan, a health provider other than a **primary provider**. Examples of specialty providers include cardiologists, neurologists, dermatologists and podiatrists.

### ***Spouse***

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

For tax purposes, the Plans follow federal law to recognize a person as your spouse. If you are legally married in a state or country that recognizes same-sex spouses, your same-sex spouse is eligible for coverage as your spouse.

### ***Step Therapy Program***

A special feature of NXP's prescription drug coverage, this Program requires patients to try a generic drug for at least 30 days before providing benefits for certain brand name prescription drugs.

### ***Supplemental Life Insurance***

Life insurance coverage in addition to your Basic Life Insurance. You make contributions to pay for this coverage, which provides additional benefits to your survivors if you die while covered. Your after-tax contribution amount to pay for this benefit depends on the level of coverage selected, your age and your tobacco use status.

### ***Taxable Income***

Income subject to federal and some state income taxes.

### ***Teladoc***

When you enroll in an NXP Aetna medical plan, you have access to Teladoc, an added benefit that gives you 24/7 access to a national network of U.S. board-certified doctors. See [Teladoc](#), on page 59, for more information.

### ***Temporomandibular Joint Disorder (TMJ)***

A combination of three symptoms that consist of pain in the muscles of mastication and jaw joints, clicking in the jaw joints, and limitation in jaw movements. Lesser symptoms may include dislocation and/or locking of jaw joints and sensory changes in hearing.

### ***Terminated Disabled Participant (TDP)***

A former employee of NXP, Freescale or Motorola SPS who:

- Terminated employment due to disability according to NXP, Freescale or Motorola SPS's Medical Leave Policy;
- Was eligible to be covered under the Medical Plan, Dental Plan or Vision Plan until December 31, 2016 and has terminated employment;
- Continues to be entitled to disability benefits under the NXP Disability Income Plan; and
- Is younger than age 65.

### ***Timely Applicant***

An employee and/or an employee's eligible dependent who applies for dental coverage within 30 days of the eligibility date.

### ***Tobacco Non-Users Discount***

A discount applied to the contribution for employees and spouses/domestic partners required for coverage under the NXP Medical and Life Insurance Plans.

### ***Uniformed Service***

Service in the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, full-time National Guard Duty, the commissioned corps of the Public Health Service and any other category of persons designated by the President in time of war or emergency, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

### ***Urgent Care***

Care for medical situations of a serious but non-life-threatening nature, for which the patient needs immediate treatment.

### ***Urgent Care Claim***

Any claim for medical care for which the applicable periods for the Claims Administrator to make non-urgent care determinations could:

- Seriously jeopardize the claimant's life or health or his or her ability to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject him or her to severe pain that cannot be adequately managed without the care or treatment.

### ***U.S. Inpatriate***

U.S. Inpatriates are employees of NXP or a participating entity that are transferred from their home country to the U.S. for an extended assignment as determined by NXP Global Mobility. A U.S. Inpatriate is an NXP employee on the payroll of an NXP entity based in the United States, regardless of where the employee actually performs work. The benefits described in this SPD, except the medical (including behavioral health and prescription drug), dental and vision benefits, apply to you if you are a U.S. Inpatriate on U.S. payroll. See the [NXP Benefits](#) chart for details on eligibility.

### ***U.S. Expatriate***

U.S. Expatriates are employees of NXP or a participating entity that are on short-term or long-term assignment outside the U.S. as determined by NXP Global Mobility. A U.S. Expatriate is defined as an NXP employee on the payroll of an NXP entity based in the United States, regardless of where the employee actually performs work. The benefits described in this SPD, except the medical (including behavioral health and prescription drug), dental and vision benefits, apply to you if you are a U.S. Expatriate on U.S. payroll. See the [NXP Benefits](#) chart for details on eligibility.

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## 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
<b>Eligibility and Administration</b>		
<b>NXP Rewards Customer Service</b>	<b>Telephone:</b> 888-375-2367 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>NXP Rewards Customer Service Center</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475
<b>Dependent Verification Center</b>	<b>Telephone:</b> 888-375-2367 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>Dependent Verification Center</b> P.O. Box 1401 Lincolnshire, Illinois 60069-1401
<b>Premium Payments (COBRA and non-COBRA)</b>	<b>Telephone:</b> 888-375-2367 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>NXP</b> P.O. Box 0752 Carol Stream, Illinois 60132-0752
<b>Health Plans/Resources</b>		
<b>NXP Medical Plan</b> <ul style="list-style-type: none"> <li>Aetna Personal Health Advocate</li> <li>Behavioral Health Program</li> </ul>	<b>Telephone — Aetna Member Services:</b> 800-626-1987 8 a.m. – 6 p.m. local time <b>TDD:</b> 800-628-3323 <b>Website:</b> <a href="http://AetnaNavigator.com">AetnaNavigator.com</a>	<b>Claims:</b> <b>Aetna</b> P.O. Box 14079 Lexington, Kentucky 40512-4079
<b>Prescription Drug Program</b>	<b>Telephone:</b> 877-505-8360 <b>TDD:</b> 800-231-4403 <b>Website:</b> <a href="http://Caremark.com">Caremark.com</a>	<b>Mail order prescriptions:</b> <b>CVS Caremark</b> P.O. Box 659541 San Antonio, Texas 78265 <b>Claims:</b> <b>CVS Caremark</b> P.O. Box 52136 Phoenix, Arizona 85072
<b>Castlight</b>	<b>Telephone:</b> 800-681-4815 7 a.m. – 8 p.m. Central time <b>Website:</b> <a href="http://NXP.com/Castlight">NXP.com/Castlight</a>	
<b>Teladoc</b>	<b>Telephone:</b> 855-835-2367 <b>Website:</b> <a href="http://Teladoc.com/NXP">Teladoc.com/NXP</a>	
<b>Health Savings Account Administrator</b>	<b>Telephone:</b> 888-375-2367 <b>Fax:</b> 888-211-9900 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>Your Spending Account</b> P.O. Box 785040 Orlando, Florida 32878-5040

Plan/Program	Telephone/Website	Address
<b>Employee Assistance Program</b>	<b>Telephone:</b> 866-702-7435 <b>Website:</b> <a href="http://resourcesforliving.com">resourcesforliving.com</a> (Username: NXP; Password: member)	<b>Aetna Resources for Living</b> 151 Farmington Avenue Hartford, Connecticut 06156
<b>Flexible Spending Accounts — Health Care/Limited Use Health Care FSA and DCFSA</b>	<b>Telephone:</b> 888-375-2367 <b>Fax:</b> 888-211-9900 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>Claims:</b> <b>Your Spending Account</b> P.O. Box 785040 Orlando, Florida 32878-5040
<b>Dental Plan</b>	<b>Telephone:</b> 800-942-0854 <b>Website:</b> <a href="http://MetLife.com/dental">MetLife.com/dental</a>	<b>Claims:</b> <b>MetLife Dental Claims</b> P.O. Box 981282 El Paso, TX 79998-1282
<b>Vision Plan</b>	<b>Telephone:</b> 800-877-7195 <b>TTY:</b> 800-428-4833 <b>Website:</b> <a href="http://VSP.com">VSP.com</a>	<b>Claims:</b> <b>VSP</b> PO Box 385018 Birmingham, AL 35238-0518
<b>Wellness Reimbursement Program</b> (\$240 Wellness Activity Reimbursement)	<b>Telephone:</b> 888-375-2367 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>Claims:</b> <b>Your Spending Account</b> P.O. Box 785040 Orlando, Florida 32878-5040
<b>Disability and Life</b>		
<b>Disability Income Plan</b>	<b>Telephone:</b> 800-842-1718 <b>Fax:</b> 877-889-4885	<b>Claims:</b> <b>The Prudential Insurance Company of America</b> Disability Management Services P.O. Box 13480, Philadelphia, PA 19176
<b>Life and Accidental Death and Dismemberment Insurance - Basic, Supplemental, Spouse/Domestic Partner and Child(ren)</b>	<b>Telephone:</b> <ul style="list-style-type: none"> <li>• <b>Evidence of Insurability and Claims:</b> 800-638-6420</li> <li>• <b>Conversion Applications:</b> 877-275-6387</li> </ul>	<b>Claims:</b> <b>MetLife Group Life Claims</b> P.O. Box 6100 Scranton, PA 18505-6100
<b>Legal Services</b>		
<b>MetLaw® Legal Services Plan</b>	<b>Telephone:</b> 800-821-6400 <b>Website:</b> <a href="http://legalplans.com">legalplans.com</a>	<b>Appeals:</b> <b>Hyatt Legal Plans, Inc. Directory of Administration</b> Eaton Center 1111 Superior Avenue Cleveland, Ohio 44114-2507

Plan/Program	Telephone/Website	Address
<b>Savings and Wealth</b>		
<b>401(k) Retirement Plan</b>	<b>Telephone:</b> 888-375-2367 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>NXP Rewards Customer Service Center</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475
<b>401(k) Retirement Plan Investment Advice — GuidedChoice</b>	<b>Telephone:</b> 800-242-6182 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a> <b>Email:</b> help@guidedchoice.com	<b>GuidedChoice</b> 8910 University Center Suite 700 San Diego, CA 92122
<b>401(k) Retirement Plan Self-Directed Brokerage Account – Hewitt Financial Services</b>	<b>Telephone:</b> 800-890-3200 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>Hewitt Financial Services</b> PO Box 563901 Charlotte, NC 28256-3901
<b>Share Success Plan (Employee Stock Purchase Plan) – E*TRADE</b>	<b>Telephone:</b> 800-838-0908 <b>Website:</b> <a href="http://etrade.com">etrade.com</a>	
<b>Work/Life</b>		
<b>Adoption Assistance Program</b>	<b>Telephone:</b> 888-375-2367 <b>Website:</b> <a href="http://NXP.com/rewards">NXP.com/rewards</a>	<b>Claims:</b> <b>NXP Rewards Customer Service Center</b> P.O. Box 1475 Lincolnshire, Illinois 60069-1475
<b>NXP eDeals</b>	<b>Website:</b> <a href="http://NXP.corporateperks.com">NXP.corporateperks.com</a>	<b>New Hires:</b> Please allow two weeks for your information to be provided to eDeals.
<b>International SOS</b> Travel Assistance Program	<b>Telephone:</b> 800-523-6586 <b>Fax:</b> 215-354-2338 <b>Int'l:</b> +1-215-942-8226 <b>Website:</b> <a href="http://internationalsos.com/member-zone">internationalsos.com/member-zone</a> (log in with NXP corporate membership number)	<b>International SOS</b> 3600 Horizon Boulevard, Ste. 300 Trevose, Pennsylvania 19053 <b>NXP Corporate Membership Number:</b> 11BCPA000145