



Plan 3



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, visit www.nxp.com/benefits 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 1-844-210-5428 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>Network</u> : \$400.00 Individual / \$800.00 Family <u>Non-Network</u> : Not Covered per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<u>Are there services covered before you meet your deductible?</u>	Yes. <u>Preventive Care</u> and primary care services with <u>copay</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
<u>Are there other deductibles for specific services?</u>	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.
<u>What is the out-of-pocket limit for this plan?</u>	For <u>network provider</u> : \$5,000.00 Individual / \$10,000.00 Family per calendar year For <u>out-of-network providers</u> : Not Covered	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u>?	Yes. See www.myuhc.com or call 1-844-210-5428 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20.00 <u>copay</u> /visit	Not covered	Virtual Visit - in-network \$10.00 <u>copay</u> per visit by a Designated Virtual Network Provider.
	<u>Specialist</u> visit	\$40.00 <u>copay</u> /visit	Not covered	If you receive services in addition to office visit, additional copays, <u>deductibles</u> , or co-insurance may apply.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.rightwayhealthcare.com	Generic Drugs	Retail: \$5 copay Mail Order: \$10 copay	Not covered	Covers up to 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Limits may apply.
	Preferred brand drugs	30% coinsurance (retail and mail order)	Not covered	Covers up to 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Limits may apply. <ul style="list-style-type: none">• \$75 maximum per prescription (retail) for 30-day supply.• \$175 maximum per prescription (mail order) for 90-day supply.
	Non-preferred brand drugs	50% coinsurance (retail and mail order)	Not covered	Covers up to 30-day supply (retail prescription); 31- to 90-day supply (mail order prescription). Limits may apply. <ul style="list-style-type: none">• \$100 maximum per prescription (retail) for 30-day supply.• \$250 maximum per prescription (mail order) for 90-day supply.
	<u>Specialty drugs</u>	See your costs above for preferred and non-preferred brand drugs.	Not covered	Contact Rightway at 1-833-502-8179 if you have questions about your specialty medications.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$100.00 <u>copay</u> /visit 10% <u>coinsurance deductible</u> does not apply	\$100.00 <u>copay</u> /visit 10% <u>coinsurance deductible</u> does not apply	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$30.00 <u>copay</u> /visit	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20.00 <u>copay</u> /visit	Not covered	Partial <u>hospitalization</u> /intensive outpatient treatment, in- <u>network</u> 10% after <u>plan deductible</u> . Intensive Behavioral Therapy (ABA) in- <u>network</u> 10%, no <u>deductible</u> . NXP Care Connect is limited to 5 visits per issue per calendar year.
	Inpatient services	10% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	\$20.00 <u>copay</u> /initial visit only	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	Limited to 120 visits per calendar year for <u>Home Health Care</u> and 120 visits per calendar year for Outpatient Private Duty Nursing.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	Not covered	Physical, Occupational, Speech and Cognitive Rehabilitation Therapy limited to 120 combined visits per calendar year. Visit Limit does not apply to members with a behavioral diagnosis.
	<u>Habilitation services</u>	Not covered	Not covered	<u>Habilitation Services</u> are not covered.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	Limited to 120 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$40.00 <u>copay/visit</u>	Not covered	Limited to 1 visit per calendar year.
	Children's glasses	Not covered	Not covered	Children's glasses are not covered.
	Children's dental check-up	Not covered	Not covered	Children's dental check-up is not covered.

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	• Long-term care	• Routine foot care
• Dental Care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Habilitation Services		

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

• Acupuncture	• Chiropractic care	• Infertility treatment
• Adult routine vision exam (i.e. refraction)	• Hearing aids	• Private-duty nursing
• Bariatric Surgery		

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. 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 on how 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: 1-844-210-5428 or visit www.myuhc.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium](#) tax credit.

Does this [plan](#) meet the Minimum Value Standards? No

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 1-844-210-5428.

Traditional Chinese (中文): 如果需要中文的帮助, [请拨打这个号码](#) 1-844-210-5428.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-844-210-5428.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-210-5428 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-210-5428.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-210-5428.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaangi tilifon ye 1-844-210-5428.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-844-210-5428.

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

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 <u>plan's</u> overall <u>deductible</u>	\$400.00
■ <u>Specialist copayment</u>	\$40.00
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400.00
<u>Copayments</u>	\$0.00
<u>Coinsurance</u>	\$1,200.00
<i>What isn't covered</i>	
Limits or exclusions	\$70.00
The total Peg would pay is	\$1,670.00

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$400.00
■ <u>Specialist copayment</u>	\$40.00
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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 \$5,600

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100.00
<u>Copayments</u>	\$200.00
<u>Coinsurance</u>	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$4,300.00
The total Joe would pay is	\$4,600.00

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$400.00
■ <u>Specialist copayment</u>	\$40.00
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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 \$2,800

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400.00
<u>Copayments</u>	\$200.00
<u>Coinsurance</u>	\$200.00
<i>What isn't covered</i>	
Limits or exclusions	\$10.00
The total Mia would pay is	\$810.00