

Medical Plan Comparison

Plan Year January 2021 - December 2021



BENEFIT	UHC							
	Medical Plan 1 (HSA Eligible)		Medical Plan 2		Medical Plan 3		Kaiser Permanente HMO Kaiser Traditional Plan	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Health Savings Account (HSA) Contribution	\$500 Individual / \$1,000 Family		Not available		Not available		Not available	
Individual Deductible	\$1,500	\$7,500	\$300	\$1,500	\$200	No Coverage	\$0	No Coverage
Family Deductible	\$3,000	\$15,000	\$600	\$3,000	\$400	No Coverage	\$0	No Coverage
Individual Out of Pocket Max	\$4,000	\$12,500	\$5,000	\$12,500	\$5,000	No Coverage	\$1,500	No Coverage
Family Out of Pocket Max	\$7,350	\$25,000	\$10,000	\$25,000	\$10,000	No Coverage	\$3,000	No Coverage
Coinsurance	20%	50%	20%	50%	10%	No Coverage	None	
Virtual Visit Copay (Teledoc)	You pay no more than \$50	N/A	\$10	N/A	\$10	N/A	Not available	
Office Visit - Primary care physician	Deductible/Coinsurance	Deductible/Coinsurance	\$20	Deductible/Coinsurance	\$20	No Coverage	\$35	No Coverage
Office Visit - Specialist	Deductible/Coinsurance	Deductible/Coinsurance	\$40	Deductible/Coinsurance	\$40	No Coverage	\$35	No Coverage
Preventive Care	Covered 100%	Deductible/Coinsurance	Covered 100%	Deductible/Coinsurance	Covered 100%	No Coverage	Covered 100%	No Coverage
Hospital - Inpatient	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	No Coverage	\$500	No Coverage
Additional Hospital Copay	-	-	-	-	-	-	-	-
Outpatient Surgery	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	Deductible/Coinsurance	No Coverage	\$150	No Coverage
Emergency Room	Deductible/Coinsurance	Deductible/Coinsurance	\$100 copay then 10% after deductible; copay waived if admitted	\$100 copay then 10% after deductible; copay waived if admitted	\$100 copay then 10% after deductible; copay waived if admitted	\$100 copay then 10% after deductible; copay waived if admitted	0%	
Additional ER Copay	None	-	\$100	-	\$100	-	\$150	
PHARMACY BENEFITS (Retail/Home Delivery)	CVS/Caremark							
Generic	Deductible/Coinsurance	-	\$5 / \$10	-	\$5 / \$10	-	\$10 / \$20	-
Preferred Brand	Deductible/Coinsurance	-	30% up to \$75 / 30% up to \$175	-	30% up to \$75 / 30% up to \$175	-	\$30 / \$60	-
Non-preferred Brand	Deductible/Coinsurance	-	50% up to \$100 / 50% up to \$250	-	50% up to \$100 / 50% up to \$250	-	\$30 / \$60	-

All amounts listed refer to the amounts you pay. For example, if 10% is listed then that means you pay 10% coinsurance and NXP pays 90% coinsurance.

All references to Deductible/Coinsurance means that once you've met your deductible for the year, you are just responsible for the coinsurance amount.

All references to "Individual" mean You Only or Employee Only. References to "Family" mean employee plus one or more covered dependents.

The Medical Comparison Chart provides only an overview of your employee benefits. The respective plan documents and policies govern your rights. You should rely on this information only as a general summary of some of the features of the plans and policies. In the event of any difference between the information contained herein and the plan documents and policies, the plan documents and policies will supersede this guide. NXP reserves the right at any time to amend, modify or terminate one or more of the plans or policies described in this communication.