The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.nxp.com/rewards or call 1-888-375-2367. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-626-1987 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: **$0** Family: **$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	Individual: **$4,000** Family: **$8,000**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Contributions, benefit reductions, amounts greater than reasonable and customary charges and any expenses not covered by the plan.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	**No.**	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	——————————none——————————
	Specialist visit	$30 copay/visit	——————————none——————————
	Preventive care/screening/ immunization	No charge	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	——————————none——————————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	——————————none——————————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	**Retail**: $5 copay **Mail**: $10 copay	Covers up to a 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Limits may apply. **Note:** Prescription drug coverage is only available if you use a network provider. Please contact www.caremark.com for additional information.
	Preferred brand drugs	30% coinsurance (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Limits may apply. **You will pay no more than:** • $75 maximum per prescription (retail) for 30-day supply. • $175 maximum per prescription (mail order) for 90-day supply. **Note:** Prescription drug coverage is only available if you use a network provider. Please contact www.caremark.com for additional information.
	Non-preferred brand drugs	50% coinsurance (retail and mail order)	Covers up to a 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Limits may apply. **You will pay no more than:** • $100 maximum per prescription (retail) for 30-day supply. • $250 maximum per prescription (mail order) for 90 day supply. **Note:** Prescription drug coverage is only available if you use a network provider. Please contact www.caremark.com for additional information.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Specialty drugs	See your costs above for preferred and non-preferred brand drugs.	Contact Caremark at **1-800-237-2767** to apply for the Caremark Specialty Guideline Management Program. **Note:** Prescription drug coverage is only available if you use a network provider. Please contact **www.caremark.com** for additional information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Precertification may be required.
	Physician/surgeon fees	10% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit then 10% coinsurance	Copay waived if admitted.
	Emergency medical transportation	10% coinsurance	If medically necessary, ambulance service to a hospital for treatment. One round trip to another facility for medically necessary tests or treatment related to that confinement. Also, if medically necessary, emergency transportation by a regularly scheduled airline, railroad or air ambulance from the place you or your covered dependent becomes ill or injured to the nearest hospital qualified to provide special treatment.
	Urgent care	10% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Must be medically necessary based on diagnosis. Preauthorization required. If pre-authorization is not completed or is denied for non-network provider then you pay 50% coinsurance.
	Physician/surgeon fees	10% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit for office visits	——————none——————
	Inpatient services	10% coinsurance	Preauthorization required. If pre-authorization is not completed or is denied for non-network provider then you pay 50% coinsurance.
If you are pregnant	Office visits	Prenatal – No charge Postnatal – 10% coinsurance	——————none——————
	Childbirth/delivery professional services	10% coinsurance	Precertification is not required for normal delivery.
	Childbirth/delivery facility services	10% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Precertification required; limited to 120 days/calendar year.
	Rehabilitation services	10% coinsurance	Limited to a total of 120 visits/calendar year for all physical, occupational and speech therapy.
	Habilitation services	10% coinsurance	Limited to a total of 120 visits/calendar year for all physical, occupational and speech therapy.
	Skilled nursing care	10% coinsurance	Must be medically necessary and in lieu of hospital stay; limited to 120 days/calendar year.
	Durable medical equipment	10% coinsurance	Limits may apply.
	Hospice services	10% coinsurance	Limited to patients with a life expectancy of twelve months or less.
If your child needs dental or eye care	Children's eye exam	Not covered	——————none——————
	Children's glasses	Not covered	——————none——————
	Children's dental check-up	Not covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limits apply)
- Bariatric surgery (limits apply)
- Chiropractic care (limits apply)
- Hearing aids (limits apply)
- Infertility treatment (limits apply)
- Private duty nursing (limits apply)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-375-2367

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.nxp.com/rewards or by calling 1-888-375-2367.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,120**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests (*blood work)*
Prescription drugs
Durable medical equipment (*glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$380
Coinsurance	$1,260
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$190
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$350**

The plan would be responsible for the other costs of these EXAMPLE covered services.