MOTOROLA SOLUTIONS
HEALTH AND WELFARE
BENEFITS BOOK

This U.S. Health and Welfare Benefits Book is effective January 1, 2018
ABOUT THIS MATERIAL

This Health and Welfare Benefits Book represents general information regarding the benefit programs under the Motorola Solutions Health and Welfare Plan (each the “Plan,” or collectively, the “Plans”). You shouldn’t rely on this information other than as a general summary of each Plan’s features.

This Health and Welfare Benefits Book, together with the relevant benefit booklets and summaries of the insurance providers that are in effect for the benefits you elect, constitute the summary plan description (“SPD” or “Summary Plan Description”) in effect as of January 1, 2018 for the Plans that require an SPD under the Employee Retirement Income Security Act (ERISA). Please see the prior SPDs and Summaries of Material Modifications (SMMs) for information concerning the Plan’s provisions before that date. Subsequent SPDs or SMMs will be provided to advise you of changes in the Plans as required by the Employee Retirement Income Security Act (ERISA).

Your rights are governed by the terms of the respective Plan documents. You should refer to the Plan documents and insurance information, such as the Summary of Benefits and Coverage, for full details on your rights and obligations under the Plans. Any questions concerning the Plans will be determined in accordance with the terms of the Plan documents, not this Summary Plan Description. You may obtain a copy of the Health and Welfare Plan documents upon written request to the Motorola Solutions Employee Service Center (“Employee Service Center”). There may be a reasonable charge for such copies.

In the event of any difference between the terms of this Summary Plan Description and the Plan documents or insurance information, the terms of the Plan documents or insurance information will control.

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

Motorola Solutions, Inc., as the Plan sponsor, reserves the right, at any time, to amend, modify or terminate one or more of the Plans described here. Motorola Solutions, Inc. has delegated the authority to amend the Plans and programs described in this SPD to the Motorola Solutions, Inc. Administrative Committee.
INTRODUCTION

There are many important decisions to make regarding your and your family’s health care coverage. This SPD describes our health and welfare benefits for employees and their dependents and provides useful information to help you make choices that match your lifestyle. Your eligibility for these Plans will depend on your personal circumstances.

THE MAIN SECTIONS

This material is divided into the following main sections:

Health Care Plans (Medical, Prescription, Dental and Vision)

- **Eligibility and Coverage:** This section defines the requirements and details regarding eligibility for medical, vision, and dental coverage.
- **Important:** The medical, prescription, dental and vision benefits that are available to you are separately described in the relevant benefit booklets and summaries of the insurance providers that are in effect for the benefits you elect on the AON Active Health Exchange.

Spending Accounts

There are several different ways you can pay for eligible health care and dependent care expenses on a pretax basis. This section describes each type of account and the eligibility requirements to participate in the accounts.

- **Health Savings Account (HSA):** This section outlines information you need to know about the HSA, including eligibility requirements.
- **Health Care Flexible Spending Account (FSA):** This section outlines information you need to know about the Health Care FSA (both the limited-purpose FSA and the general-purpose FSA), including eligibility requirements.
- **Dependent Care Account (DCA):** This section outlines information you need to know about the DCA, including eligibility requirements.

Life Insurance

This section explains your life insurance coverage, as well as coverage for your dependents, and your accidental death and dismemberment coverage.

Disability

This section provides information on short- and long-term disability protection.

Work/Life

This section includes information on programs that assist with daily needs, such as child care assistance, adoption assistance, and business travel medical and accident coverage.
General Administration

This section provides information to help you take advantage of your benefits as your situation changes, including:

- **Life events tables**: Easy-to-use charts to help you know what you need to do and when
- **Administration information**: Your ERISA rights and other important Plan information
- **Glossary**: Explanations of commonly used terms and phrases
- **Contact information**: A handy reference of telephone numbers, websites and other resources available for additional benefits program information
# TABLE OF CONTENTS

## WHAT’S INSIDE

- Explanations of welfare benefits, with helpful charts and tables
- Tips on getting the most from your benefits
- Important facts, dates and deadlines

Keep this information handy, and refer to it often as your resource for information.

## ELIGIBILITY AND COVERAGE

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### SOME GENERAL TIPS ON USING YOUR HEALTH AND WELFARE BENEFITS BOOK

If you’re reviewing your book online:

- Selecting web addresses will quickly redirect you to that website.
- Selecting the **Contact** reference will redirect you to the **Contact Information** subsection of the General Administration section, where you can find more details.
- Selecting a linked subsection will redirect you to that subsection within the book for more information.

**LOOK FOR THE **⚠️** ICON FOR IMPORTANT ALERTS THAT REQUIRE YOU TO TAKE ACTION.**

Be sure to read the content in the callouts for important details.
ELIGIBILITY AND COVERAGE

Overview

- This section summarizes eligibility and coverage requirements for the medical, vision and dental plans (the “Health Care Plans”). Additional details regarding eligibility and coverage for disability, life insurance and special medical programs are described within the subsections that cover the specific program.
- Keep this and your insurance benefits booklets and summaries in a convenient place and refer to it and your benefits booklets and summaries regularly as your source of information for taking steps to build better health. You may also access this information via mySolutions and on the AON Active Health Exchange.

You and your dependents must meet certain eligibility requirements before you may begin or maintain coverage under the Health Care Plans. This section includes important eligibility, enrollment and coverage information, including:

- **Eligibility**: Who’s eligible for the Health Care Plans
- **Enrollment**: When you may enroll yourself and your eligible dependents in the Health Care Plans
- **Beginning coverage**: When medical, vision and dental coverage begins for you and your eligible dependents
- **Changing coverage**: Instances when you may change coverage during the calendar year, including what’s considered a qualifying change in status and other times when you may make midyear coverage changes
- **Ending coverage**: When your medical, vision and dental coverage ends, when coverage ends for a dependent, and in what instances coverage continues if you stop working
- **Other important facts about coverage**: Including tax implications, how Motorola Solutions handles the confidentiality of your health information, what happens to your coverage if you work beyond age 65, and how the Health Care Plans coordinate with benefits you may be eligible for from other coverage
- **Continuation rights**: Your medical, vision and dental coverage continuation rights under the federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985)
- **If you’re denied coverage**: You may request a review and file an appeal

Continue reading to learn more about eligibility, enrollment and coverage information as it pertains to the Health Care Plans.
Who’s Eligible

To be covered under the Health Care Plans, you and your dependents must meet certain eligibility requirements.

Your Eligibility Requirements

You’re eligible for the Health Care Plans if:

- You’re a domestic employee of a company that participates in the Health Care Plans;
- You’re regularly scheduled to work at least 20 hours per week;
- Your regular paycheck is processed by the company’s U.S. payroll department; and
- You’re actively at work on the day your coverage becomes effective.

If you’re a member of a group of employees who become employees of the company as a result of a merger, an acquisition, or the ending of a joint venture in which the company took part, you’ll be eligible only if, and to the extent that, Motorola Solutions, Inc., or its delegate, expressly extends coverage under the Health Care Plans to your group.

You’re not eligible for the Health Care Plans if:

- You provide services under an independent contractor, consultant or employee leasing agreement;
- You’re an intern or co-op student and are employed for less than 90 days;
- You’re classified as contract labor;
- You provide services at a location outside of the U.S. and you are paid on a non-U.S. payroll; or
- You’re a collective bargaining employee (unless your union agreement provides for your participation in the Health Care Plans).

You will not be considered an eligible employee even if a third party subsequently recharacterizes you as a common law employee of the company.

Dependent Eligibility Requirements

You may enroll a dependent under the Health Care Plans if he or she is:

- Your legally recognized spouse;
- Your domestic partner; or
- Your dependent child who is your:
  - Natural-born child;
  - Adopted child or child placed with you for adoption (even if the adoption is pending and not yet final);
  - Stepchild;

For the purpose of coverage under the Health Care Plans, a spouse is a person to whom you’re legally married if the marriage is recognized in the jurisdiction in which you are married. See Domestic partner eligibility requirements for details regarding eligibility for domestic partners.
— Child for whom you have legal guardianship; or
— Domestic partner’s child who lives with you (see Domestic partner eligibility requirements for details).

Such dependent children are eligible for coverage through age 25, regardless of student, residence or marital status. Although you may enroll your eligible adult child regardless of his or her marital status, you may not enroll his or her spouse and/or children.

If you’re enrolled in high deductible medical plan, make sure you read the specific details regarding adult child coverage under a Health Savings Account (HSA).

Incapacitated dependent requirements

A dependent child may remain eligible beyond age 26 if he or she becomes incapacitated while covered under the Health Care Plans. If a dependent child becomes incapable of sustaining employment due to a mental or physical disability, such individual may continue to qualify as an eligible dependent under the Health Care Plans regardless of age until such incapacity ends. This coverage may be extended only to a dependent child who was covered under the Motorola Health Care Plans on December 31, 2010. You must furnish proof of incapacity and dependency to the Plan Administrator within 60 days of the date your child turns age 26. Contact the Motorola Solutions Employee Service Center for further details.

Domestic partner eligibility requirements

“Eligible dependent” includes your domestic partner as well as your domestic partner’s natural children, adopted children, or children for whom your domestic partner is a legal guardian, as long as you provide more than one-half of the child’s support and the child resides principally in your home. Your dependent is considered an eligible dependent as long as he or she meets either the dependent child eligibility requirements or the domestic partner eligibility requirements. The following eligibility requirements must be met for domestic partnership:

- You and your domestic partner are registered as domestic partners or have entered into a civil union in accordance with applicable city, county or state laws.
- In the absence of domestic partner registration, all of the following requirements must be met:
  - You and your domestic partner must be at least 18 years of age.
  - You and your domestic partner must not be related to one another to a degree that would prevent marriage under the law of the state where you live.
  - Neither you nor your domestic partner is married to another person under statutory or common law, and neither of you is in another domestic partnership.
  - You and your domestic partner are in a single, dedicated relationship with each other, have been in such relationship for at least six consecutive months, and intend to remain in the relationship indefinitely.
  - You and your domestic partner share the same residence and have shared the same residence for at least six consecutive months.
Qualifying Tax Dependents

If you enroll a domestic partner or a domestic partner’s child who is not a tax-qualifying dependent (per Internal Revenue Code [IRC] Section 152) for medical, vision or dental coverage, you must pay for that dependent’s coverage on an after-tax basis.

To be an eligible IRC Section 152 dependent, your domestic partner or the child of your domestic partner must meet the requirements under IRC Section 152 as a “qualifying relative.”

To be a “qualifying relative,” the individual must:

- Bear a specified relation to you (for a list of such relations, see the definition of “qualifying relative” in the Glossary) or be an individual who has the same principal residence as you and is a member of your household;
- Receive more than one-half of his or her support from you; and
- Not be a qualifying child of you or of any other taxpayer for the year.

A qualifying relative must also be a U.S. citizen or national, or a resident of the U.S. or a country contiguous to the U.S. (there is an exception for certain adopted children).

The cost of any medical, vision and dental coverage that Motorola Solutions provides is included in your reportable income. The current-year cost of medical and dental coverage that Motorola Solutions provides can be found on Your Benefits Resources.

Therefore, before enrolling your domestic partner or domestic partner’s child for medical, vision or dental coverage, check with your tax adviser to determine how these additional benefits affect your personal income tax situation. Different rules may apply for state income tax purposes.

If your domestic partner, or his or her child, is your qualified tax dependent for benefit purposes, you must call the Motorola Solutions Employee Service Center to verify his or her tax status annually to avoid imputed income on the cost of your domestic partner’s or his or her child’s health care coverage provided by Motorola Solutions. You need to verify his or her tax status no later than December 1 of each year to ensure unnecessary imputed income is not included on your Form W-2 or Form 1099 for that calendar year. Also, if you have a same-sex spouse with health care coverage provided by Motorola Solutions, you should contact the Employee Service Center to avoid future imputed income on the value of company-provided coverage for him or her. Motorola Solutions is entitled to rely on your representations regarding the tax status of your covered dependents.

Enrolling in Coverage

You can enroll in the health care coverage of your choice. You should also elect the appropriate coverage if you want to enroll your eligible dependents for medical, vision and/or dental coverage.
Coverage Categories

You can choose the level of coverage that fits your needs.

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<td>Employee + spouse/domestic partner</td>
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<td>Employee + child(ren)</td>
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<td>Family</td>
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<td>Opt out / No coverage</td>
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<th>Vision</th>
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<td>No coverage</td>
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The coverage category you elect remains in effect for the calendar year (unless you choose to change your coverage based on a qualifying change in status or other applicable change event during the calendar year).

How to Enroll a New Eligible Dependent

Visit Your Benefits Resource or call the Motorola Solutions Employee Service Center to enroll a new eligible dependent within 31 days of a qualifying change in status. (See Qualifying change in status for details.)

Your dependent is considered an eligible dependent as long as he or she is a spouse or meets either the dependent child eligibility requirements or the domestic partner eligibility requirements.

Enrolling Yourself and Your Eligible Dependents

If you want to cover yourself and/or your eligible dependents, elect the appropriate coverage category for medical, vision and/or dental coverage when you enroll. You may not cover your spouse and dependents if you do not elect coverage for yourself. You may enroll as shown in the table below.
## When to Enroll

<table>
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<th>Coverage</th>
<th>When to enroll yourself and your eligible dependents</th>
<th>You and your enrolled eligible dependents can enroll in:</th>
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</table>
| Medical  | - Within 31 days of when you (or your dependent) initially meet the eligibility requirements  
- During annual enrollment  
- When you have a qualifying change in status or other applicable change event (see *When coverage can be changed* for details)  
- If a special enrollment opportunity occurs (see *Other applicable change events* for details) | - The health care programs available in the AON Active Health Exchange |
| Vision   | - Within 31 days of when you (or your dependent) initially meet the eligibility requirements  
- During annual enrollment  
- When you have a qualifying change in status or other applicable change event* (see *When coverage can be changed* for details) | - The vision care programs available in the AON Active Health Exchange |
| Dental   | - Within 31 days of when you (or your dependent) initially meet the eligibility requirements  
- During annual enrollment  
- When you have a qualifying change in status or other applicable change event* (see *When coverage can be changed* for details) | - The dental care programs available in the AON Active Health Exchange |

*Employee must be currently enrolled.

## Proof of Dependent Status

The Motorola Solutions Employee Service Center may require verification of your dependents’ status at any time, including a valid Social Security number for any dependent (over the age of 2). If you don’t provide the necessary verification on a timely basis as requested, coverage under the Health Care Plans for your dependents will end.

## Coverage for Spouses

If you get married, you may enroll your legally recognized spouse for medical, vision and/or dental coverage. Coverage begins on the date of your marriage, provided you apply for coverage and enroll your eligible spouse within 31 days after your marriage.
Coverage for Domestic Partners

You may enroll your domestic partner for medical, vision and/or dental coverage within 31 days of a qualifying change in status or other applicable change event, or during the annual enrollment period, provided you and your domestic partner meet specific eligibility requirements. See Domestic partner eligibility requirements for details. Also, see When coverage can be changed for details.

If you’re not currently enrolled in the vision care or dental care programs, you may not elect coverage for either yourself or your spouse or domestic partner until the next annual enrollment period.

Additional Income if Your Dependent Doesn’t Meet IRC Requirements

The Internal Revenue Code (IRC) allows you to exclude the amount Motorola Solutions spends to provide you with medical, vision or dental coverage from your reportable income. This exclusion also extends to coverage the company provides to your tax-eligible dependents under IRC Section 152.

Motorola Solutions has chosen to extend health care coverage to certain dependents beyond those who are defined under IRC Section 152 as eligible for tax-favored benefits. As a result, in addition to the monthly contribution you pay for your dependents’ health care coverage, it’s necessary to impute income for the coverage for those covered dependents who are not tax-eligible dependents under IRC Section 152.

Your reportable income includes the value of any health care coverage the company provides to dependents who aren’t tax dependents under IRC Section 152. The IRS values the medical, vision and dental coverage provided by the company at its fair market value. This amount will be considered imputed income to you. Imputed income is taxable, which means it increases your taxable gross income for federal and state income taxes, as well as for FICA (Social Security and Medicare) and FUTA (Unemployment). This additional income is reported on the Form W-2 that’s sent to you and the Internal Revenue Service (IRS) each January. Based on IRS requirements, imputed income applies only to coverage of an eligible dependent who isn’t your tax dependent. If you rightfully claim your covered dependent as your tax dependent, you should have no imputed income.

If you enroll a domestic partner or a child of a domestic partner for coverage in the medical, vision or dental plans, you should contact the Motorola Solutions Employee Service Center to verify your dependent’s tax status to avoid any unnecessary federal or state imputed income.

You should consult your tax adviser if you’re not sure whether your dependents qualify as “tax dependents.”

Dual Motorola Solutions Employees

If both you and your spouse/domestic partner are employed by Motorola Solutions, you have various options for enrollment in the Health Care Plans. For example, each of you may enroll for employee-only medical, vision and/or dental coverage, or one of you may opt out of coverage and enroll as an eligible dependent under your spouse/domestic partner’s coverage (employee + spouse/domestic partner). However, you can’t enroll in the Health Care Plans under your own coverage and also be covered as an eligible dependent under your spouse/domestic partner. In addition, your children may be covered as dependents under either you or your spouse/domestic partner, not under both.
Divorce/End of Domestic Partnership

Your ex-spouse/domestic partner isn’t eligible to remain covered under the Health Care Plans after your marriage (or domestic partnership) ends. You must notify the Employee Service Center within 31 days of the date of your divorce or the date your domestic partnership ends.

If you get divorced, your dependents’ eligibility for medical, vision and/or dental coverage can be affected. To inquire about your dependents’ continuing eligibility, contact the Employee Service Center before the date of your divorce. If you’re required to cover your eligible dependent child under the terms of a Qualified Medical Child Support Order, see Qualified Medical Child Support Order for details. Also refer to Health Care Plans continuation rights under COBRA for details regarding continuing coverage.

If You’re Rehired

If you’re rehired within 31 days after your employment with Motorola Solutions ends, your coverage will be automatically reinstated to what was in place as of your previous last day worked.

If your rehire date is more than 31 days from your prior termination date, you should enroll for coverage within 31 days of your rehire date on Your Benefits Resources. If you don’t enroll, you’ll have no medical, vision or dental coverage.

Monthly Contributions

You and Motorola Solutions share the cost of your medical, vision and dental coverage under the Health Care Plans. Your contribution depends on which coverage option you select and whether you elect individual or family coverage. As a participant, you pay a monthly pretax contribution that’s deducted from your paycheck. You’ll be notified of the contribution for the upcoming year for medical, vision and dental coverage during annual enrollment.

When Coverage Begins

As long as you meet the eligibility requirements, your coverage under the Health Care Plans begins on the day you start work. If you’re not working when your coverage is scheduled to begin, coverage begins on the date you actually start work. Your coverage won’t start until you’ve reported to work on your first day of employment.

Making Benefit Elections

If you’re a new employee, you may enroll online on Your Benefits Resources within 31 days from your hire date. Once you make an election, you can’t change your coverage under the Health Care Plans during the year (unless you experience a qualifying change in status or other applicable change event during the year). If you do not elect vision care or dental when you’re hired, you’ll have to wait until the next annual enrollment period to elect coverage to begin on the following January 1.

You have an opportunity to keep or change your coverage each year during annual enrollment. The coverage you elect during the annual enrollment period takes effect the following January 1. Each fall, you’ll receive materials specific to that enrollment period that describe the coverage options and costs for the upcoming calendar year.
If you experience a qualifying change in status or other applicable change event during the year and want to change your coverage, you can make those changes on Your Benefits Resources or by calling the Employee Service Center. See **When coverage can be changed** for details.

### Earliest Date Coverage Can Begin

<table>
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<tr>
<th>Coverage</th>
<th>When your coverage begins*</th>
<th>When coverage for your eligible dependents begins*</th>
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<tr>
<td>Medical</td>
<td>The day you begin work if you enroll within 31 days of that date.</td>
<td>The day you begin work if you enroll your eligible dependents within 31 days of that date.</td>
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<td>Dental</td>
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<td>Vision</td>
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*Under some circumstances, a late enrollment may be permitted between 32 and 60 days after you begin work. See **Late Enrollment**.

### QUESTIONS?

**Contact** the Motorola Solutions Employee Service Center as your primary resource for questions regarding your eligibility under the Health Care Plans.

### When Coverage Can Be Changed

There are certain events and situations when you can make a change to your medical, vision or dental coverage. The information below explains when and how you can make changes to your coverage.

You can make coverage changes during any of the following times:

- During the annual enrollment period.
- Within 31 days of a qualifying change in status or other applicable change event — within 60 days if your State Children's Health Insurance Program eligibility changes.

### Annual Enrollment Period

Each year during the annual enrollment period, you have an opportunity to change your coverage elections under the Health Care Plans for the following year. When you elect a coverage change it will take effect the following January 1. Your annual coverage elections remain in effect from January 1 through December 31 unless you change your elections in accordance with the provisions described in the following sections.

Coverage you have in place for the current year will continue to the next calendar year, unless you elect to make changes to your coverage elections or if you have been notified the benefit option is no longer available.

### Qualifying Change in Status and Other Applicable Change Events

Generally, once you make your elections for the year, you can’t change them until the next annual enrollment period, unless you experience a qualifying change in status that affects your eligibility for certain benefits. This means that you can change your coverage under the Health Care Plans — as long as the change is consistent with the event. An eligible event would allow you to add or decrease your
level of coverage (such as changing from employee-only coverage to employee + spouse/domestic partner coverage due to marriage) or change your current plan election.

Eligible qualifying change in status events include:

- An increase or decrease of your eligible dependents due to:
  - The birth, adoption or placement for adoption of your child
  - Your marriage
  - Your domestic partner becoming eligible for coverage
  - Your divorce
  - Ending your domestic partnership
  - The death of your dependent

- A change in employment status by you, your spouse/domestic partner, or your dependent child that affects coverage, including:
  - Termination or commencement of employment
  - A switch from part-time to full-time status, or vice versa
  - Commencement or return from a leave of absence
  - Change in a work site location
  - Any other change in employment status that affects your or your dependent’s health coverage

- A change in residence that affects your or your dependent’s coverage

- Any other event recognized under applicable law and regulations as a reason to change an election under the Health Care Plans.

Other Applicable Change Events

You may change certain coverages under the Health Care Plans if you have a special enrollment opportunity that qualifies under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if the changes are initiated under a Qualified Medical Child Support Order (QMCSO), or if there is a significant cost or coverage change. You have a special enrollment opportunity if:

- You acquire a new dependent due to marriage or birth, adoption or placement for adoption

- You or your eligible dependents lose coverage under another group health plan because:
  - You or your dependents exhaust Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage under another employer’s group health plan (other than because of failure to pay contributions or for cause)
  - The employer contributions toward the other group health plan coverage terminate
  - You or your dependents lose eligibility under the other group health plan

Special enrollment rights allow you and your dependents to enroll in your medical coverage as of the date of the event and participate in the Flexible Spending Account (FSA), as long as you request the change within 31 days of the event. If you request a change in coverage, the new coverage will become effective the first of the following month, unless you specifically request the change to become effective on the date of the event.
Qualified Medical Child Support Order (QMCSO)

You may become subject to a Qualified Medical Child Support Order (QMCSO) that requires you to provide health coverage for a child. If this is the case, you may change your medical, vision and/or dental coverage accordingly. The changes you elect take effect on the first day of the month following the month in which the Plan Administrator determines that the order is a QMCSO.

At your request, the Motorola Solutions Employee Service Center will furnish QMCSO procedures that describe the process you must follow when entering a QMCSO. You can get more information at Alight’s Qualified Order Center website at www.qocenter.com. You can obtain procedures and model language for a QMCSO, check on the status of an existing order, or get answers to frequently asked questions. You can also call the Employee Service Center or email gocenter@alight.com.

Significant Cost or Coverage Change

You may also change your medical, vision and/or dental coverage midyear if:

- The cost of your current coverage option significantly increases or significantly decreases;
- An event occurs that significantly curtails coverage or causes you to lose coverage under your current coverage option;
- A coverage option is added or is significantly improved under the Health Care Plans during the year, and you’re eligible for that option;
- You, your spouse/domestic partner, or your eligible 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 under another employer’s 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 Health Care Plans (the event is the date your coverage changes, not the date of your annual enrollment under the other plan); or
  - If the other employer’s plan allows you or your dependent to change elections due to the reasons described in this section (qualifying change in status, special enrollment, QMCSO, significant cost or coverage changes, and Medicare or Medicaid entitlement).

The request for a change in coverage must be made within 31 days of the significant cost or coverage change. Your election takes effect the first day of the month following the date in which the change occurred once the Motorola Solutions Employee Service Center approves your coverage change.

YOUR COVERAGE CONTINUATION RIGHTS (COBRA)

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for the continuation of coverage for some health care benefits if you leave Motorola Solutions. In certain circumstances, you (or your covered dependents) can continue medical, vision and dental coverage under COBRA. See Health Care Plans Continuation Rights Under COBRA for details.

Medicare or Medicaid Entitlement

If you or your spouse/domestic partner enrolls in or loses coverage under Medicare (Part A or Part B) or Medicaid, you may change your medical coverage election and/or your Flexible Spending Account (FSA)
contribution election accordingly. The change in coverage and/or contribution takes effect on the first day of the month following the date the Employee Service Center approves the change.

Repatriation to the U.S. for Expatriates

When you repatriate to the U.S., your coverage will change. Any eligible changes must be made within 31 days of moving back to the U.S. Contact the Employee Service Center for assistance with your changes.

FOR NEWBORN CHILDREN

Precertifying your hospitalization doesn’t automatically enroll your newborn child for coverage under the Health Care Plans. You must complete your election on Your Benefits Resources within 31 days of your child’s birth.

Terminating Coverage for a Non-152 Dependent

You may drop medical, vision and/or dental coverage for a dependent who’s not an IRC Section 152 dependent because of the additional cost that’s reported as income to you with applicable tax withholdings. See Additional Income If Your Dependent Doesn’t Meet IRC Requirements for more information. You may drop your dependent from coverage within 31 days of the date you’re first notified of the additional imputed income and tax withholdings.

Initiating Your Change

To make a coverage change, visit Your Benefits Resources or call the Employee Service Center within 31 days of the date of the event. Your change in coverage is approved only if it’s consistent with the qualifying change in status.

Late Enrollment

If you missed the 31-day enrollment period to add your child, spouse or domestic partner, under certain conditions you may still enroll them. To take advantage of this late enrollment opportunity, you must contact the Employee Service Center no later than 60 days from the date of birth, adoption, placement for adoption, marriage or date you qualify for domestic partnership. Remember, you may add a new dependent to your dental or vision coverage only if you currently have such coverage; otherwise, you must wait until annual enrollment. Although coverage for your dependents will be retroactive to the date of the event, the tax status of your contributions may be affected. See When Coverage Begins for a Midyear Change for details.

When Coverage Begins for a Midyear Change

The date your new election begins depends on the type of change and when you requested it. The type of change you make, when the event occurred, and when you request the change may affect when coverage begins, as well as the tax status of your contributions for coverage, as summarized in the chart below. After-tax contributions will continue through the remainder of the calendar year and, depending on the elections you make at annual enrollment, will be on a pretax basis in the next calendar year.

<table>
<thead>
<tr>
<th>Event</th>
<th>Coverage for dependent begins</th>
<th>The tax status of your contributions is based on when your enrollment was made</th>
</tr>
</thead>
</table>

U.S. Health and Welfare Benefits Book for Employees
<table>
<thead>
<tr>
<th>Event</th>
<th>Timeframe</th>
<th>Pretax</th>
<th>After-tax*</th>
</tr>
</thead>
</table>
| Birth, adoption or placement for adoption                             | • Date of birth  
• Date of adoption  
• Placement date                                                           |        |            |
| Marriage or established domestic partner relationship**              | • Marriage date  
• Date all the domestic partner requirements are met                      |        |            |
| SCHIP enrollments (loss of Medicare or eligibility for premium assistance under state plans) | First day of the month following the date the plan receives notice        |        |            |
| All other eligible events that allow adding a dependent to coverage  | First day of the month following the date the event is reported           |        |            |

*If two or more children under medical or vision coverage (one or more children for dental) were already covered before the change, contributions will continue on a pretax basis.
**The Plan will impute income for the cost of coverage provided by Motorola Solutions for a domestic partner or child of a domestic partner who is a non-152 dependent.

### Making a Midyear Change to or From High Deductible Medical Coverage

Whether you have a qualifying change in status or other applicable change event, please note the following if you’re changing your medical coverage to or from high deductible medical coverage:

- If you elected to participate in the general-purpose FSA for the year and have a qualifying change in status or other applicable change event during the year, you won’t be allowed to enroll in high deductible medical coverage for the remainder of the year in which the event occurred. However, you’ll be able to enroll in high deductible medical coverage during the next annual enrollment period for coverage beginning January 1 of the following year. Refer to **Spending Accounts** for additional information.

- If you discontinue your coverage under high deductible medical coverage during a calendar year, and you elected to participate in the limited-purpose FSA during the year, you may continue to participate in the limited-purpose FSA for the year, and the eligible expenses will continue to be limited to dental and vision care for the remainder of such year, regardless of whether you become covered under any other medical coverage..

### When Coverage Ends
There are certain circumstances under which medical, vision and dental coverage ends for you and/or your covered eligible dependents. Your coverage will end on the earliest of the following dates:

- The last day of the month in which your employment ends
- The last day of the month in which you begin a layoff or a leave of absence (other than a military service leave under the 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 in which you begin a layoff or leave of absence (other than a military service leave under the Military Service Pay Policy or a disability leave of absence) if you have at least six months of service
- The last day of the month in which you fail to pay the required monthly contributions for coverage
- The last day of the month in which you fail to meet the Health Care Plans’ eligibility requirements (other than because of a layoff or leave of absence)
- The last day of the month in which you receive military service pay under the Military Service Pay Policy
- If you’re on a disability leave of absence, the earliest of:
  - The last day of the month in which you’re no longer disabled unless you return to active employment;
  - The last day of the month in which you fail to pay the required monthly contributions for coverage;
  - The last day of the month in which your employment ends
- Ninety days after the Plan Administrator requires repayment from you or your covered dependent of amounts that are subject to reimbursement under any Motorola Solutions welfare plan or overpayments or mistaken payments if you fail to repay or set up an acceptable repayment schedule approved by the Plan Administrator
- The day you commit an intentional misrepresentation or fraud on the Health Care Plans
- The day a Health Care Plan amendment takes effect that eliminates such coverage
- The day a Health Care Plan terminates

When Dependent Coverage Ends

Your eligible dependent’s medical, vision and/or dental coverage 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 a reason other than death
- The last day of the month in which you have paid for dependent coverage if you stop making your required contributions
- The last day of the month in which your dependent child enters the military service of any country
- The last day of the month in which your dependent spouse/domestic partner enters the military service of any country but the U.S.
- Ninety days after the Plan Administrator requires repayment from you or your covered dependent of amounts that are subject to reimbursement under any Motorola Solutions welfare plan or
overpayments or mistaken payments from any Motorola Solutions welfare plan if you fail to repay or set up an acceptable repayment schedule

- Ninety days after the Plan Administrator requests proof of your dependent’s eligibility under the Plan and does not receive it
- The day you or your dependent commits an intentional misrepresentation or fraud against the Health Care Plans
- The last day of the month in which your employment ends for a reason other than death
- The day a Health Care Plan amendment takes effect that eliminates such coverage
- The day a Health Care Plan terminates

Your dependent may be eligible for extended coverage beyond the standard age and coverage limitations listed.

Continued Protection for Survivors

Your covered eligible surviving spouse/domestic partner and covered eligible dependents may continue their medical, vision and dental coverage if you die while you’re still employed by the company that participates in the Health Care Plans and while your dependents are still covered.

Coverage may continue for up to 36 months at the applicable active contribution rate for employee-only or other family level of coverage rate. This special continued protection for survivors extends to the earliest of the dates indicated in the chart below.

How Long Survivor Coverage Continues

<table>
<thead>
<tr>
<th>Continued protection for survivors extends to the earliest of the following:</th>
<th>Additional details</th>
</tr>
</thead>
<tbody>
<tr>
<td>36 months from the date of your death</td>
<td>At that time, your covered dependents are eligible to continue coverage under COBRA for up to an additional 36 months by paying the full cost of coverage plus an administrative fee.</td>
</tr>
<tr>
<td>The date your covered dependent no longer meets the Plans’ definition of dependent (for example, because of age)</td>
<td>Your covered dependent is eligible to continue coverage under COBRA for up to 36 months by paying the full cost of coverage plus an administrative fee.</td>
</tr>
<tr>
<td>The date your spouse/domestic partner or other covered dependent becomes eligible for coverage in any other group health plan (including Medicare) or HMO, or enrolls in the Motorola Solutions Post-Employment Health Benefits Plan</td>
<td>Your spouse/domestic partner and/or covered dependents may be eligible to continue coverage under COBRA for up to 36 months by paying the full cost of coverage plus an administrative fee if the other plan contains a pre-existing condition rule or if COBRA is elected after the other coverage begins.</td>
</tr>
<tr>
<td>The end of the last month for which your survivors make the required contribution</td>
<td>No additional coverage is available.</td>
</tr>
<tr>
<td>The date your spouse remarries or your domestic partner marries or establishes a relationship with another domestic partner</td>
<td>Your spouse/domestic partner and/or covered dependents may be eligible to continue coverage under COBRA for up to 36 months by paying the full cost of coverage plus an administrative fee.</td>
</tr>
</tbody>
</table>
Pre-existing Conditions

The Motorola Solutions Medical Plan doesn’t have a “pre-existing condition” restriction.

Confidentiality of Health Information

Motorola Solutions respects the confidentiality of your health information (medical, prescription drug, health screening, disability, workers’ compensation, etc.). This means that the company generally won’t share health information with individual coworkers, supervisors or managers. Exceptions may occur, however, in limited situations when you may grant permission to share the information or when a manager has a need to know in accordance with applicable law.

As part of our efforts to continually improve the Health Care Plans’ quality of care and customer service, the company and its health care vendors look for opportunities to improve performance. As part of this effort, aggregate health care information collected by the Health Care Plans is evaluated and reported. In some cases, courses of treatment are examined and compared to peer group norms.

Based on reviews of health care information, a health care vendor may contact you regarding a specific health care program(s) that’s designed to enhance your or your covered dependent’s care. Otherwise, the company doesn’t report the information to those vendors in a way that reveals the identity of individual employees or their family members.

Other HIPAA policies adopted by the Health Care Plans contain standards designed to maintain the security of your protected health information.

This is only a brief summary of HIPAA. As a participant, you’ll receive a “privacy notice” that more fully describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a free copy of this notice, contact the Health Care Plans’ Privacy Officer.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Your “protected health information” is subject to safeguard under the privacy provisions of HIPAA. Under HIPAA, the Health Care 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.

At Retirement

As a retiree, you may be eligible for coverage under the Motorola Solutions Post-Employment Health Benefits Plan if you began employment before January 1, 2005, and:

- When your employment terminates, your combined age and service equals at least 75 (for example, you are age 49 with 26 years of service); or
- When your employment terminates, you are:
  - Age 55 with 20 or more years of service;
  - Age 56 with 18 or more years of service;
  - Age 57 with 16 or more years of service;
  - Age 58 with 14 or more years of service;
- Age 59 with 12 or more years of service; or
- Age 60 or older with at least 10 years of service.

The Post-Employment Health Benefits Plan counts only full and complete years of age and full and complete years of service (no partial years).

Any employee acquired by Motorola Solutions after January 1, 2005 is not eligible for the Post-Employment Health Benefits Plan regardless of potential prior service credit with a former employer for any other Motorola Solutions’ benefit plan or program.

If you did not begin employment with Motorola before January 1, 2005, or you began employment before January 1, 2005, but you do not meet the previously mentioned age and service requirements for retirees when your employment terminates, you are not eligible for Post-Employment Health Benefits Plan coverage. However, you may be eligible to continue health care coverage under COBRA. Contact the Motorola Solutions Employee Service Center if you have any questions about your eligibility for coverage after your retirement.

**Working beyond Age 65**

If you intend to continue working for the company past age 65, although you may be entitled to Medicare, the company may 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 without penalty until you retire. Please contact your local Social Security office before your 65th birthday for details.

<table>
<thead>
<tr>
<th>MEDICARE AND YOUR HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are enrolled in high deductible medical coverage, and you or your covered spouse is over the age of 65 and enroll in any Medicare plan, this will have an effect on your eligibility to make or receive contributions to your HSA. See <strong>At age 65</strong> under Spending Accounts.</td>
</tr>
</tbody>
</table>

**Coordination of Benefits**

If, in addition to your coverage under the Health Care Plans, you have medical, vision and/or dental coverage under a group health plan or Medicare, the Plans follow National Association of Insurance Commissioners (NAIC) rules to determine when a plan pays first and when benefits will be calculated as secondary to another plan. These rules prioritize how benefit payments are coordinated to avoid duplication of benefits.

When the Plan is the secondary plan, it pays benefits only after the benefits payable from the primary plan are determined. The benefits payable from our Plan may be reduced so that the benefits paid by all plans do not exceed the allowable benefits under our Plan. When our 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 our Plan.

If your spouse/domestic partner or other covered eligible dependent has health care coverage under a government-sponsored program in another country based on his or her citizenship in that country and your dependent is covered under the Health Care Plans, the NAIC rules do not apply. The Health Care Plans pay benefits as the secondary plan. The following table summarizes the NAIC rules. The first rule that applies will determine which plan is primary and which is secondary.

<table>
<thead>
<tr>
<th>WHAT DOES COORDINATION OF BENEFITS MEAN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>When plans coordinate coverage to avoid duplication of benefits, the plan that’s considered the primary</td>
</tr>
</tbody>
</table>
plan pays benefits before the plan that’s considered the secondary plan.

NAIC Rules for Coordination of Benefits

<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rule #1: No coordination of benefits provisions</strong></td>
<td>If one plan doesn’t have a coordination of benefits provision, it’s the primary plan. As a result, the plan with the coordination provision is the secondary plan.</td>
</tr>
</tbody>
</table>
| **Rule #2: Dependent/non-dependent**      | A plan that covers a person as a non-dependent is primary over a plan that covers the person as a dependent.  
Exception: An exception applies if you’re a Medicare beneficiary and your Medicare coverage is secondary by law. |
| **Rule #3: Child of parents not separated or divorced** | In this case, the “birthday rule” applies. Under the birthday rule, the plan of the parent whose birthday falls earlier in the year pays benefits first. If both parents have the same birthday, the plan of the parent who has been covered longer pays first. |
| **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 noncustodial parents pays next; and  
  – The plan of the spouse of the noncustodial 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 doesn’t have this rule, and the plans don’t agree on the order of benefits, this rule doesn’t apply. |
| **Rule #6: Continuation coverage**        | COBRA coverage is secondary to the plan that covers the person as an employee or retiree.  
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 provides non-dependent coverage, Rule #2 applies. |
<p>| <strong>Rule #7: Longer or shorter</strong>            | If none of the above rules determines the order of payment, the plan pays benefits before the plan that’s considered the secondary plan. |</p>
<table>
<thead>
<tr>
<th>Rule</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>length of coverage</td>
<td>that has covered the person longer pays before the plan that has covered the person for the shorter period of time.</td>
</tr>
<tr>
<td>Rule #8: Other rules do not apply</td>
<td>If none of the above rules determines which plan is primary, the plans share expenses equally.</td>
</tr>
</tbody>
</table>

You must notify the Claims Administrator any time you obtain or lose other health coverage. If you or a covered dependent has primary coverage under another medical, vision or dental plan, you must file a claim for benefits under that coverage before your Health Care Plan claim is processed.

Coordination of Benefits If You’re Eligible for Medicare

If you or any of your dependents is eligible for Medicare, the coordination of your benefits works differently from the NAIC rules. Congress has established rules to determine whether Medicare or another plan pays first.

If you intend to continue working for the company past age 65, although you may be entitled to Medicare, the company may 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 without penalty until you retire. Please contact your local Social Security office before your 65th birthday for details.

Medicare is secondary (and the Health Care Plan is primary) if you or any of your dependents is enrolled for Medicare benefits, but only while coverage under the Health Care Plan is due to your “current employment status” under Medicare rules (generally while you’re employed and during the first six months you’re receiving disability benefits from an employer). If coverage under the Health Care Plan 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.

Medicare is secondary (and the Health Care Plan is primary) if you or any of your dependents is suffering from end-stage renal disease (ESRD) (i.e., on kidney dialysis or needing a kidney transplant), but only for the first 30 months of ESRD treatment (the 30-month period begins with the month in which eligibility for Medicare benefits for ESRD begins). Thereafter, Medicare is primary. When this provision determines that Medicare is primary, the Health Care Plan is secondary regardless of whether you or your dependent (whoever is eligible) has enrolled in Medicare.

The federal Medicare coordination of benefits rules do not apply to domestic partners covered under a group health plan when Medicare coverage of the domestic partner is due to age. Therefore, Medicare will be primary for a participant covered as a domestic partner. However, this doesn’t apply if your domestic partner’s coverage under Medicare is due to disability.

If you or any of your dependents has other group health coverage, or is eligible for Medicare, please notify the insurer of your health benefit program so claims will be processed correctly.

In addition, notify the insurer of your health dental program if you or your dependents have other group dental coverage.

Medicare Part A and Part B

There are special rules related to Medicare payments to a government facility, such as a Veterans Administration medical center, that does not get reimbursements from Medicare. In that case, the Health Care Plans pay benefits as if the service had not been provided by a government facility. Therefore, the
Health Care Plans pay benefits based on what Medicare should pay even though Medicare doesn’t actually pay the claim.

Health Care Plans Continuation Rights under COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires health care plans (including HMOs) to offer employees and certain members of their families the opportunity to extend coverage temporarily at group rates after coverage would otherwise end. The Health Care Plans also offer covered domestic partners (and covered children of domestic partners) continuation coverage rights that are equivalent to those offered under COBRA to covered spouses and dependent children of employees as described below. This extension of coverage is called “continuation coverage.”

In general, the coverage that may be continued is the same as the coverage in which you and your eligible dependents were enrolled under the Health Care Plans as an active employee on the day before the qualifying event (described below). You and your covered dependents may continue coverage in the Health Care Plans and, in some instances, in the Health Care Flexible Spending Account.

Qualifying Events and Maximum COBRA Periods

To be eligible for continuation coverage, you must have experienced a qualifying event. After the qualifying event, continuation coverage must be offered to each person who is a continuation coverage beneficiary.

The following table lists the medical, vision, and dental continuation choices available to continuation coverage beneficiaries under COBRA, based on specific qualifying events that would otherwise result in a loss of medical, vision and/or dental coverage. Continuation coverage beneficiaries must have medical, vision and/or dental coverage at the time of the qualifying event to be eligible for continuation coverage. You may also elect COBRA coverage for an eligible child who is born, adopted or placed with you for adoption while your COBRA coverage is in effect.

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Maximum continuation coverage period*</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Termination of your employment (other than for gross misconduct)</td>
<td>You and your covered dependents have the right to continue medical, vision and dental coverage for up to 18 months.</td>
</tr>
<tr>
<td>▪ Reduction in your hours of employment that would cause you to lose eligibility</td>
<td></td>
</tr>
<tr>
<td>▪ Retirement</td>
<td></td>
</tr>
<tr>
<td>▪ Your death</td>
<td>Your covered dependents have the right to continue medical, vision and dental coverage for up to 36 months.</td>
</tr>
<tr>
<td>▪ Divorce or legal separation between you and your spouse (unless a Qualified Medical Child Support Order provides otherwise)</td>
<td></td>
</tr>
<tr>
<td>▪ Termination of your relationship with your domestic partner</td>
<td></td>
</tr>
<tr>
<td>▪ Your child or the child of your domestic partner no longer meets the definition of a dependent under the Health Care Plans</td>
<td></td>
</tr>
</tbody>
</table>
You become entitled to Medicare (under Part A, Part B, or both)**

You or your covered dependents are determined to be disabled under Title II or Title XVI of the Social Security Act

The initial 18-month period of continuation coverage may be extended for medical, vision and dental coverage for up to 11 months (for a total of up to 29 months of continuation coverage). See About the disability extension below for details.

*The duration of coverage is from the date of the qualifying event.
**The 36-month coverage begins on the day you enroll in Medicare.

WHO IS A CONTINUATION COVERAGE BENEFICIARY?
The following people could become continuation coverage beneficiaries if coverage under the Health Care Plans is lost because of a qualifying event:

- You
- Your covered spouse
- Your covered domestic partner
- Your covered dependent children
- Your domestic partner’s covered children

Important Notes

If a second qualifying event (that’s not termination of employment or reduction in your hours of employment) occurs within the 18- or 29-month period, the COBRA continuation period for medical, vision and dental coverage may be extended for up to 36 months from the first qualifying event. If a second qualifying event occurs during a continuation coverage period, contact the Motorola Solutions Employee Service Center to report it immediately.

A continuation coverage beneficiary doesn’t have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to eligibility for coverage under the Health Care Plans. The Health Care Plans reserve the right to terminate a continuation coverage beneficiary’s continuation coverage retroactively if such continuation coverage beneficiary is determined to be ineligible.

A plan option may also subject to state COBRA requirements. This means that you could be entitled to additional continuation coverage if you’re a resident of such a state and enrolled in an eligible plan option. If you want more information, contact your plan.

About the Disability Extension

The Social Security Administration (SSA) must determine that you were disabled at any time within 60 days of the qualifying event (i.e., the disability started at some time before the 60th day of continuation coverage and must continue at least until the end of the 18-month continuation coverage period). The 11-month extension applies to all disabled and non-disabled continuation coverage beneficiaries entitled to continuation coverage as a result of the same qualifying event to which the disability extension applies, subject to the notice requirements. (See Reporting a qualifying event for details.)
Notify the Motorola Solutions Employee Service Center about the SSA’s determination within 60 days of receiving it and before the end of the initial 18-month continuation coverage period. Monthly contributions for continuation coverage increase to 150 percent (from 102 percent) of the monthly amount for each of the 11 additional months of continuation coverage. If the SSA determines that the individual is no longer totally disabled, continuation coverage ends. The continuation coverage beneficiary with respect to the qualifying event to which the disability extension relates must notify the Employee Service Center within 31 days after the determination. Continuation coverage ends on the first day of the month that is 31 or more days after the SSA’s determination that the disability has ended.

Reporting a Qualifying Event

You must notify the Employee Service Center either in writing, online, or by phone within 60 days of the date on which any of the following qualifying events occurs and results in your and/or a covered dependent’s loss of medical, vision or dental coverage:

- You divorce or become legally separated, or your domestic partnership ends.
- Your child or the child of your domestic partner no longer meets the definition of an eligible dependent under the Health Care Plans. (See Glossary for details.)
- Your domestic partner no longer meets the definition of an eligible dependent under the Health Care Plans. (See Glossary for details.)
- 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.
- You become entitled to Medicare.

U.S. EXPATRIATES

Although you’ll lose coverage under the Health Care Plans if you move from U.S. payroll to another international Motorola Solutions entity, this is not a COBRA qualifying event. However, COBRA benefits may be extended to your covered dependents who continue to reside in the U.S. Contact the Employee Service Center for additional information.

Where to Report a Qualifying Event

To report a qualifying event, go to Your Benefits Resources, and if required, documentation of your event may be sent to:

Motorola Solutions Employee Service Center
P.O. Box 785081
Orlando, FL 32878-5081

Or contact the Employee Service Center.

Motorola Solutions automatically notifies the Employee Service Center within 31 days of 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
- Your death

Deciding Whether or Not to Elect Continuation Coverage
Motorola Solutions notifies the Employee Service Center within 31 days after the date of the employment-related qualifying events indicated above. The Employee Service Center will send you a notice and election form within 14 days of receiving notification.

Under the law, you and each continuation coverage beneficiary have 60 days to elect continuation coverage from the later of the day:

- Coverage would otherwise end because of one of the qualifying events described here; or
- The notice of your and your continuation coverage beneficiary’s right to elect continuation coverage is sent to you by the Employee Service Center.

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

If neither you nor your continuation coverage beneficiary chooses continuation coverage within this 60-day period, your and/or your continuation coverage beneficiary’s coverage under the Health Care Plans will end.

Payment

To continue your medical, vision and dental coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2 percent fee for administrative costs (or a 50 percent administrative fee in the case of an 11-month extension due to disability). You make this payment during the 18-month or 36-month period of continuation coverage.

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 contributions are due on the first of the month, whether or not you receive a bill. If the Motorola Solutions Employee Service Center doesn’t receive your monthly contribution within 31 days of the due date, continuation coverage is cancelled as of the last day of the month in which you paid a contribution.

If you don’t want to elect continuation coverage, contact the Employee Service Center. Medical, vision and dental coverage under the Health Care Plans ends on the last day of the month in which the qualifying event occurred.

When Continuation Coverage Ends

Continuation coverage continues until the earliest of the following:

- The end of the applicable 18-month, 29-month or 36-month continuation coverage period
- The day a continuation coverage beneficiary fails to pay the required monthly contribution within 31 days of its due date (or 45 days for initial coverage elections under COBRA)
- The day a continuation coverage beneficiary first becomes covered after the date of his or her election under another group medical, vision or dental plan that doesn’t contain a pre-existing condition rule that affects his or her benefits
- The day a continuation coverage beneficiary first becomes entitled to Medicare after the date of his or her continuation coverage election
- The day on which there has been a final determination by the Social Security Administration that the continuation coverage beneficiary who elected to extend coverage for up to 29 months due to a disability is no longer disabled
Special Rules for Severance Plans

Under the severance plans offered by Motorola Solutions, medical and/or vision coverage in effect under the Health Care Plans on the employee’s termination date may continue at the Active Employee rate for some period of time (this coverage will be counted against your maximum coverage period under COBRA).

Refer to the severance plan Summary Plan Description for more details. If you’re covered under a severance plan that provides such extended coverage, and you stop paying your required contributions, your medical and/or vision coverage ends as of the last day of the month in which you stopped making the required contributions.

Special Consideration for Employees Who Are Disabled and Terminate Under the Medical Leave Policy

If your employment was terminated under the Medical Leave Policy, you and your eligible family members may be eligible for a reduction in the cost of your medical COBRA coverage. To be considered for this subsidy, you must continue to be eligible to receive benefits under the Motorola Solutions Disability Income Plan, and you and your dependents may not be eligible for or enrolled in other group health coverage (including Medicare). Contact the Employee Service Center for more information.

Decision on Your Request for Coverage

We want to be sure that you and your dependents receive the full benefits that you’re eligible to receive under the Plans. You need to submit any requests for eligibility or coverage changes by the last day of the Plan year, or in accordance with the procedures noted in this book, if later. The Plan administrator may either approve or deny your request for eligibility, and you’ll receive notice of the decision in writing.

Your Right to Appeal

If your request for eligibility for coverage under the Plan is denied, in whole or in part, in a letter from the Claims Administrator or otherwise, you may request a review of the denial. Your request for review must be in writing, and it should contain the reasons why you believe you’re entitled to benefits, as well as any additional information or documentation to support your claim.

Second Level of Review

If your appeal is denied, you may submit a written second-level appeal of that denial. You’ll receive the final decision about your appeal in writing. This decision will give you the specific reasons for the decision and also provide you with the corresponding Plan provision(s). The decisions are final and binding on all parties except as required by law. You or your covered dependents must exhaust all of the internal administrative remedies described above before bringing an action for benefits under the Plans under Section 502(a) of ERISA.

Where to Send Your Request for Review

<p>| Plan or            | Send request for review to: |</p>
<table>
<thead>
<tr>
<th>Program</th>
<th>First level of review</th>
<th>Second level of review</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility for health care plan coverage</td>
<td>Contact the Motorola Solutions Employee Service Center at (800) 585-5100 for a Claim Initiation Form. Your completed form should be returned to: Claims &amp; Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407</td>
<td>Contact the Motorola Solutions Employee Service Center for a Level II Appeal Initiation Form. Your completed form should be returned to: Claims &amp; Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407</td>
</tr>
</tbody>
</table>

**MEDICAL/PRESCRIPTION, DENTAL, AND VISION COVERAGE**

The medical/prescription, dental and vision benefits available to you are separately described in the benefits booklets that apply to the benefits that you elect on the AON Active Health Exchange. Please refer to those booklets for information about your coverage.

The insurance providers will administer claims for benefits in accordance with the procedures described in the benefits booklets. The insurers shall be solely responsible for the payment of any benefits under the Health Care Plans.

**A Snapshot of Your Medical/Prescription Coverage Options**

You have several coverage levels to choose from, including:

- **Bronze**: a basic, high-deductible plan with a Health Savings Account (HSA) and prescription drug coinsurance
- **Bronze Plus**: a high-deductible plan with a Health Savings Account (HSA) and prescription drug coinsurance with slightly more coverage
- **Silver**: a preferred provider organization (PPO) plan with prescription drug copays
- **Gold**: a PPO plan with more coverage and prescription drug copays

**Advocacy Services**

Advocacy Services, provided through Alight, are designed to help you and your family easily navigate your benefits. Confidential help at no additional cost is a phone call away for you, your dependents and your extended family members.
With direct access to doctors, pharmacies, hospitals, and Advocacy Services’ benefit partners, Advocates can make phone calls and follow up on your behalf, giving you time to focus on more important things. They have extensive experience and can handle complex issues such as:

- Health care billing problems and claims disputes, and working with credit agencies
- Prescription needs and mail-order issues
- Obtaining medical treatment and locating doctors and hospitals
- Helping you understand and access your benefits, including medical, pharmacy, dental, vision care, flexible spending accounts, behavioral health and the Employee Assistance Program
- Clarifying Explanation of Benefits (EOB) statements
- Assisting with a referral process that is taking too long
- Explaining what is meant by “reasonable and customary” charges
- Helping you understand a diagnosis, procedure or other concern if you or someone in your family has a serious medical condition
- Helping you understand paperwork you received regarding a request from your pension, life insurance or disability
- Helping you or your parents understand Medicare

Your Advocate is an expert resource available to help you. Your Advocate will ensure that your concerns are addressed and handled fairly, promptly and with your well-being in mind.

How to Access Advocacy Services

If you have an issue with your health care or other benefits that you’ve been unable to resolve on your own, contact Advocacy Services. **Contact** the Employee Service Center and follow the prompts to speak with an Advocate.

**Important Exception—U.S. Expatriate and Guam Employees**

U.S. employees on-long term assignment and employees located in Guam will be covered by Cigna Global Health Benefits.

If you’re enrolled in medical coverage (including prescription drug) and or dental coverage prior to your assignment, you and your covered dependents will be automatically enrolled in Cigna global medical and/or dental coverage based on the plans and level of coverage you had prior to assignment.

If you want to change your medical or dental elections or covered dependents, you **must** make enrollment changes within 31 days of starting your assignment. Contact the Employee Service Center (800) 585-5100 to make coverage changes.

Below is a summary of the medical, prescription drug and dental coverage available through Cigna Global Health Benefits.

<table>
<thead>
<tr>
<th>Medical (and Prescription Drug)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Deductible (Per Calendar year)</td>
<td>Outside of US</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Individual</td>
<td>$500</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Coinsurance (what the plan pays)</th>
<th>Outside of US</th>
<th>In-Network US</th>
<th>Out-of-Network US</th>
</tr>
</thead>
<tbody>
<tr>
<td>90% of covered expenses</td>
<td></td>
<td>80% of covered expenses</td>
<td>60% of covered services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Out of Pocket Limit (Per Calendar Year)</th>
<th>Outside of US</th>
<th>In-Network US</th>
<th>Out-of-Network US</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$2,500</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
<td>$5,000</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

### Dental

<table>
<thead>
<tr>
<th>Annual Maximum</th>
<th>$1,500 per person</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Deductible (Per Calendar year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive</td>
</tr>
<tr>
<td>Basic</td>
</tr>
<tr>
<td>Major</td>
</tr>
</tbody>
</table>

Cigna will send you additional information regarding coverage, ID cards, and administration after you've started your assignment or enrolled in coverage.

For additional information on coverage and claim submission you may contact Cigna at:

**Phone**

<table>
<thead>
<tr>
<th>Phone</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll-Free (U.S. &amp; Canada)</td>
<td>1.800.441.2668</td>
</tr>
<tr>
<td>Toll-Free TDD telephone number for the hearing impaired</td>
<td>1.800.558.3604</td>
</tr>
<tr>
<td>Direct Phone (Collect calls Accepted)</td>
<td>001.302.797.3100</td>
</tr>
</tbody>
</table>

**Fax**

<table>
<thead>
<tr>
<th>Fax</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Toll-Free Facsimile</td>
<td>1.800.243.6998</td>
</tr>
</tbody>
</table>
VISION COVERAGE

A Snapshot of Your Vision Coverage Options

- You have several coverage levels to choose from, including:
  - **Bronze**: Exam-only option that provides in-network discounts for materials (e.g., lenses, frames, contacts)
  - **Silver**: A PPO plan that covers in-network and, for certain services, out-of-network care. Also includes in-network discounts for materials (e.g., lenses, frames, contacts)
  - **Gold**: An enhanced PPO plan that covers in-network and, for certain services, out-of-network care. Also includes in-network discounts for materials (e.g., lenses, frames, contacts)

DENTAL COVERAGE

A Snapshot of Your Dental Coverage Options

- You have several coverage levels to choose from, including:
  - **Bronze**: A basic PPO plan that covers in- and out-of-network care (remember, you'll receive a discounted rate with in-network providers), but does not cover major or orthodontic expenses
  - **Silver**: An upgrade to the basic PPO plan that covers in- and out-of-network care (remember, you'll receive a discounted service fees with in-network providers), including coverage for major services and orthodontic expenses for children up to 19 years old
  - **Gold**: An enhanced PPO plan that covers in- and out-of-network care (remember, you'll receive a discounted service fees with in-network providers), including coverage for major services and orthodontic expenses for children and adults
  - A Dental HMO plan that covers in-network care only, including orthodontic expenses for children and adults. The Dental HMO plan may not be available in all areas.

SPENDING ACCOUNTS

Overview

Motorola Solutions offers you several different ways to pay for eligible health care and dependent care expenses on a pretax basis. These accounts offer you a way to save on certain eligible health care expenses not covered by your medical, vision or dental plans, or qualified elder care or dependent care expenses, by using pretax dollars. In some situations, eligibility for the spending accounts may be tied to your Health Care Plan eligibility and enrollment.
Access the Your Spending Account site through the **Your Benefits Resources** home page. Click on "Other Benefits," then "Your Spending Account." You’ll be able to:

- View your account balances
- Check the status of your claims
- Learn which expenses are eligible for reimbursement
- Access your HSA through UMB Bank

You’ll also receive a new Your Spending Account debit card that allows you to easily pay for eligible health care expenses.

There are three different types of spending accounts: a Health Savings Account, a Health Care Flexible Spending Account, and a Dependent Care Account. Below is a brief description of each spending account and how each may provide a beneficial savings to you.

### Spending Account Options Available to You

The spending account options available to you depend on your medical coverage election. Below is a snapshot of which spending account options may be available to you.

<table>
<thead>
<tr>
<th>Your medical coverage</th>
<th>Health Care FSA</th>
<th>Health Care FSA</th>
<th>Health Care FSA</th>
<th>Health Care FSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General-purpos</td>
<td>Limited-purpos</td>
<td>HSA</td>
<td>DCA</td>
</tr>
<tr>
<td>Non-High Deductible Medical Coverage</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>High Deductible Medical Coverage</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HMO</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opt-Out</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health Savings Account (HSA)

Participants in high deductible medical coverage may elect to enroll in an HSA, which can be used to pay for certain health care expenses.

### Health Care Flexible Spending Account (FSA)

As a participant in any of the Health Care Plans, or if you have opted out of coverage, you can elect to enroll in a Health Care FSA. This account is designed to help you save on certain eligible health care expenses not covered by your medical, vision and/or dental coverage.
Dependent Care Account (DCA)

You may want to enroll in a DCA to help pay for day care-related services to care for your eligible dependents while you are at work. This account lets you use pretax dollars to reimburse eligible elder care or child care expenses. You can participate in the DCA regardless of your medical plan election.

Using Your Health Care Spending Accounts

The following section contains the specific details of each type of health care spending account: the Health Savings Account and the Health Care Flexible Spending Account. See Dependent Care Account (DCA) for details on how a DCA works.

Eligible Expenses

The following list is a general sample of expenses and is not inclusive of all potential eligible expenses. Some expenses may be eligible under one health care spending account and not under another, so be sure to review the list carefully.

For questions regarding eligible expenses, contact the Motorola Solutions Employee Service Center.

Visit www.irs.gov and refer to Publication 502 for a list of covered expenses according to IRS guidelines.

<table>
<thead>
<tr>
<th>Eligible expenses (as defined by the IRS)</th>
<th>General purpose FSA</th>
<th>Limited- purpose FSA</th>
<th>HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Non-high deductible medical plan members)</td>
<td>(High deductible medical plan members)</td>
<td>(High deductible medical plan members)</td>
</tr>
<tr>
<td>Out-of-pocket copayment and coinsurance amounts, deductibles and eligible medical expenses:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under the Medical Plan; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under any other medical plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible expenses include:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>▪ Routine full-body scans</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Hearing care expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Expenses beyond the coverage limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Amounts greater than the reasonable and customary (R&amp;C) allowance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Eligible sales tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket copayment and coinsurance amounts, deductibles and eligible prescription drug expenses:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Eligible expenses (as defined by the IRS)</td>
<td>General purpose FSA</td>
<td>Limited-purpose FSA</td>
<td>HSA</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-----</td>
</tr>
<tr>
<td>(Non-high deductible medical plan members)</td>
<td>(High deductible medical plan members)</td>
<td>(High deductible medical plan members)</td>
<td></td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under the Prescription Drug Program; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under any other medical or drug plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible expenses include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Expenses beyond the coverage limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Over-the-counter drugs that include a physician’s prescription</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Certain supplies for medical treatment, such as bandages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Eligible sales tax</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket copayment and coinsurance amounts, deductibles and eligible dental expenses:</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under the Dental Plan; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under any other dental plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible expenses include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Expenses beyond the coverage limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Amounts greater than the R&amp;C allowance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Orthodontia expenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket copayment and coinsurance amounts, deductibles and eligible vision expenses:</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under the Vision Care Program; and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Not covered or reimbursed under any other vision plan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible expenses include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Contact lenses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Contact lens solution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Glasses (lenses and frames)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Corrective vision surgery (such as</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible expenses (as defined by the IRS)</td>
<td>General purpose FSA</td>
<td>Limited-purpose FSA</td>
<td>HSA</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>---------------------</td>
<td>---------------------</td>
<td>-----</td>
</tr>
<tr>
<td>(Non-high deductible medical plan members)</td>
<td>(High deductible medical plan members)</td>
<td>(High deductible medical plan members)</td>
<td></td>
</tr>
<tr>
<td>LASIK)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Eligible sales tax</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Expenses for transportation essential to, and primarily for, covered medical care</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Up to $50 per night, per person, for lodging that is essential to, and primarily for, covered medical care — and that meets IRS rules</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Premiums for other health insurance coverage (including Medicare Part B premiums)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In addition, the following OTC items may be eligible for reimbursement if accompanied by a prescription and an explanation of medical necessity from your physician that supports treatment of a medical condition:

- Dietary or nutritional supplements (weight-loss supplements, vitamins, etc.)
- Homeopathic or holistic products
- Lotions, sunscreen
- Lip balms
- Contraceptives (condoms, sponges, foams, etc.)
- Diagnostic supplies (ovulation predictors, thermometers, etc.)

**More about Over-the-Counter (OTC) Items and Medicines**

You may use your FSA or HSA to reimburse certain eligible OTC items. The OTC items eligible for reimbursement are those used for “medical care,” as defined by the IRS. According to the IRS, medical care is defined as the “diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.” The types of OTC items included under this definition are those used to alleviate or treat personal injuries or illness. This excludes items intended for an individual’s overall general health and OTC medicines not prescribed by a physician.

You’re required to provide the following for reimbursement for OTC medicines:

- Proof of purchase (receipt required)
- Evidence of the medicine and/or drug name (name of medicine or drug on receipt required)
- Prescription from your doctor

**Non-Eligible Expenses**
Some expenses aren’t eligible for reimbursement through your FSA or HSA. The following list highlights some common expenses that are generally not eligible, but it is not inclusive of all potential non-eligible expenses:

What May Not Be Covered Under Your Health Care Spending Accounts

<table>
<thead>
<tr>
<th>Expenses (as defined by the IRS)</th>
<th>General-purpose FSA</th>
<th>Limited-purpose FSA</th>
<th>HSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments for expenses that will be incurred in the future</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Expenses for treatment, services or other expenses not incurred by the covered or eligible participant</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Expenses incurred before you become eligible for coverage in the Plan</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Other expenses not eligible include:</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>▪ Elective cosmetic services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Teeth whitening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Swimming lessons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Babysitting and child care services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Electrolysis and hair removal</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>▪ Diaper services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Hair transplants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using the Your Spending Account Card

If you enroll in the FSA or have a high deductible medical plan with HSA, you’ll receive a Your Spending Account card.

**IMPORTANT NOTE FOR U.S. EXPATRIATES**

The Your Spending Account card may not be used for services or purchases incurred outside of the U.S. See How to file for reimbursement for details on filing a claim.

The Your Spending Account card allows you to easily pay for eligible health care expenses, such as your coinsurance for a doctor’s visit or to pay for your prescription at the pharmacy or via mail order. You can use the Your Spending Account card at merchants and providers that sell health care products and services (for example, a pharmacy, physician office, hospital or dental office). You’ll find a list of eligible health care expenses on the Your Spending Account page from the Your Benefits Resources website.

At checkout, simply swipe the Your Spending Account card and select “credit” or “debit,” and it will pay only for eligible items that you’ve purchased. Then, use another payment method for the other items. If you choose the “credit” option, you’ll just have to sign for your purchase. If you select “debit,” you’ll have to use a Personal Identification Number (PIN). You don’t have to set up a four-digit PIN to use your card.
But, if you don’t, you’ll always have to use the credit option at the point of sale. To set up a PIN for your YSA card:

1. Call (888) 999-0194
2. Enter your card number, ZIP code and three-digit security code located on the back of your YSA card.
3. Enter a four-digit PIN that you’ll remember.

If you have additional YSA cards for your dependents, the PIN you set up for your card applies to all YSA cards associated with your account.

You can change your PIN at any time by following these steps again.

### ADDITIONAL CARDS

You can request additional cards for your eligible dependents. Go to the Your Spending Account page located on the Your Benefits Resources website to submit your request.

When you swipe your debit card, Your Spending Account will automatically pay the amount owed from the right account:

| If you enrolled in high deductible medical coverage | **Medical expenses**: Your HSA pays.  
**Dental and vision care expenses**: Your limited-purpose FSA (if you have one) pays first. After you’ve used all the funds in your limited-purpose FSA, you can use the funds in your HSA to cover any remaining expenses. |
|-----------------------------------------------------|------------------------------------------------------|
| If you enrolled in non-high deductible medical coverage | **Medical and vision care expenses**: Your FSA (if you have one) covers eligible medical and vision care expenses.  
**Dental expenses**: Your FSA pays. |
| If you enrolled in an HMO | Medical, dental and vision care expenses: Your FSA (if you have one) pays. |
| If you opted out of medical coverage (chose “No Coverage”) | Medical, dental and vision care expenses: Your FSA (if you have one) pays. |

### Keep Your Receipts

Your Spending Account may still need to verify an expense. If Your Spending Account requests documentation for an expense paid with the Your Spending Account card, and you don’t send in this documentation, you won’t be able to use your card until you either provide the required documentation to Your Spending Account or reimburse your account.

### IRC Section 152

Besides meeting any other specific spending account eligibility requirements, for reimbursement of a dependent’s eligible expenses, he or she must be either a qualifying child or qualifying relative as defined by IRC Section 152 in the chart below.
Qualifying child | Qualifying relative
---|---
To satisfy the definition of “qualifying child,”* a child must: | To be a “qualifying relative,” the individual must:
- Bear one of the following relationships to you: | - Bear a specified relation to you or be an individual who has the same principal residence as you and is a member of your household; and
  - Your child or a descendant of your child | - Receive more than one-half of his or her support from you but not be a qualifying child of you or of any other taxpayer for the year;
  - Your brother, sister, stepbrother, stepsister or a descendant of any such relative; | - Have the same principal residence as you for more than one-half of the taxable year;
- Unless disabled, be younger than age 19 if not a student, or if a student, younger than age 24; and | - Not provide more than one-half of his or her own support.
- Not provide more than one-half of his or her own support. | *A qualifying child or relative must also be a U.S. citizen or national, a resident of the U.S., or a resident of a country contiguous to the U.S. (there’s an exception for certain adopted children).

Your domestic partner or child of a domestic partner must meet the qualifying relative requirements for his or her expenses to be eligible for reimbursement.

HEALTH SAVINGS ACCOUNT

General Information

A Health Savings Account (HSA) is a personal account for participants of high deductible medical coverage to use in paying for certain health expenses. For 2018, if you’re under age 55, you and Motorola Solutions combined can contribute up to $3,450 for single coverage and up to $6,900 for family coverage. Your eligible HSA contribution amount will increase each year there is a corresponding increase in the annual maximum contribution as announced by the IRS. If you’re age 55 or over, you can make an additional catch-up contribution of $1,000 at any time during the year. The company makes contributions to your HSA as long as you participate in high deductible medical coverage.

The HSA is an interest-bearing account with an optional Money Market Sweep Account feature. This FDIC-insured account is maintained in your name at UMB Bank. You own the funds in this account at all times. Funds are not subject to use-it-or-lose-it rules.

With an HSA, you can contribute pretax dollars up to a maximum amount. Any dollars left unspent at the end of the year can build savings to help you pay for qualified medical expenses in future years. Qualified
medical expenses include deductibles, coinsurance and other out-of-pocket costs not covered by high deductible medical coverage.

The HSA offers a unique advantage. It not only allows you to contribute dollars pretax but also enables you to withdraw those dollars from your HSA (without paying a penalty) to pay for qualified medical expenses without taxation.

For a detailed list of the types of qualified medical expenses you can pay for out of your HSA, see Publication 502 on the IRS website at www.irs.gov/publications/p502/index.html.

Eligibility and Coverage Requirements

This section summarizes eligibility and coverage requirements for the Health Savings Account (HSA).

You and your dependents must meet certain eligibility requirements before you may begin or maintain an HSA. This section includes important eligibility, enrollment and coverage information.

Eligibility

Who Is Eligible

You’re eligible for the Health Savings Account (HSA) if you’re enrolled in a high-deductible medical plan, and you meet the following criteria:

- You’re scheduled to work at least 20 hours per week.
- You’re enrolled in high deductible medical coverage on the first day of the month; otherwise, your eligibility to make or receive contributions to your HSA begins the first day of the following month.

Who Isn’t Eligible

You’re not eligible for the HSA if any of the following is true:

- You’re covered by another medical coverage that’s not an HSA-qualified health plan. (However, this doesn’t include specific disease or illness coverage, such as automobile and homeowner, accident, disability, dental, vision and independent or group long-term care insurance.)
- You’re enrolled in Medicare.
- You’re claimed as a dependent on someone else’s tax return.
- You provide services under an independent contractor, consultant or employee leasing agreement.
- You’re classified as contract labor.
- You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in the HSA).

Dual Motorola Solutions Employees

If you and your spouse have separate coverage under high deductible medical coverage, each of you may elect and open your own HSA. The combined total of your HSA contributions is the IRS limit for family coverage. In 2018, that amount is $6,900. This maximum annual contribution will correspondingly increase in future years if an increase is announced by the IRS. If you or your spouse/domestic partner or both are eligible to make catch-up contributions, you may each contribute the eligible catch-up contribution to your individual HSA (up to $1,000).
Enrolling for Coverage

Electing Coverage

When you initially enroll, you'll make your elections on Your Benefits Resources. If you're a new employee, you may complete your enrollment online within 31 days from your hire date.

As long as you're enrolled in high deductible medical coverage, you may elect to open a Health Savings Account (HSA) when you initially enroll or at any time while you're covered under the Plan. Once you've enrolled in the HSA, you can change your payroll contributions as often as you wish during the plan year up until the first day of December.

Earning Interest on Your Account

When you enroll, you will have the option to select an interest-bearing account or decline any interest that may be accrued. See the Account Interest section for additional details.

Starting Your Coverage

As long as you meet the eligibility requirements when you enroll in high deductible medical coverage, an HSA will be set up for you automatically when you choose the “with HSA” option and agree to the terms and conditions for Health Savings Accounts at UMB Bank. If you do not enroll in the HSA when you first enroll in high deductible medical coverage, you can enroll anytime by contacting the Motorola Solutions Employee Service Center. Within three weeks of enrolling, you’ll receive a Your Spending Account card and other details regarding your UMB Bank account.

If You Change Your Coverage

If You Make a Midyear Change to or From a High Deductible Medical Plan

You can change your medical coverage midyear if you experience a qualifying change in status or during the next annual enrollment period. Even if you enroll in different medical coverage (e.g., you switch from coverage under a high deductible medical plan to coverage under a non-high deductible medical plan), the money remains in your HSA. You can then use the money to pay for future qualified medical expenses tax-free.

Because high deductible medical plans meet the IRS guidelines for HSA eligibility, you are no longer eligible to contribute to your HSA if you switch to a non-high deductible medical plan or an HMO or if you’re covered under a spouse’s plan which is not a high-deductible medical plan or your spouse is enrolled in a general-purpose FSA. Once you’re no longer enrolled in a high deductible medical plan, you also become responsible for the HSA monthly service charge that the company paid on your behalf while you were a high deductible medical plan participant.

Your Dependents

You won’t have to enroll each of your dependents for coverage in the HSA. Instead, you’ll determine when and how to request your reimbursement and you’ll be responsible for determining whether your dependent is a qualified dependent and whether the expenses are eligible. Unlike the FSA, the federal tax code change for dependents does not extend to an HSA. To be eligible for HSA reimbursement of a qualified expense incurred by your dependent, he or she must be either a qualifying child or a qualifying relative, as defined by IRC Section 152.
QUALIFYING DEPENDENTS

Contact your tax adviser if you're unsure whether your dependent qualifies for reimbursement of eligible expenses from the Health Savings Account.

Ending Coverage

If You No Longer Participate in a High Deductible Medical Plan

If you no longer participate in a high deductible medical plan or you terminate employment, you can't continue to contribute to your HSA unless you continue your high deductible medical coverage under COBRA or become covered by another high-deductible medical plan (as long as you do not have any other disqualifying medical coverage). You may take any amounts left in your HSA with you, since your HSA is portable. This means that your HSA belongs to you and carries forward into the future to be used for qualified medical expenses at any time. You can continue to use the account to pay for qualified medical expenses; however, you'll be responsible for the monthly service charge as well as other account fees.

If You Become Disabled

If you become disabled (according to the Social Security Administration) and enroll in Medicare, you must stop contributing to your HSA as of the first day of the month in which your Medicare coverage takes effect. You can continue to use your HSA to reimburse qualified medical expenses. You can also use your HSA to reimburse nonqualified medical expenses, but those distributions are subject to ordinary income tax. You don't, however, have to pay the 20 percent penalty. See Using your HSA for more information.

At Age 65

When you reach age 65 and continue to work and have high-deductible medical plan coverage, you can continue to contribute to your HSA and use your account, tax-free, for qualified medical expenses as long as you aren't enrolled in Medicare. When you enroll in Medicare, you may use your account to pay for Medicare (Parts A, B, D, and Medicare Advantage) premiums, deductibles, copayments and coinsurance — but neither you nor the company can contribute additional funds to the HSA. Also, an HSA can't be used to pay for a Medicare supplement or Medigap policy.

You may also reimburse yourself for your monthly contributions for post-65 medical coverage through a previous employer. In addition, once you reach age 65, you may use your HSA to pay for nonmedical expenses, without penalties. However, the amount withdrawn will be taxable as income.

In the Event of Your Death

If your spouse is your designated beneficiary, he or she becomes the owner of your HSA after your death and continues to receive the same tax benefits that were available to you. If you're not legally married (as recognized under federal law), or you choose someone other than your spouse as your beneficiary, that person won't become the owner of the account but will receive a taxable distribution of the remaining funds. He or she can then use any of the remaining funds, for up to one year, to pay for your qualified medical claims, which reduces the beneficiary's taxable distribution.

Using Your HSA
You may use your HSA in several ways:

- **Pay for qualified medical expenses:** After you receive your medical expense bill, decide whether to pay the qualified medical expenses from your HSA using a Your Spending Account card or online bill pay.

- **Save and invest for future medical expenses:** The HSA is a tax-exempt savings account to help you fund future medical expenses. All amounts that you and the company contribute to your HSA are yours to keep, even if you discontinue your participation in a high deductible medical plan or you leave the company.

- **Pay for non-medical-related expenses:** You can use your HSA to pay for non-medical-related expenses at any time. However, withdrawals from your HSA for non-medical-related expenses are included as part of your gross income and are subject to an additional 20 percent tax on that amount except in the case of withdrawals made if you become disabled, reach age 65 or die.

### HSA MEMBERS

Remember: If you use your HSA for non-qualifying eligible expenses, you’re subject to a 20 percent excise tax.

---

**HSA Contributions**

You may make contributions to your HSA after you establish your account with UMB Bank. The amount of all contributions that you make to your HSA is limited to the statutory annual amount set by the government.

If you enroll in a high deductible medical after January 1, but on or before December 1, you can contribute up to the statutory maximum HSA contribution amount provided you continue to participate in a high deductible medical plan for the next 13 months. This time period begins with December of the year in which you first become covered by an HSA-qualified, high-deductible health plan.

### 2018 MAXIMUM HSA

For 2018, the annual maximum HSA contribution is $3,450 for single coverage or $6,900 for family coverage, plus an additional $1,000 if you are age 55 or over. This annual maximum contribution limit will increase in future years if there is a corresponding increase in the amount as announced by the IRS.

**Your Pretax HSA Contributions**

You can make pretax payroll contributions to your HSA up to the contribution limit. If you decide to make pretax contributions, they can be deducted from your pay and deposited in your UMB HSA. Pay-period contributions are withheld from your pay in the first two pay periods of each month (maximum of 24 deductions per year) and are generally available to you within a week after the pay date.

To elect or change your HSA pretax contribution amount, contact the Employee Service Center or visit Your Benefits Resources. Changes must be made by Tuesday at 5 p.m. Central time, one week before the date paychecks are issued.

As long as you remain eligible and enrolled for coverage in a high deductible medical plan, you may change your HSA contribution at any time throughout the year, up until Dec. 1. However, if you don’t continue your high deductible medical coverage (or other HSA-qualified, high-deductible health plan coverage) for the entire year, a prorated amount of the HSA contribution will be considered income and
subject to income taxes and possibly penalties, if you contribute more than 1/12 of the annual HSA contribution maximum for each month you participate in a high deductible medical plan. In addition, you may also be subject to a tax penalty, depending on when you withdraw any excess contributions from your HSA.

After-Tax Contributions

You also have the option to make an after-tax contribution, up to the remainder of the contribution limit using your checking account. Use information from your checking account to do this online at Your Benefits Resource in the HSA section. When you file your tax return for the year, you’ll receive a tax deduction.

HSA “Catch-Up” Contributions

If you’re at least 55 years old and enrolled in a high deductible medical plan for the entire year, you may make the full catch-up contribution ($1,000) regardless of when you reached age 55 during that year. If you don’t have a high deductible medical plan coverage for the full year, you must prorate your catch-up contribution for the number of full months you were covered under this Plan. You can make these contributions on a pretax basis through payroll contributions or by check as an after-tax contribution.

Excess HSA Contributions

It’s your responsibility to make sure you don’t exceed the maximum allowable contributions to your HSA. You can adjust your pretax payroll contribution levels throughout the year. To monitor your year-to-date HSA contribution levels, visit www.yourbenefitsresources.com/mot-solutions or contact the Motorola Solutions Employee Service Center.

UMB Bank prevents contributions in excess of the maximum amount you can contribute in a calendar year. For 2018, the maximum limit is $7,850 ($6,900 for family coverage, plus $1,000 for catch-up contributions for those age 55 or older). This annual maximum contribution limit will increase in future years if there is a corresponding increase to the amount as announced by the IRS.

How to Access Your HSA Funds

Access to your HSA funds is available with a Your Spending Account card, with the bill pay feature, or from the UMB Bank website, where you can request that a check be sent directly to you.

When you establish an HSA, you’ll receive a Your Spending Account card. The card allows you to access your account directly:

- When you incur an eligible out-of-pocket expense, such as paying coinsurance or a copayment for an eligible expense; or
- To pay any balance owed to your provider, such as the amount applied to your deductible or your coinsurance amount, after your claim has been considered under the medical, vision or dental plans.

The HSA also includes a bill pay feature that allows you to pay your eligible health care bills directly from your HSA with no transaction fee. Simply log on to Your Benefits Resources, and follow these steps:

- Select “Other benefits”
- Select “Your Spending Account”
- Select “Manage your account”
Select “Manage your account at UMB”
Complete the instructions under the “Bill Pay” tab.

Other HSA Information

Once you’ve established your HSA, you need to make sure you understand how other details, such as your account interest and investing options, affect you. In this section, you’ll read more about these HSA components and learn where to find contact information.

Account Fees

There’s a fee to open your account and a monthly service charge. As an additional benefit, Motorola Solutions pays both of these fees on behalf of high deductible medical plan participants while they’re still employed at the company. Other account service fees may apply. Contact UMB for a full list of account fees.

If you terminate employment and retain high deductible medical coverage under COBRA, under a Motorola Solutions severance plan, or as a surviving beneficiary (in which case coverage may continue for up to 36 months before the COBRA period starts), you’ll be responsible for the monthly service charge. This monthly service charge will be effective the first of the month following your termination of employment.

Account Interest

Your account balance earns tax-free interest. This is credited monthly. The rate is based on money market interest rates and is adjusted from time to time. This interest is shown on your account statements and can be viewed on Your Benefits Resources. Click on “Other Benefits,” then “Your Spending Account.” Contact the Motorola Solutions Employee Service Center if you do not want to receive interest on your HSA balance. Any interest you earn in your account does not count toward the annual maximum contribution limit.

Investment Options

Once your account balance is over $1,000, you may enroll in UMB’s automated Money Market Sweep Account option, which may earn a higher interest rate than your base account. Each night, funds in excess of $1,000 in your base account are automatically used to purchase shares of the institutional money market fund. As ongoing contributions are made, additional dollars are moved into your Money Market Sweep Account each night. Contributions cannot be made directly to your Money Market Sweep Account.

There is no fee for electing the Money Market Sweep Account option.

You have the opportunity to select and manage your investments through an online brokerage account once you select the Money Market Sweep Account and create a separate user name and password.

You can choose how you want to invest your Money Market Sweep Account. There are more than 170 mutual funds available in seven nationally recognized fund families:

- AIM Funds
- American Funds
- Federated Investments
- Fidelity Investments
- Franklin Templeton Investments
- Oppenheimer Funds
- UMB Scout Funds

All funds are “no-load” funds offered at net asset value (NAV).

There is a standard fee for any initial investment, as well as a reduced fee for recurring transactions. These fees are subtracted from your base account. More information is available on Your Spending Account, which you can access by logging on to Your Benefits Resources and clicking on “Other Benefits,” then “Your Spending Account.”

**Note:** Investments in securities offered through the brokerage account are not FDIC insured, may lose value and have no bank guarantee.

**How to Transfer Funds from another HSA**

If you already have funds in an HSA with another bank (such as ACS|BNY Mellon, if you had Motorola Solutions coverage before 2013), you have the option to move your balance to your new HSA with UMB Bank. There are three ways to do this:

- **Option 1:** You can print and complete a copy of the trustee-to-trustee transfer form on the UMB Bank website. If your prior account has a checkbook, you can write a check to UMB for the balance of your prior account. Make your check payable to: *UMB Bank, N.A. as HSA Custodian for [name of account owner]*. You must note on the check that the UMB deposit is a rollover from another HSA. Send the form and check to:
  
  UMB Bank
  P.O. Box 419226
  Mail Stop 1170203
  Kansas City, MO 64141

  You should contact your prior bank to find out if there is a fee, as well as to notify them to close your account.

- **Option 2:** You can print and complete a copy of the trustee-to-trustee transfer form on the UMB Bank website and request your prior bank to close out your HSA. You can then submit the form to your prior bank and request that, to transfer your funds, they send a check in the amount of your balance to the address on the form. UMB Bank will charge you a $25 fee for this option.

- **Option 3:** You can contact your prior HSA bank to ask if there is a transfer form and to request that they close out your HSA and transfer your funds to UMB Bank. Your prior bank may charge you a fee for this option.

**Note:** You may transfer only HSA dollars into another HSA.

**Keeping Track of Your HSA**

Beginning the first of the month after you activate your HSA, you'll receive monthly account statements online that reflect current and year-to-date debits and withdrawals, as well as all credits (deposits or interest earnings) to your account. You'll receive quarterly statements if your account reduces to a zero balance. You can also view your account balance at any time at Your Benefits Resources.
HSA Tax Advantages

The contributions that you make to your HSA are tax-free. Interest earned on these contributions is tax-free, and any withdrawal you make from your HSA is tax-free, provided you use the amounts to pay for eligible medical expenses for you and your dependents who qualify under IRC Section 152.

To Learn More about HSAs

For more information regarding your HSA, visit Your Benefits Resources. Click on “Other Benefits,” then “Your Spending Account.” You can:

- Verify your account balance(s)
- Find answers to frequently asked questions
- View claim activity
- Check eligible expenses
- Request additional Your Spending Account cards
- Learn more about the spending accounts

Check out the site for these and other resources available to you. You may also call the Motorola Solutions Employee Service Center if you have questions or need assistance.

How to Receive Your HSA Benefits

Refer to How to access your HSA funds or Your Spending Account materials for details about receiving reimbursement from your HSA.

Note: If you wish to dispute your participation in an HSA, you may appeal. See If your benefits are denied for more information.

Questions?

Contact the Motorola Solutions Employee Service Center as your resource for questions regarding HSA coverage.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

General Information

Whether you’ve opted out of medical coverage, enrolled in an HMO, or are a participant in a high deductible medical plan or non-high deductible medical plan, you can elect to enroll in a Health Care Flexible Spending Account (FSA). This account is designed to help you save on certain eligible health care expenses not covered by your medical, vision or dental coverage. If you enroll, you can direct pretax dollars into your FSA and then use those dollars to reimburse yourself for eligible health care expenses. Contributing to the FSA reduces your taxable income. The company does not make contributions to your FSA.
There are two types of FSAs: the limited-purpose FSA and the general-purpose FSA. The type of FSA coverage depends on your medical plan election as described below.

<table>
<thead>
<tr>
<th>Your medical coverage</th>
<th>Health Care FSA options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>General-purpose</td>
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<tr>
<td>Non-High Deductible Medical Coverage</td>
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<td>High Deductible Medical Coverage</td>
<td></td>
</tr>
<tr>
<td>HMO</td>
<td>X</td>
</tr>
<tr>
<td>Opt-Out</td>
<td>X</td>
</tr>
</tbody>
</table>

**Limited Purpose FSA**

Funds in a limited-purpose FSA may be used to reimburse only eligible dental and vision expenses. You may elect a limited-purpose FSA if you participate in a high deductible medical plan, regardless of whether or not you have a Health Savings Account. All high deductible medical plan participants already have the option to use a Health Savings Account to reimburse eligible medical expenses. Because of this, IRS rules prohibit you from also reimbursing medical expenses with a limited-purpose FSA. Refer to IRS Publication 502 for a description of eligible dental and vision expenses. In addition, when you use the Your Spending Account card, your vision and dental claims will be automatically reimbursed from the available balance in your FSA before reimbursing from any funds in your HSA.

Once you elect a limited-purpose FSA, you won’t be permitted to elect a general-purpose FSA for the remainder of the year, regardless of whether you change your medical coverage election midyear. If you do elect another medical coverage option during the year, you may continue to participate in the limited-purpose FSA. In addition, if you’re enrolled in a general-purpose FSA for the year, you won’t be permitted to make a midyear medical plan enrollment change to a high deductible medical plan regardless of the balance remaining in your general-purpose FSA.

**Note:** If you’re enrolled in a high deductible medical plan, you can only use the Health Care Flexible Spending Account (FSA) for eligible dental and vision expenses ("limited-purpose FSA"). This is because you’re entitled to tax benefits from your HSA.

**General Purpose FSA**

Funds in a general-purpose FSA may be used to reimburse any eligible health care expense, including medical, dental and vision expenses. You may open a general-purpose FSA if you participate in non-high deductible health coverage or an HMO. You may also open a general-purpose FSA if you opt out of medical coverage.

The general-purpose FSA may be used to reimburse your deductibles, coinsurance, copayments and other eligible health care expenses that aren’t reimbursed under your health coverage.

**Eligibility and Coverage Requirements**

This section summarizes eligibility and coverage requirements for the Health Care Flexible Spending Account (FSA).
You and your dependents must meet certain eligibility requirements before you may begin or maintain an FSA. This section includes important eligibility, enrollment and coverage information, including how and when you can elect to change your coverage.

## Eligibility

### Who Is Eligible

You may participate in an FSA regardless of whether you’re enrolled in a Plan as long as you work at least 20 hours per week. However, your current medical coverage will determine whether you’re eligible for a general-purpose FSA or a limited-purpose FSA.

- **For a general-purpose FSA:** You may enroll in a general-purpose FSA if you participate in a non-high deductible medical plan or an HMO, or if you opt out of medical coverage.
- **For a limited-purpose FSA:** You may enroll in a limited-purpose FSA if you participate in a high deductible medical plan.

### Who Isn’t Eligible

You’re not eligible for the FSA if any of the following is true:

- You aren’t scheduled to work more than 20 hours per week.
- You provide services under an independent contractor, consultant or employee leasing agreement.
- You’re classified as contract labor.
- You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in the FSA).

## Dual Motorola Solutions Employees

If both you and your spouse work for the company, each of you may contribute from $60 to $2,550 to separate FSAs. However, an eligible expense can only be reimbursed from either your, or your spouse’s FSA (not both).

## Enrolling for Coverage

### Electing Coverage

⚠️ When you initially elect coverage, you’ll make your elections on Your Benefits Resources. If you’re a new employee, you may complete your enrollment online within 31 days from your hire date. Once you make an election, you can’t change your coverage under the FSA during the calendar year (unless you experience a qualifying change in status or other applicable change event during the calendar year).

## Health Care FSA Contributions

When you enroll in an FSA, you’ll need to indicate the annual amount you want withheld from your paycheck. The annual contribution you elect is divided by the number of pay periods for which benefit deductions are withheld during the year. For 2018, the minimum amount you may contribute to your FSA is $60 annually. The maximum amount is $2,600 annually.
Benefit deductions occur from the first two pay periods of each month. The per-pay-period portion of the amount you elected is automatically deducted from your pay pretax throughout the year and deposited into your own FSA. As a result, the total amount you elect is deducted in full by December 31 of the applicable year regardless of the month in which you make the election. Your taxable income is reduced by the amount you choose to contribute.

Starting Your Coverage

As long as you meet the eligibility requirements, your coverage under the Health Care Flexible Spending Account (FSA) begins on the day you start work. If, when your coverage is scheduled to begin, you’re off work for any reason other than illness, your coverage begins on the date you actually start work. Your coverage will never begin before you’ve reported to work on your first day of employment. Coverage for you and your dependents does not begin until you are enrolled.

**ATTENTION NEW EMPLOYEES**

If you’re a new employee eligible for the Health Care Flexible Spending Account (FSA), be sure to complete your benefit elections promptly so that coverage can begin under the account(s) you select. You should choose your coverage under the FSA within 31 days from your date of hire.

Your Dependents

Reimbursement for eligible expenses from the FSA can be extended to certain dependents based on their relationship to you, as well as their tax eligibility for health care coverage. To be eligible for FSA benefits, your dependent(s) must meet all of the eligibility requirements. Grandchildren and parents are not eligible for coverage.

You may be reimbursed for expenses incurred by a dependent who meets the requirements of the federal tax code and is your:

- Legally recognized spouse;*
- Domestic partner who is a qualifying relative (refer to IRC Section 152 for details); or
- Dependent child who is either:
  - A child who is your son, daughter, stepchild, adopted child or child legally placed for adoption, or eligible foster child;
  - A child for whom you have legal guardianship and who resides principally in your home and is a member of your household; or
  - A child of a domestic partner who is his or her natural child, adopted child, child for whom he or she is a legal guardian or foster child and who resides principally in your home and is a member of your household.

Dependent children are eligible for coverage through age 25. Under certain conditions, a dependent child may be eligible to remain covered beyond age 25 if he or she is incapacitated and continues to be dependent primarily on you for support.

*For the purpose of coverage under the Health Care Plans, a spouse is a person to whom you’re legally married if the marriage is recognized in the jurisdiction in which you are married. See below for details regarding eligibility for domestic partners.
Contact your tax adviser if you're unsure whether your dependent qualifies for FSA coverage.

You may be reimbursed by your FSA for qualified expenses incurred by a dependent described above as long as the dependent meets certain criteria that make him or her tax-eligible for health care expenses under the federal tax code. Health care coverage can be provided tax-free to a child who has not attained age 27 by the end of a year, regardless of his or her status as a “qualifying child” or “qualifying relative.” However, this change in the law does not extend to domestic partner children. Therefore, for FSA coverage of a domestic partner and an eligible domestic partner child, the dependent must continue to meet the requirements under IRC Section 152. In other words, the domestic partner and eligible domestic partner child(ren) must be “qualifying relatives” in order for their medical expenses to be reimbursed from the FSA.

Your Contributions and Coverage

Estimate Your Expenses for the Health Care FSA

When deciding to enroll in the FSA, make sure you estimate your expenses carefully. Keep in mind that the FSA is a “use-it-or-lose-it” benefit. You'll need to think about what eligible health care expenses you expect to incur during the upcoming calendar year so you don’t elect a contribution amount that exceeds your eligible expenses. You may request reimbursement for eligible expenses from your account as soon as your coverage begins. If you've enrolled in an FSA, your entire elected amount will be available to you as needed when you submit your eligible expenses, as long as you remain eligible. However, the deductions for your FSA contribution will occur throughout the year from your paychecks.

**HEALTH CARE FSA EXAMPLE**

Phyllis elects to contribute $500 to the FSA. In February, she has a dental expense that’s applied to her dental plan deductible and coinsurance. Phyllis requests and receives her FSA reimbursement of $500 in March. She receives the full reimbursement even though she hasn’t contributed the entire $500 amount as of March.

Determining Your Contributions

Before your FSA becomes active, you'll need to decide how much to contribute. It's important that you carefully estimate your FSA contributions. The IRS requires that you forfeit any money you don’t use for the year (a “use-it-or-lose-it” benefit). Make sure all the eligible expenses you incur during the year are mailed and received no later than March 31 of the following year. You forfeit any amounts that remain in your FSA unclaimed on or after April 1. The Plan uses forfeited amounts to offset its benefits administrative costs.

You'll also want to keep in mind how much you’ve allotted to your other spending accounts. It’s also important to consider the type of medical, vision and/or dental coverage you may have available under the Health Care Plans and from other external coverage.

When You Can Change Your Coverage

You may change the amount of your contribution under the FSA at one of three times:

- During annual enrollment
- If you have a qualifying change in status
- If you experience another applicable change event
These are each explained in greater detail below.

Changing Coverage during Annual Enrollment

Each year during annual enrollment, you can change your contribution amount under the FSA for the following year. When you elect a contribution change during the annual enrollment period, your change takes effect the following January. 1. Your annual contribution election remains in effect from January 1 through December 31 unless you change your election in accordance with the provisions described in this section. If you don’t make a change to your current contribution during annual enrollment, your current election will automatically continue for next year.

Changing Coverage When You Have a Qualifying Change in Status

If you experience a qualifying change in status that affects your eligibility, it’s possible for you to change your FSA coverage as long as the change to your election to increase or decrease your contribution is consistent with the circumstances of the change in status. The date your election change will take effect is based on the reason for your request.

Your change will take effect on the first day of the month following the date of the event, once approved, if your requested change was due to:

- Marriage or the establishment of an eligible domestic partnership
- The birth, adoption or placement for adoption of a child
- Death of a child
- Divorce or dissolution of a domestic partnership
- Legal separation, annulment or death of a spouse/domestic partner
- A change in employment status by you or a dependent
- A commencement of employment
- A termination of employment when continued coverage is not provided
- A switch from part-time to full-time status, or vice versa
- A strike, lockout or layoff
- A commencement or return from an unpaid or significantly reduced paid leave of absence
- A change in worksite
- Any other change in employment status that affects your, your spouse’s/domestic partner’s or your dependent’s health coverage
- Commencement or termination of a dependent’s eligibility on account of age or other similar circumstance
- A change in the place of residence of you, your spouse/domestic partner or your dependent that affects your coverage
- Any other event recognized under applicable law and regulations as a reason to change an election under the Health Care FSA

Changing Coverage Because of another Applicable Change Event
Your change in coverage is approved only if it’s consistent with the qualifying change in status or other applicable change event. If you change your election due to another applicable event, it will take effect the first day of the following month (or the month in which the election is approved, if later).

- **Qualified Medical Child Support Order (QMCSO)** — You may become subject to a Qualified Medical Child Support Order (QMCSO) that requires you to provide health coverage for a child. If this occurs, you may change your FSA contributions accordingly. Your change will take effect as of the first day of the month following the month when the Plan Administrator determines that the order is a QMCSO. Contact the Motorola Solutions Employee Service Center for procedures to follow when entering a QMCSO.

- **Significant cost or coverage change** — If you experience an unanticipated or significant change in cost, you can’t change your contribution election for the FSA.

- **Medicare or Medicaid entitlement** — If you or your spouse/domestic partner enrolls in or loses coverage under Medicare (Part A or B) or Medicaid, you may change your FSA contribution election accordingly. The change in contribution takes effect on the first day of the month following the date the Employee Service Center approves the change.

To obtain more information about other applicable change events described here, contact the Employee Service Center.

**If You Are Called to Active Duty**

If you are a reservist and called to active duty for more than 179 days (or for an indefinite period), you may withdraw the balance in your FSA. The available balance you are eligible to receive is the total amount of contributions you have made to date, minus any reimbursements. Since the military provides free health care to you, this provision is in place so that you are not penalized by having to forfeit any remaining balance in your FSA at the end of the plan year. Contact the Motorola Solutions Employee Service Center to request the withdrawal at any time between the date you are called to active duty and the last day of that calendar year.

**How to Change Your Coverage**

To make a coverage change, report your life event change on **Your Benefits Resources** or contact the Employee Service Center within 31 days of a qualifying change in status. Your change in coverage is approved only if it’s consistent with the qualifying change in status.

**If You Make a Midyear Change to or From a High Deductible Medical Plan**

Whether you have a qualifying change in status or another applicable change event, please note the following if you’re changing your medical coverage to or from a high deductible medical plan.

If you elected to participate in the general-purpose FSA for the year (e.g., with a non-high deductible plan or HMO coverage, or if you’ve opted out of medical coverage) and have a qualifying change in status or other applicable change event during the year, you won’t be allowed to enroll in a high deductible medical plan for the rest of the year in which the event occurred. However, you can still enroll in a high deductible medical plan during the next annual enrollment period for coverage beginning January 1 of the following year.

If you discontinue your coverage under a high deductible medical plan during a year and you elected to participate in the limited-purpose FSA during the year, you may continue to participate in the limited-purpose FSA for the year. In this case, the eligible expenses will still be limited to dental and vision care for the remainder of such year regardless of whether you become covered under any other medical coverage such as non-high deductible medical coverage or an HMO.
Ending Coverage

Your participation in the FSA ends on the earliest of the following dates:

- The last day of the month in which your employment ends
- The last day of the month in which you fail to meet the FSA eligibility requirements (other than due to a layoff or leave of absence)
- The last day of the month in which you begin a layoff or a leave of absence (other than a military service leave of absence under the 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 layoff or leave of absence (other than a military service leave of absence under the Military Service Pay Policy or a disability leave of absence) if you have at least six months of service
- If you’re on a disability leave of absence, the earliest of:
  - The last day of the month in which you’re no longer disabled unless you return to active employment
  - The last day of the month in which you pay the required monthly contributions for coverage
  - The last day of the month in which your employment ends
- The last day of the month for which you pay the required monthly contributions
- The last day of the month in which you have a change in status and discontinue your participation in the FSA
- The last day your election to participate remains in effect
- The last day of the month in which you receive military service pay under the Military Service Pay Policy
- The day your status changes to one where you aren’t eligible to participate, other than due to a layoff or leave of absence
- Ninety days after the Plan Administrator requires repayment from you or your covered dependent of amounts that are subject to reimbursement under any Motorola Solutions welfare plan, or overpayments or mistaken payments, if you fail to repay or set up an acceptable repayment schedule approved by the Plan Administrator
- The day you commit an intentional misrepresentation or fraud against the Plan
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

Even though you can’t make contributions to the FSA after the earliest of the above dates, your request for reimbursement of eligible expenses incurred before your contributions end must be received no later than March 31 of the year following the earliest of the above dates. Any eligible expense incurred after you stop contributions isn’t eligible for reimbursement (unless you elect continuation coverage under COBRA).

**DON’T WAIT UNTIL MARCH 31!**

Your FSA claims must be received by Your Spending Account no later than March 31. Regardless of any mishaps that may occur with postal or fax delivery, any claim received after this date is not eligible.
Leave of Absence

If you go on an approved leave of absence and you stop receiving regular paychecks, your FSA contributions and coverage may be affected.

- You may continue to make your FSA contributions on an after-tax basis.
- You may elect to discontinue your FSA contributions. If you return from your leave of absence in the same calendar year, your contributions will automatically begin on a pro rata basis at the same contribution election that was in effect immediately before your leave.
- You may elect to discontinue coverage.

You may submit only eligible health care expenses incurred up to the last day of the month in which you stop making FSA contributions. If you’re on a paid leave, your FSA contributions will continue to be deducted from your paycheck. However, if you’re receiving disability benefits, you’ll receive a monthly invoice to pay your FSA contributions.

Health Care FSA Continuation Rights under COBRA

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires most employers that sponsor medical benefit plans, including Motorola Solutions, to offer employees and certain members of their families the opportunity to extend coverage temporarily after coverage would otherwise end. The extension of coverage to employees and their eligible dependents is called "continuation coverage."

In general, the coverage that may be continued is the same as the coverage in which you and your eligible dependents were enrolled when you were an active employee on the day before the qualifying event (described below). You and your covered dependents may be able to continue FSA coverage.

After termination of your FSA coverage due to a qualifying event, you may continue FSA coverage under COBRA. To continue coverage under COBRA, you’re required to pay your previous contribution amount plus 2 percent. COBRA contributions can be paid only on an after-tax basis. COBRA coverage allows you to be reimbursed from your previously accumulated pretax contributions for eligible health care expenses you incur after your termination. When you stop paying your COBRA contributions, your participation ends. You may continue FSA coverage under COBRA only until the end of the calendar year in which the COBRA qualifying event occurred.

Qualifying Events and Maximum COBRA Periods

To be eligible for continuation coverage, you must have experienced a qualifying event. After the qualifying event, continuation coverage must be offered to each person who is a continuation coverage beneficiary.

The table below lists the FSA continuation choices available to continuation coverage beneficiaries under COBRA, based on specific qualifying events that would otherwise result in a loss of FSA coverage. Continuation coverage beneficiaries must have been participating in the FSA at the time of the qualifying event to be eligible for continuation coverage in the FSA. You may also elect COBRA coverage for an eligible child who is born, adopted or placed with you for adoption while your COBRA coverage is in effect.

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Maximum continuation coverage period*</th>
</tr>
</thead>
</table>

U.S. Health and Welfare Benefits Book for Employees 51
Termination of your employment (other than for gross misconduct)  
Reduction in your hours of employment that causes you to lose eligibility  
Retirement  
Your death  
Divorce or legal separation between you and your spouse  
Termination of your relationship with your domestic partner  
Your child or the child of your domestic partner no longer meets the definition of a dependent  
You become entitled to Medicare (under Part A, Part B or both)  

You have the right to continue FSA coverage until the last day of the calendar year in which the qualifying event occurs.

*The duration of coverage is from the date of the qualifying event.

Deciding Whether or Not to Elect Continuation Coverage

Motorola Solutions notifies the Motorola Solutions Employee Service Center within 31 days after the date you lose coverage under the Health Care Plans because of the qualifying event. The Employee Service Center sends you a notice and election form within 14 days of receiving notification of the qualifying event.

Under the law, you have 60 days to elect continuation coverage from the later of the day that either:

- Coverage would otherwise end because of one of the qualifying events described here; or
- The notice of you and your beneficiary’s right to elect continuation coverage is sent to you by the Employee Service Center.

If you don’t choose continuation coverage within this 60-day period, your participation under the FSA will end.

If you don’t want to elect continuation coverage, just call the Employee Service Center or simply do nothing. FSA coverage ends on the last day of the month in which the qualifying event occurred.

Paying for Your COBRA FSA Continuation Coverage

To continue your FSA coverage, you and/or your covered dependents must pay the full cost of coverage, plus a 2 percent fee for administrative costs. You make this payment during the period of continuation coverage.

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 contributions are due on the first of the month, whether or not you receive an invoice. If the Motorola Solutions Employee Service Center doesn’t receive your monthly contribution within 31 days of the due date, continuation coverage is cancelled as of the last day of the month in which you paid a contribution.

When Continuation Coverage Ends
Your FSA continuation coverage will continue through the last day of the year in which the qualifying event occurs.

If You’re Rehired

If your employment ends midyear and you’re rehired in the same year, you’ll be eligible to reestablish an FSA on a pro rata basis for the remainder of the year in which you were rehired. Otherwise, you may participate in the account beginning in the next year.

If your employment ends and you’re rehired in a subsequent year, you’ll be treated like a new hire for eligibility purposes.

Using Your Health Care FSA

You may use your FSA to reimburse eligible health care expenses not paid for by the Health Care Plans or any other group coverage. This includes any eligible health care expense that your spouse’s medical, dental, vision, hearing or prescription drug plan excludes from coverage. However, if you’re a high deductible medical plan participant, you may use your FSA to reimburse eligible dental and vision expenses only.

Eligible Reimbursable Health Care Expenses

You or your eligible dependent must incur the expense while you’re participating in the FSA. Eligible health care expenses must be for health care, as defined in Section 213(d) (Publication 502) of the Internal Revenue Code and any IRS guidance. See Eligible Expenses and Non-Eligible Expenses for samples of eligible and non-eligible expenses. Visit www.irs.gov for a complete list of covered expenses according to IRS guidelines or refer to Publication 502.

You may request reimbursement for eligible expenses incurred in the period when you participate and make contributions to your FSA. An exception applies to orthodontia-related claims. Certain advance payments for orthodontic services may be reimbursed before the services are provided. You must show proof of the advance payment of the orthodontic services. These orthodontic services are considered incurred when you make the advance payment.

<table>
<thead>
<tr>
<th>INCURRED EXPENSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Incurred” refers to the date when a service is rendered, not the date the service is invoiced or paid.</td>
</tr>
</tbody>
</table>

Using the Tax Deduction Instead of the FSA

Instead of using the FSA, you may choose to take direct tax deductions for eligible health care expenses, but you can’t deduct expenses paid from the FSA from your taxes. If your health care expenses are less than the allowable percentage of your adjusted gross income, it’s usually to your advantage to use the FSA rather than deducting the amount from your taxes. Consult a tax adviser to determine the best way to pay out-of-pocket health care expenses.

<table>
<thead>
<tr>
<th>HEALTH CARE FSA DEADLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all of your eligible expenses in a year, be sure to file your claims so that they’re received by Your Spending Account no later than March 31 of the following year. If Your Spending Account receives your claim after March 31, you won’t be eligible to receive any reimbursement from your FSA related to those</td>
</tr>
</tbody>
</table>
How to Receive Your Health Care FSA Benefits

Benefit payments may be deposited directly into a U.S. bank account. If you’re interested in direct deposit, please contact Your Spending Account directly.

The following table shows the information needed, where you need to send your claim (if necessary), and the deadline when filing for benefits.

<table>
<thead>
<tr>
<th>Account</th>
<th>Information needed</th>
<th>Where to send your claim</th>
<th>Deadline and initial decision</th>
</tr>
</thead>
</table>
| Health Care Flexible Spending Account (FSA)   | FSA reimbursement form that includes eligible expense amount and statement that claim won’t be reimbursed from any other source | Mail: Your Spending Account  
P.O. Box 785040  
Orlando, FL 32878-5040  
Fax: (888) 211-9900 | Deadline: Received no later than March 31* of the following year  
Initial decision: Within 30 days after claim is filed, plus extension of up to 15 days in special circumstances |

*If you wait any longer than this deadline, you won’t be eligible for benefits related to those expenses. According to Internal Revenue Service rules, any balance that remains in your FSA after the deadline is forfeited. So be sure not to contribute more money than you think you’ll use. Forfeited amounts are used to offset the costs of administering the FSA.

You may also submit a claim online and upload your documentation at Your Benefits Resources. Access the “Other Benefits” tab and link to “Your Spending Account (YSA).” When there, access the “Submit a Claim” section, and follow the instructions.

How to File for Reimbursement

If your claim isn’t reimbursed using your Your Spending Account card, you must file a claim by sending a completed claim form along with the itemized bill or a copy of the Explanation of Benefits (EOB).

How to Get a Claim Form and Submit Your Expenses

You must submit a claim form (or cover sheet) with your FSA claim. You may obtain your claim form by following the online steps below (or if you don’t have online access, instructions to obtain a cover sheet are available by phone).

- **Online:** Access the “Your Spending Account” page from Your Benefits Resources, and select “Submit Health Care Claim” under the “Take Action” toolbar. Indicate whether you will “Upload” your claim or “Send by fax or mail,” and then enter the required expense detail for each claim. After you complete the expense information, continue to follow the prompts to create a cover sheet to upload with your claim(s) or to print and fax.

- **By phone:** If you don’t have online access, you can contact the Motorola Solutions Employee Service Center and follow the Your Spending Account prompts to request a form or speak to a representative who will complete the online claim form for you. The representative will then mail you the required cover sheet to attach to your claim(s), and you may mail or fax as instructed on the claim form.

Your completed claim form must be received no later than March 31 of the following year.
What to Remember When Filing Your Claim

- Write your Member Identification Number and the patient's name on each bill.
- If you have other group health coverage, include the EOB from the other carrier.
- Provide a copy of the medical, vision or dental EOB, if applicable.
- Provide the incurred date of service (e.g., the date when the service was rendered).
- Submit receipts for proof of payment with orthodontia claims.
- For prescriptions, submit the tab from the prescription or a printout from the pharmacy showing the name of the drug, the pharmacy and the date the prescription was filled.
- For OTC prescriptions, submit the prescription from your doctor and a valid receipt.

**Note:** Verbal or handwritten information for general merchandise, illegible receipts, credit card receipts and statements with a forwarding balance will not be accepted.

If you submit a claim, you may be reimbursed up to the total annual amount you elected to contribute to your account for the calendar year. This applies even if your claim exceeds the amount you actually contributed to your FSA as of the date you request reimbursement.

**Note:** If your claim is denied in whole or in part, you have the right to appeal. See If your benefits are denied for more information.

**DEPENDENT CARE ACCOUNT (DCA)**

**General Information**

As long as you have qualifying dependent care expenses, you can elect to participate in the Dependent Care Account (DCA). This account lets you use pretax dollars to reimburse eligible elder care or dependent care expenses.

You can use the pretax dollars you contribute to the DCA to reimburse eligible expenses you incur to care for your qualified dependents while you and your spouse (if you’re married) work or attend school full time.

**Activating Your Account**

As an eligible employee with qualifying dependent care expenses, you can establish a DCA:

- Within 31 days from your first day at work;
- During an annual enrollment period; or
- Within 31 days after you experience a qualifying change in status or a significant change in cost or coverage.

If you’re married, both you and your spouse must either be working, looking for work, and/or attending school full time to participate in a DCA.

**Eligibility and Coverage Requirements**

This section summarizes eligibility and coverage requirements for the Dependent Care Account (DCA).
You and your dependents must meet certain eligibility requirements before you may begin or maintain a DCA. This section includes important eligibility, enrollment, and coverage information, including how and when you can elect to change your coverage.

Eligibility

Who Is Eligible

You’re eligible for the DCA if you’re scheduled to work more than 20 hours per week.

Who Isn’t Eligible

You’re not eligible for the DCA if any of the following is true:

- You aren’t scheduled to work more than 20 hours per week.
- You provide services under an independent contractor, consultant or employee leasing agreement.
- You’re classified as contract labor.
- You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in the DCA).

Dual Motorola Solutions Employees

If you and your spouse both work for Motorola Solutions, certain rules apply to your DCA. If both you and your spouse work for the company, each of you may contribute to a separate DCA. However, the combined total of your contributions can’t exceed the annual $5,000 maximum during the calendar year. If you are married and don’t file a joint return, the most you may contribute to a DCA is $2,500 annually. An eligible expense can be reimbursed from either your or your spouse’s DCA (not both).

Enrolling for Coverage

Electing Coverage

When you initially elect coverage, you’ll make your elections on Your Benefits Resources. If you’re a new employee, you may complete your enrollment online within 31 days from your hire date. Once you make an election, you can’t change your coverage under the Dependent Care Account (DCA) during the calendar year (unless you experience a qualifying change in status).

If you experience a qualifying change in status or other applicable change event during the year and want to change your coverage, you may do so on Your Benefits Resources or contact the Motorola Solutions Employee Service Center. See When you can change your coverage for details.

How Much You May Contribute

You may contribute from $600 to $5,000 annually ($2,500 if married and not filing a joint return) on a pretax basis to your DCA.

Note: Currently there are no limitations for highly compensated employees (defined by the IRS for 2018 as those who earned more than $120,000 in 2017). Motorola Solutions reserves the right to reduce DCA contributions, if necessary, based on the nondiscrimination test results. The Employee Service Center will notify you if this applies to you.
DUAL COVERAGE

If you and your spouse both participate in a DCA, make sure that your combined DCA contributions don’t exceed the maximum IRS limits.

Starting Your Coverage

As long as you meet the eligibility requirements and establish a DCA within 31 days of the day you start work, your coverage under the DCA begins on the day you start work. If, when your coverage is scheduled to begin, you’re off work for any reason other than illness, your coverage begins on the date you actually start work. Your coverage will never begin before you’ve reported to work on your first day of employment.

ATTENTION NEW EMPLOYEES

If you’re a new employee eligible for the DCA, be sure to complete your benefit elections promptly so that coverage can begin. You should choose your coverage under the DCA within 31 days from your date of hire.

Your Dependents

You may request reimbursement for dependent care expenses that are incurred by your qualified dependents.

For reimbursement of DCA expenses, your dependent must be considered either a “qualifying child” or a “qualifying relative,” as defined under IRC Section 152. In addition, your dependent (e.g., your child, parent, spouse/domestic partner or domestic partner’s child) must:

- Be under the age of 13, unless he or she is physically or mentally incapable of self-care;
- Qualify as your dependent under IRC Section 152; and
- Have the same principal residence as you for more than one-half of the taxable year.

Your spouse is considered a qualifying relative if he or she is physically or mentally incapable of self-care and has the same principal residence as you for more than one-half of the taxable year. If you’re divorced or legally separated, your child may qualify if you satisfy certain 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.

QUALIFYING DEPENDENTS

Contact your tax adviser if you’re unsure whether your dependent qualifies for DCA coverage.

Your Contributions and Coverage

Estimate Your Expenses for the DCA

When deciding to enroll in the DCA, make sure you estimate your expenses carefully. Keep in mind that the DCA is a “use-it-or-lose-it” benefit. You’ll need to think about what eligible dependent care expenses you expect to incur during the upcoming calendar year, so you don’t elect a contribution amount that exceeds your eligible expenses. You may request reimbursement for eligible expenses from your account.
as soon as your coverage begins. You may only request reimbursement up to the amount that has been deducted to date from your paycheck and contributed to your DCA.

**Dependent Care Account (DCA) Tax Implications**

There may be tax implications if you receive benefits from any other Motorola Solutions-subsidized dependent care program (as defined by Internal Revenue Code [IRC] Section 129) and the combined values of these benefits and your DCA exceed the annual amount allowed by the IRS. Also, 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 for information on the child care credit. You can calculate the exact amount of your child care credit by following the instructions on IRS Form 2441. You may want to consult a tax adviser to determine whether a DCA or a child care credit is the better choice for you.


**DCA Tax Advantages**

With a Dependent Care Account (DCA), you pay for your eligible dependent care expenses before taxes, so your taxable income is reduced. To show how the DCA can help you save on taxes, consider a single parent who files as head of household and earns an annual salary of $80,000. This person also deposits $4,000 a year in a DCA.

Here’s a tax savings comparison between using a DCA and paying dependent care expenses with after-tax dollars.

<table>
<thead>
<tr>
<th></th>
<th>Paying expenses with a DCA</th>
<th>Paying expenses with after-tax dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Taxable income</strong></td>
<td>$80,000</td>
<td>$80,000</td>
</tr>
<tr>
<td><strong>DCA deposit</strong></td>
<td>–$4,000</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Net taxable income</strong></td>
<td>$76,000</td>
<td>$80,000</td>
</tr>
<tr>
<td><strong>Taxes</strong></td>
<td>–$19,494</td>
<td>–$20,520</td>
</tr>
<tr>
<td><strong>After-tax payment of expenses</strong></td>
<td>$0</td>
<td>–$4,000</td>
</tr>
<tr>
<td><strong>Spendable income</strong></td>
<td>$56,506</td>
<td>$55,480</td>
</tr>
<tr>
<td><strong>Tax savings</strong></td>
<td>$1,026 annually (or $85.50 per month)</td>
<td></td>
</tr>
</tbody>
</table>

The figures above assume a tax rate of 15 percent federal, 3 percent state, and 7.65 percent FICA (Social Security and Medicare). For this example, itemized deductions (or the standard deduction) and personal exemptions the individual may claim have been disregarded.

**When You Can Change Your Coverage**

You may change coverage under the DCA at one of three times:

- During annual enrollment
- If you have a qualifying change in status
- If you experience another applicable change event

These are each explained in greater detail below.

**Changing Coverage during Annual Enrollment**

Each year during annual enrollment, you can change your coverage under the DCA for the following year. When you elect a coverage change during the annual enrollment period, your change takes effect the following January 1. Your annual coverage election remains in effect from January 1 through December 31 unless you change your election in accordance with the provisions described in this section.

**Changing Coverage When You Have a Qualifying Change in Status**

If you experience a qualifying change in status that affects your eligibility, it’s possible for you to change your Dependent Care Account (DCA) coverage as long as the change to your election is consistent with the circumstances of the change in status. If you change your election because of a change in status, it will take effect the first day of the following month or on the first day of the month in which the election is approved, whichever occurs later. A qualifying change in status includes any one of the following:

- Marriage, divorce or legal separation, annulment or death of a spouse
- A change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent
- A change in employment status by you or your spouse
  - A commencement of employment
  - A termination of employment when continued coverage is not provided
  - A switch from part-time to full-time status, or vice versa
  - A strike, lockout or layoff
  - A commencement or return from an unpaid or significantly reduced paid leave of absence
  - A change in worksite
- A change in the place of residence of you, your spouse/domestic partner, or your dependent that affects your coverage
- Any other event recognized under applicable law and regulations as a reason to change an election under the DCA

The events described above must have an effect on your or your dependent’s care, and your change must be consistent with these events.

**Changing Coverage Because of a Significant Cost or Coverage Change**

You may change your DCA election midyear if either of the following is true:

- You experience an unanticipated and significant change in cost of dependent care during the year (election changes are not permitted if the increase is imposed by a provider who is your relative).
- An unexpected and unforeseeable event curtails your current dependent care arrangement or causes it to cease.

If you change your DCA election because of a significant change in cost or coverage, the change will take effect the first day of the following month after the request. Retroactive changes are not permitted.

**How to Change Your Coverage**

To make a coverage change, go to Your Benefits Resources or **contact** the Motorola Solutions Employee Service Center within 31 days of a qualifying change in status. Your change in coverage is approved only if it’s consistent with the qualifying change in status.

Your new coverage takes effect on the first of the month following the qualifying change in status event.

**Ending Coverage**

Your ability to contribute to your Dependent Care Account (DCA) ends on the earliest of the following dates:

- The last day of the last pay period before your employment ends
- The last day of the last pay period before you no longer meet the DCA eligibility requirements
- The last day of the last pay period before you begin a leave of absence
- The last day of the last pay period in which you made a contribution
- The last day of the last pay period before you have a change in status or a significant change in cost or coverage, and discontinue your DCA
- Ninety days after the Plan Administrator requests repayment from you or your covered dependent of amounts that are subject to reimbursement under any Motorola Solutions welfare plan, or overpayments or mistaken payments from any Motorola Solutions welfare plan, if you fail to repay or set up an acceptable payment schedule approved by the Plan Administrator
- The day you commit an intentional misrepresentation or fraud against the Plan
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

Even though contributions aren’t permitted after the earliest of these dates, you may submit claims for reimbursement of expenses incurred during the year (whether incurred before or after your participation terminates), as long as the claim is received no later than March 31 of the following year.

**Leave of Absence**

If you go on a leave of absence, your DCA contributions and coverage may be affected. Generally, expenses for dependent care are not eligible unless you’re working.

**Paid leaves:** Your DCA contributions will continue to be deducted from your paychecks unless you make a change to your contributions.

**Unpaid leaves:** Your DCA contributions and coverage will automatically discontinue. If you return from your leave of absence in the same calendar year, your contributions and coverage will automatically begin again.
If You’re Rehired

If your employment ends midyear and you’re rehired in the same year, you may participate in the DCA, as long as you reenroll when you are rehired.

If your employment ends and you’re rehired in a subsequent year, you’ll be treated as a new hire for eligibility purposes.

Using Your DCA

You can pay eligible dependent care expenses with tax-free dollars by setting aside money in a Dependent Care Account (DCA). You may use your DCA in several ways:

<table>
<thead>
<tr>
<th>DON’T WAIT UNTIL MARCH 31!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your DCA claims must be received no later than March 31. Regardless of any mishaps that may occur with postal or fax delivery, any claim received after this date is not eligible.</td>
</tr>
</tbody>
</table>

Eligible Reimbursable Dependent Care Expenses

You may receive a reimbursement from your DCA for the following eligible expenses:

- Payments to a qualified child or elder care center, babysitter, nanny or au pair (including employment taxes)
- Services performed outside of the home for the care of a dependent child under age 13
- Nursery or preschool fees
- Registration or application fees
- Agency fees
- Payments to relatives who provide care (except children under age 19 and relatives who are your dependents)
- Specialty day camps, such as sports camps, music camps, computer camps, if the primary purpose is to care for your child while you (or your spouse, if married) work or attend school full time
- After-school care
- Expenses for transportation furnished by a dependent care provider (such as transportation to a day camp or after-school program not on premises)
- Out-of-home care for a disabled adult dependent, provided the dependent resides in your home at least eight hours per day
- Room and board for a care provider

<table>
<thead>
<tr>
<th>DCA DEADLINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all of your eligible expenses in a year, be sure to file your claims so that they’re received no later than March 31 of the following year. If Your Spending Account receives your claim after March 31, you won’t be eligible to receive any reimbursement from your DCA related to those expenses.</td>
</tr>
</tbody>
</table>
Examples of What Isn’t an Eligible Expense

You can’t be reimbursed from your DCA for any of the following expenses:

- 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
- Payments to a care provider who is your child and under age 19, or your relative who is a dependent
- Expenses for which a dependent care tax credit is taken on your annual tax return
- Expenses for any overnight camp, regardless of its 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
- Expenses incurred while you’re on a leave of absence

How to Receive Your DCA Benefits

Benefit payments may be deposited directly into a U.S. bank account. If you’re interested in direct deposit, please contact Your Spending Account directly at Your Benefits Resources.

The following table shows the information needed, where you need to send your claim (if necessary), and the deadline when filing for benefits.

<table>
<thead>
<tr>
<th>Account</th>
<th>Information needed</th>
<th>Where to send your claim</th>
<th>Deadline and initial decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Care Account</td>
<td>A completed DCA claim form that includes dates of service, the dependent’s name,</td>
<td>Mail: Your Spending Account P.O. Box</td>
<td>Deadline: Received no later than March 31* of the following year</td>
</tr>
<tr>
<td></td>
<td>description of services rendered and the total billed amount, the provider’s or</td>
<td>785040 Orlando, FL 32878-5040</td>
<td>*Initial decision: Within 30 days after claim is filed, plus extension of up to 15 days in special circumstances</td>
</tr>
<tr>
<td></td>
<td>caregiver’s name and tax identification number (or Social Security number) and</td>
<td>Fax: (888) 211-9900</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The provider’s or caregiver’s signature in the Provider Certification section; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An itemized receipt or bill</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your DCA itemized bill should include the name, address and taxpayer identification number (or Social Security number) of the caregiver.
that includes the provider’s or caregiver’s name

*If you wait any longer than this deadline, you won’t be eligible for benefits related to those expenses. According to Internal Revenue Service rules, any balance that remains in your DCA after the deadline is forfeited. So be sure not to contribute more money than you think you’ll use. Forfeited amounts are used to offset the costs of administering the DCA.

How to Get a Claim Form and Submit Your Expenses

You must submit a claim form (or cover sheet) with your DCA claim. You may obtain your claim form by following the online steps below (or if you don’t have online access, instructions to obtain a cover sheet are available by phone).

- **Online:** Access the “Your Spending Account” page from Your Benefits Resources, and select “Submit Dependent Care Claim” under the “Take Action” toolbar. Indicate whether you will “Upload” your claim or “Send by fax or mail,” and then enter the required expense detail for each claim. After you complete the expense information, continue to follow the prompts to create a cover sheet to upload with your claim(s) or to print and fax.

- **By phone:** If you don’t have online access, you can contact the Motorola Solutions Employee Service Center and follow the Your Spending Account prompts to request a form or speak to a representative who will complete the online claim form for you. The representative will then mail you the required cover sheet to attach to your claim(s), and you may mail or fax as instructed on the claim form.

If Your Benefits Are Denied

Motorola Solutions wants to make sure that you, your covered dependents and your beneficiaries all receive the full benefits that you and they are eligible to receive under the Plans.

Denied Benefits Requests and the Appeals Process

Once you apply for a specific benefit, you’ll receive a decision from the Claims Administrator in writing. The Claims Administrator may either approve or deny your request. If your benefits request is denied, you’ll receive a written notice that explains this denial. The notice will contain the following information:

- The specific reasons for the denial
- The specific Plan provisions upon which the denial is based
- A description of any additional material or information you’ll need to perfect the claim for benefits, as well as an explanation of why those materials are necessary
- An explanation of the appeal for this 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
- In the case of health care benefits, information that cites any specific rule, guideline, or protocol that was relied upon, or a statement that such rule, guideline or protocol was relied upon, and that states 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
- In the case of 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 that are in the possession of either Motorola Solutions or Your Spending Account. You’re also entitled to receive these documents 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; and
- In the case of health care 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

If an initial claim for benefits is denied, in whole or in part, in a letter from Your Spending Account or otherwise, you may request a review of the denial. If you aren’t satisfied with the determination, please call the Motorola Solutions Employee Service Center at (800) 585-5100. If, after a Your Spending Account representative investigates the determination, you are still not satisfied, you may appeal the denial at no cost to you within 180 days of the denial. The Your Spending Account representative will send you a Claim Initiation Form to submit with your appeal. (Instructions for completing the Claim Initiation Form and types of relevant information to provide will be included with the Claim Initiation Form.)

To help determine whether your claim is eligible for reimbursement, you should submit information that helps substantiate a valid claim under plan provisions (e.g., third party receipts). If you don’t submit a Claim Initiation Form during the 180-day period, no further action will be taken, and you won’t be able to file an appeal for this claim at a later date.

Second Level of Review

If your initial appeal is denied, you will receive a Level II Claim Initiation Form to submit a written second-level appeal within 180 days of that denial.

You’ll receive the final decision about your appeal in writing. This decision will give you the specific reasons for the decision and also provide you with the corresponding Plan provision(s). The decisions are final and binding on all parties except as required by law.

You or your covered dependents must exhaust all of the internal administrative remedies described above before bringing an action for benefits under the Plans under Section 502(a) of ERISA.

Where to Send Your Request for Review

<table>
<thead>
<tr>
<th>Plan or program</th>
<th>Send request for review to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Savings Account (HSA)</td>
<td>First level of review</td>
</tr>
<tr>
<td>Health Care Flexible Spending Account (FSA)</td>
<td>Second level of review</td>
</tr>
<tr>
<td>Dependent Care Account (DCA)</td>
<td>Contact:</td>
</tr>
<tr>
<td></td>
<td>The Motorola Solutions Employee Service Center for a Claim Initiation Form</td>
</tr>
<tr>
<td></td>
<td>Claims and Appeals Management</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1407</td>
</tr>
<tr>
<td></td>
<td>Lincolnshire, IL 60069-1407</td>
</tr>
<tr>
<td>Deadline for submitting written request for review</td>
<td>180 days from notification of denial</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Date for final decision on appeal</td>
<td>Decision will be made within 30 days of receipt of your written appeal</td>
</tr>
<tr>
<td>Date for filing suit in federal court</td>
<td>180 days after final denial of appeal</td>
</tr>
</tbody>
</table>
LIFE INSURANCE

Group Life Insurance Benefit Plan

The Motorola Solutions Group Life Insurance Benefit Plan (the “Life Insurance Plan”) provides financial support if you or a covered dependent dies for any reason.

This main section summarizes the coverage available under the Life Insurance Plan. Read on to learn more about the Plan’s eligibility requirements, how the Plan determines your coverage, how each Plan determines benefits and how to use the available tools to build financial security and replace income, no matter what circumstances life may bring.

The Motorola Solutions group life insurance coverage is administered by the MetLife Insurance Company. Keep this resource in a convenient place and refer to it often as your source for information about the Life Insurance Plan.

Business Travel Accident Insurance coverage is provided under the Motorola Solutions Global Business Travel Accident Program, insured by ACE American Insurance Company. Refer to Business Travel for more details.

The Life Insurance Plan

Overview

Motorola Solutions provides you with various means to help ensure your family’s financial security. The Life Insurance Plan pays benefits to your designated beneficiary(ies) in the event of your death, for any reason. It also pays a benefit to you or your designated beneficiary(ies) if you suffer a covered loss as the result of a non-work-related accident.

We offer Life (Basic, Supplemental and Dependent) and Accidental Death and Dismemberment (AD&D) under the Life Insurance Plan. The table below lists the various coverage options available for you and your eligible dependents. To participate, you or your dependent must meet the Plan’s eligibility requirements as detailed in About the Life Insurance Plan. Coverage is automatic in some cases, while others require you or your dependents to enroll. Here’s an overview of the coverage available.

Note: If the terms and provisions are different between this document and the insured contract, the insured contract will govern.

Life Insurance Plan Coverage

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Coverage amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Insurance (no cost to you)</td>
<td>Elect $50,000 or one times eligible compensation, rounded to the next higher $100*</td>
</tr>
<tr>
<td></td>
<td>Maximum benefit is $3 million (when combined with Supplemental Life Insurance benefit)</td>
</tr>
<tr>
<td>Supplemental Life Insurance (optional)</td>
<td>Elect from one to ten times eligible compensation, rounded to the next higher $100</td>
</tr>
</tbody>
</table>
### About the Life Insurance Plan

You and your dependents must meet the Plan’s eligibility requirements to be eligible for coverage. In this section, you can learn who’s eligible for the Plan and what you’ll need to do to enroll.

### Who’s Eligible

Before making a decision about what type of life insurance coverage would work best for you, it’s important to know if you’re eligible to receive coverage. You’re eligible for the Plan if all of the following requirements are met:

- You’re a domestic employee of Motorola Solutions or any company that participates in this Plan.
- You’re actively at work on the day your coverage becomes effective. If you’re not actively at work on the day your coverage would otherwise become effective, your coverage will take effect on the day that you return to active work.
- You’re regularly scheduled to work at least 20 hours per week.
- The company’s U.S. payroll department processes your regular paycheck.

You’re not eligible to participate in the Plan if:

- You provide services under an independent contractor, consultant or employee leasing agreement.
- You’re classified as a leased employee.
- You’re classified as contract labor.
- Your eligible compensation isn’t processed by the company’s U.S. payroll department.

---

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Coverage amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum benefit is $3 million (when combined with Basic Life Insurance benefit)</td>
<td></td>
</tr>
</tbody>
</table>
| **Dependent Life Insurance** (optional) | **Spouse/domestic partner:**
|                                    | $5,000                                                |
|                                    | $10,000                                               |
|                                    | $25,000                                               |
|                                    | $50,000                                               |
|                                    | $100,000                                              |
|                                    | $150,000                                              |
|                                    | $200,000                                              |
|                                    | **Each child:**
|                                    | $2,500                                                |
|                                    | $5,000                                                |
|                                    | $10,000                                               |
|                                    | $25,000                                               |
| **Accidental Death and Dismemberment (AD&D) Insurance** (no cost to you) | **Principal Sum** is one times eligible compensation, rounded to the next higher $100
| The Plan pays up to 100% of your “Principal Sum” (see definition at right) to you or your beneficiary for a non-work-related accidental injury. |
|                                    | **Maximum benefit is $3 million**                      |

*If you don’t make any election within your first 31 days of active work, you’ll automatically have coverage at one times your eligible compensation, rounded to the next higher $100.*
You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in this Plan).

**IF YOU WERE HIRED DURING A MERGER, ACQUISITION OR ENDING OF A JOINT VENTURE**

If you became employed by Motorola Solutions or a related company that has adopted the Life Insurance Plan as the result of a merger, an acquisition or the ending of a joint venture, you’ll only be eligible if, and to the extent that, the company expressly extends coverage under the Life Insurance Plan to your group of employees.

**Coverage Options and Eligibility**

The table below contains a description of each type of insurance and who’s eligible for each type of coverage.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
<th>Who’s eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Life Insurance</strong></td>
<td>Pays a benefit to your beneficiary(ies) if you die</td>
<td>You (automatic coverage)</td>
</tr>
<tr>
<td><strong>Supplemental Life Insurance</strong></td>
<td>Pays a benefit to your beneficiary(ies) if you die (this is in addition to your Basic Life Insurance benefit)</td>
<td>You, if you enroll and pay for coverage</td>
</tr>
<tr>
<td><strong>Dependent Life Insurance</strong></td>
<td>Pays a benefit to you if your covered spouse/domestic partner or dependent child dies</td>
<td>Your eligible dependents, if you enroll them and pay for coverage</td>
</tr>
<tr>
<td><strong>Accidental Death and Dismemberment (AD&amp;D) Insurance</strong></td>
<td>Pays a benefit to you or your beneficiary(ies) if you suffer a covered loss in a non-work-related accident</td>
<td>You (automatic coverage)</td>
</tr>
</tbody>
</table>

*You must elect Supplemental Life Insurance coverage for yourself before you may enroll your eligible dependents for Dependent Life Insurance coverage.*

**Dependent Eligibility**

If you elect Supplemental Life Insurance coverage for yourself, you may enroll your spouse/domestic partner and/or your children for Dependent Life Insurance coverage. Your spouse/domestic partner and children must meet certain requirements to be eligible for this coverage.

**Domestic Partner Eligibility Requirements**

Certain rules apply if you’d like to enroll your domestic partner in Dependent Life Insurance coverage. Your domestic partner is eligible for coverage provided all of the following requirements are met:

- You and your domestic partner are registered as domestic partners in accordance with applicable city, county or state laws.
- In the absence of domestic partner registration, all of the following requirements must be met:
  - You and your domestic partner are at least 18 years of age.
  - You and your domestic partner aren’t related to one another to a degree that would prevent marriage under the law of the state in which you reside.
Neither you nor your domestic partner is married to another person under statutory or common law, and neither of you is in another domestic partnership.

You and your domestic partner are in a single, dedicated relationship with each other and have been in such relationship for a minimum of six consecutive months, and intend to remain in the relationship indefinitely.

You and your domestic partner share the same residence and have shared the same residence for a minimum of six consecutive months.

You and your domestic partner have an exclusive mutual commitment to share the responsibility for each other’s welfare and financial obligations for a minimum of six months. In addition, two or more of the following exist as evidence of your joint responsibility for basic financial obligations:

- A joint mortgage or lease
- Designation of your domestic partner as beneficiary for life insurance coverage or retirement benefits
- Joint wills or designation of your domestic partner as executor and/or primary beneficiary
- Designation of your domestic partner as durable power of attorney or health care proxy
- Ownership of a joint bank account or joint credit cards or other evidence of joint financial responsibility
- Other evidence of economic interdependence

**DUAL MOTOROLA SOLUTIONS EMPLOYEES**

A Motorola Solutions employee may not be considered a dependent of another employee for Dependent Life Insurance. In addition, one person can’t be considered a dependent of two employees.

**Dependent Child Eligibility Requirements**

Certain rules apply if you’d like to enroll any of your unmarried dependent children in Dependent Life Insurance coverage. An unmarried dependent child is eligible for coverage if any of the following is true:

- He or she is your natural-born child.
- He or she is your adopted child or a child placed with you for adoption (even if the adoption isn’t yet final).
- He or she is your foster child and is legally placed with you by a licensed agency.
- He or she is your stepchild.
- He or she is your domestic partner’s child.

Your dependent child is eligible for coverage from 14 days through age 25.

If your child is incapacitated and unable to support himself or herself at the time coverage would otherwise end, continued coverage may be available. **Contact** the Motorola Solutions Employee Service Center for details.
Naming Your Beneficiaries

When you elect to receive Basic and Supplemental Life Insurance coverage, you must name one or more primary beneficiaries. The beneficiary you designate for your Basic Life Insurance coverage also receives any death benefit under your AD&D Insurance coverage. A primary beneficiary is a person, trust, or estate that you designate to receive a Plan benefit if you die for any reason. You can also name one or more contingent beneficiaries for your Basic and Supplemental Life Insurance coverage. If you designate a contingent beneficiary, he or she receives the benefit if your primary beneficiary is no longer living at the time the benefit becomes payable.

To designate a primary or contingent beneficiary, visit Your Benefits Resources.

If you don’t designate a beneficiary, the Plan pays benefits in accordance with the Basic Life Insurance Policy. According to that policy, if you fail to designate a beneficiary, the Plan pays benefits to the first of the following beneficiary classes where there’s a surviving person:

- Your spouse/domestic partner
- Your children
- Your parents
- Your brothers and sisters
- Your estate

If more than one surviving person exists in a beneficiary class, everybody in that beneficiary class will share in the benefits equally.

Changing Your Beneficiary

You can change your primary or contingent beneficiary by logging on to Your Benefits Resources. You can’t use any other type of agreement or document (such as a will or divorce settlement agreement) to change your beneficiary. However, the Plan Administrator does recognize a valid Qualified Domestic Relations Order that assigns your benefits.

How to Log on to Update or Change Your Beneficiary

Access Your Benefits Resources. If an “Action Needed! Update Your Beneficiary Information” message appears, you can click on “Review and Update” to make your designation or change. If this message doesn’t appear, you may:

- Click on the “Health and Insurance” tab on the home page; and
- Choose “Beneficiaries” under “Overview” in the drop down box that will pop up.

Evidence of Insurability

In some instances, you or your dependent may be required to submit a completed Evidence of Insurability form. Coverage doesn’t begin until the first day of the month following the date the Plan Administrator or its designee approves your /your dependent’s application. You must provide a completed Evidence of Insurability form for any of the following circumstances:

- You decide to take advantage of any additional insurance more than 31 days after the day you begin working, and you choose Supplemental Life or Dependent Life Insurance for the first time. (Your
Your spouse/domestic partner must provide a completed Evidence of Insurability form; this isn’t required for your eligible child or children.)

- You increase your Basic or Supplemental Life Insurance coverage.
- You increase your Dependent Life Insurance coverage.
- Your initial election of Supplemental Life Insurance coverage is more than six times your eligible compensation.

To complete an Evidence of Insurability form, go to Your Benefits Resources and follow the online instructions.

### How the Plan Pays Benefits

If you die while your Basic Life, Supplemental Life and/or AD&D Insurance coverage is in effect, the Plan pays the total benefit due to your designated beneficiary(ies). The Plan pays the total benefit in a lump-sum payment or in installments.

Your beneficiary(ies) can get more information from the Motorola Solutions Employee Service Center regarding the form in which the benefits may be received.

### Life Insurance Coverage Options

In this section, we identify the four types of life insurance coverage that you may be eligible to receive: Basic Life Insurance, Supplemental Life Insurance, Dependent Life Insurance and AD&D Insurance. Each section identifies the type of coverage, when coverage begins and ends, and what happens in the event of a leave of absence. You’ll also learn more relevant information about each Plan.

#### Basic Life Insurance

Basic Life Insurance is the foundation of your survivor income benefits. This section includes information about Basic Life Insurance, when coverage begins and ends, and any exclusions that may apply.

#### Basic Life Insurance Coverage

As an eligible employee, your Basic Life Insurance coverage is provided by the company. You may select from two different levels of coverage. The maximum Basic Life Insurance benefit you can receive under the Plan is $3 million. This amount includes Supplemental Life Insurance (if elected).

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Coverage amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life Insurance</td>
<td>Elect $50,000 or one times eligible compensation, rounded to the next higher $100*</td>
</tr>
</tbody>
</table>

*If you don’t make any election within your first 31 days of active work, you’ll automatically have coverage at one times your eligible compensation, rounded to the next higher $100.
**TOTAL DISABILITY**

For purposes of continuing Basic Life Insurance coverage, the Plan considers you to have a "total disability" and to be "totally disabled" if you're disabled within the meaning of, and entitled to receive a benefit under, the Motorola Solutions Disability Income Plan.

---

**When Coverage Begins**

As long as you meet the Life Insurance Plan’s eligibility requirements, your Basic Life Insurance coverage begins on your first day of work (when you’re actively at work). You may elect your Basic Life Insurance coverage within 31 calendar days of your first day of active employment. If you don’t elect coverage within this period, you’ll automatically have Basic Life Insurance coverage at one times your eligible compensation, rounded to the next higher $100.

If you elect a lower coverage amount later than 31 calendar days after your first day of active employment, your new coverage will take effect on the first day of the month after the election is correctly completed. If you later want to increase your Basic Life Insurance, and you’re approved for this coverage by MetLife based on review of your evidence of insurability, your higher coverage begins on the first day of the month after MetLife approves the change. You can designate your beneficiary(ies) online on Your Benefits Resources. See [Naming your beneficiaries](#).

**When Coverage Ends**

Your Basic Life Insurance coverage ends on the earliest of the following occurrences:

- The last day of the month in which your employment ends
- The last day of the month in which you’re no longer eligible for disability continuation coverage under the Plan
- The last day of the month in which your employment status changes to a status that makes you ineligible for coverage (other than due to a layoff or a leave of absence)
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

**What Happens When You’re on a Leave of Absence, Disability Leave or Military Service Leave of Absence**

If you go on a leave of absence, disability leave or military service leave of absence, the effect on your Basic Life Insurance coverage will depend upon how long you’ve been insured under the Plan.

If you’ve been insured for less than six months, your Basic Life Insurance coverage ends on the last day of the month in which your leave begins (unless coverage during military service leave is required by law).

If you’ve been insured for at least six months and go on a leave, your Basic Life Insurance coverage ends depending on the type of leave you take:

- **Leave of absence**: Your coverage ends on the last day of the sixth month after your leave of absence begins.
- **Disability leave**: Your coverage ends on the last day of the 12th month after the month in which your disability leave of absence begins, unless you qualify for the “extension” period. See [Continuation of coverage during a disability leave of absence](#).

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Military service leave of absence: Your coverage ends on the last day of the month in which your military service leave pay ends under the Military Service Pay Policy, unless additional coverage during military service leave is required by law.

Exclusions

The Life Insurance Plan doesn’t pay a Basic Life Insurance benefit to your designated beneficiary if your death was caused by the beneficiary while involved in the commission of, or the attempt to commit, a felony. If this is the case, the Plan pays the Basic Life Insurance benefit to your contingent beneficiary. If no contingent beneficiary is designated, the Plan pays the benefit as if you failed to designate a beneficiary, as described in Naming your beneficiaries.

Supplemental Life Insurance

You may decide that you need more coverage than just your Basic Life Insurance coverage. If this is the case, you may elect Supplemental Life Insurance coverage for yourself. This coverage isn’t automatic; you must enroll and pay for this additional coverage on an after-tax basis.

Supplemental Life Insurance Coverage

As long as you meet the Plan’s eligibility requirements, you have 10 different options to choose from when electing your Supplemental Life Insurance coverage.

TO CONFIRM YOUR HEALTH STATUS

You may need to provide a completed Evidence of Insurability form, and it must be approved by MetLife before your Supplemental Life Insurance coverage takes effect.

Your Cost for Coverage

You pay for Supplemental Life Insurance coverage with monthly after-tax contributions deducted from your pay. Your cost for coverage is based on the level of coverage you choose and your eligible compensation. For the current cost associated with each coverage level, visit Your Benefits Resources or contact the Motorola Solutions Employee Service Center.

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Coverage amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>One times eligible compensation, rounded to the next higher $100</td>
</tr>
<tr>
<td>Level 2</td>
<td>Two times eligible compensation, rounded to the next higher $100</td>
</tr>
<tr>
<td>Level 3</td>
<td>Three times eligible compensation, rounded to the next higher $100</td>
</tr>
<tr>
<td>Level 4</td>
<td>Four times eligible compensation, rounded to the next higher $100*</td>
</tr>
<tr>
<td>Level 5</td>
<td>Five times eligible compensation, rounded to the next higher $100*</td>
</tr>
<tr>
<td>Level 6</td>
<td>Six times eligible compensation, rounded to the next higher $100*</td>
</tr>
<tr>
<td>Level 7</td>
<td>Seven times eligible compensation, rounded to the next higher $100*</td>
</tr>
<tr>
<td>Level 8</td>
<td>Eight times eligible compensation, rounded to the next higher $100*</td>
</tr>
<tr>
<td>Level 9</td>
<td>Nine times eligible compensation, rounded to the next higher $100*</td>
</tr>
</tbody>
</table>
Level 10 | Ten times eligible compensation, rounded to the next higher $100*

*For any election more than three times your eligible compensation, evidence of insurability is required.

The maximum amount of Supplemental Life Insurance coverage you may have is $3 million. This includes your Basic Life Insurance coverage.

When Coverage Begins

If you enroll for Supplemental Life Insurance within 31 calendar days after your first day of active employment, coverage will begin on your first day of active employment.

If you enroll for coverage later than 31 calendar days after your first day of active employment, you must submit a completed Evidence of Insurability form and be approved for this coverage by MetLife. In this case, your Supplemental Life Insurance coverage begins the first day of the month following MetLife’s approval of your coverage.

During the Annual Enrollment period, special rules regarding Evidence of Insurability may apply and you may be able to elect Supplemental Life, or, increase your Supplemental Life without providing Evidence of Insurability. The company will communicate the Evidence of Insurability requirements during the Annual Enrollment period.

When Coverage Ends

Your Supplemental Life Insurance coverage ends on the earliest of the following occurrences:

- The last day of the month in which your employment ends
- The last day of the month in which you’re no longer eligible for disability continuation coverage under the Plan
- The last day of the month in which you fail to pay the required contributions for Supplemental Life Insurance coverage
- The last day of the month in which your employment status changes to one where you’re no longer eligible for coverage (other than because of a layoff or leave of absence)
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

What Happens When You’re on a Leave of Absence, Disability Leave or Military Service Leave of Absence

If you go on a leave of absence, disability leave, or military service leave of absence, the effect on your Basic Life Insurance coverage will depend upon how long you’ve been insured under the Plan.

If you’ve been insured for less than six months, your Supplemental Life Insurance coverage ends on the last day of the month in which your leave begins (unless coverage during military service leave is required by law).

If you’ve been insured for at least six months and go on a leave, when your Supplemental Life Insurance coverage ends depends on the type of leave you take:
- **Leave of absence**: Your coverage ends on the last day of the sixth month after the month in which your leave of absence begins.

- **Disability leave**: If you are disabled for more than nine months, your Supplemental Life Insurance coverage may continue as described in *Continuation of coverage during a disability leave of absence*.

- **Military service leave of absence**: Your coverage ends on the last day of the month in which your military service leave pay ends under the Military Service Pay Policy, unless additional coverage during military service leave is required.

**Exclusions**

The Life Insurance Plan doesn’t pay a Supplemental Life Insurance benefit to your designated beneficiary if your death was caused by the beneficiary while involved in the commission of, or the attempt to commit, a felony. If this is the case, the Plan pays the Supplemental Life Insurance benefit to your contingent beneficiary. If you don’t designate a contingent beneficiary, the Plan pays the benefit as if you failed to designate a beneficiary, as described in *Naming your beneficiaries*.

If you commit suicide within the first two years of the effective date of your Supplemental Life Insurance coverage (or within two years of the day you increase your Supplemental Life Insurance coverage), the Plan won’t pay a Supplemental Life Insurance benefit (or the increased amount of coverage). If this occurs, the Plan refunds the contributions you paid for the cost of Supplemental Life Insurance coverage (or the increased amount) to your beneficiary.

**Dependent Life Insurance**

If you want to elect Dependent Life Insurance coverage for your eligible dependents, you must first enroll for Supplemental Life Insurance coverage. Dependent Life Insurance coverage isn’t automatic, and you pay for this coverage on an after-tax basis. You may choose a different option level for your spouse/domestic partner from the level chosen for your child(ren). Example: You may choose $25,000 for your spouse/domestic partner and $5,000 for your child(ren).

<table>
<thead>
<tr>
<th>TO CONFIRM YOUR DEPENDENT’S HEALTH STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you don’t enroll your dependent within 31 days of your first day of active work, you must submit a completed Evidence of Insurability form for your dependent.</td>
</tr>
</tbody>
</table>

**Your Cost for Coverage**

You pay for Dependent Life Insurance coverage with monthly after-tax contributions deducted from your pay. Your cost for coverage depends on the level of coverage you choose and the number of your covered dependents. Spouse/domestic partner life insurance is also based on the individual’s age.

**Dependent Spouse/Domestic Partner Life Insurance**

The amount of Dependent Life Insurance coverage you may choose for your spouse/domestic partner may not exceed the amount of your Basic and Supplemental Life Insurance combined. For example, if your Basic and Supplemental Life Insurance combined equals $175,000, the maximum amount of coverage you can choose for your spouse/domestic partner is $150,000.
<table>
<thead>
<tr>
<th>Option</th>
<th>Coverage Amount*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$5,000</td>
</tr>
<tr>
<td>Option 2</td>
<td>$10,000</td>
</tr>
<tr>
<td>Option 3</td>
<td>$25,000</td>
</tr>
<tr>
<td>Option 4</td>
<td>$50,000</td>
</tr>
<tr>
<td>Option 5</td>
<td>$100,000*</td>
</tr>
<tr>
<td>Option 6</td>
<td>$150,000*</td>
</tr>
<tr>
<td>Option 7</td>
<td>$200,000*</td>
</tr>
</tbody>
</table>

*Evidence of Insurance is required for any option above $50,000

Dependent Child Life Insurance

<table>
<thead>
<tr>
<th>Option</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$2,500 per child</td>
</tr>
<tr>
<td>Option 2</td>
<td>$5,000 per child</td>
</tr>
<tr>
<td>Option 3</td>
<td>$10,000 per child</td>
</tr>
<tr>
<td>Option 4</td>
<td>$25,000 per child</td>
</tr>
</tbody>
</table>

When Coverage Begins

If you enroll your dependent for Dependent Life Insurance coverage within 31 calendar days after your first day of active employment, coverage begins on your first day of active employment.

If you enroll your spouse/domestic partner for Dependent Life Insurance coverage later than 31 calendar days after your first day of active employment, you must submit a completed Evidence of Insurability form for your spouse/domestic partner. In addition, MetLife must approve this coverage. In this case, your Dependent Life Insurance coverage for your spouse/domestic partner begins the first day of the month following MetLife’s approval of your spouse’s/domestic partner’s coverage.

During the Annual Enrollment period, special rules regarding Evidence of Insurability may apply and you may be able to elect Spouse/Domestic Partner Life without providing Evidence of Insurability. The company will communicate the Evidence of Insurability requirements during the Annual Enrollment period.

You can enroll your child(ren) for Dependent Life Insurance at any time. Evidence of insurability isn’t required. You may enroll a dependent for Dependent Life Insurance coverage if the dependent is confined at home under a physician’s care or hospitalized; however, coverage isn’t effective until your dependent is released from the confinement.

Remember, to be eligible for Dependent Life Insurance coverage, you must enroll for Supplemental Life Insurance coverage for yourself, enroll your eligible dependent for Dependent Life Insurance coverage, and pay the monthly contributions.

Beneficiaries

If you have Dependent Life Insurance coverage, you’re the only beneficiary. This means that if any of your covered dependents die for any reason while their Dependent Life Insurance coverage is in effect, the Plan pays a benefit to you. Exclusions do apply. See Exclusions for details.
When Coverage Ends

Dependent Life Insurance coverage ends on the earliest of the following occurrences:

- The last day of the month in which your covered dependent is no longer an eligible dependent*
- The day your Supplemental Life Insurance coverage ends for any reason
- The last day of the month in which you fail to pay the required contributions for Dependent Life Insurance coverage
- The day your covered dependent enters the military service of any country*
- The last day of the month in which your employment status changes to one in which you’re no longer eligible for coverage
- The last day of the month in which you terminate employment
- The last day of the month in which your disability leave of absence begins, unless you continue coverage as described under Continuation of coverage during a disability leave of absence
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

*However, you must actively cancel Dependent Life Insurance by contacting the Motorola Solutions Employee Service Center; otherwise, your contributions will continue even though coverage will have ended.

Exclusions

If your dependent commits suicide within the first two years of the effective date of his or her Dependent Life Insurance coverage (or within two years of the day you increase Dependent Life Insurance coverage), the Life Insurance Plan won’t pay a Dependent Life Insurance benefit (or the increased amount of coverage). If this occurs, the Plan refunds any contributions you paid for the cost of Dependent Life Insurance coverage (or the increased amount).

Accidental Death and Dismemberment (AD&D) Insurance

As long as you meet the Life Insurance Plan’s eligibility requirements and you have Basic Life Insurance coverage, the Plan also provides you with Accidental Death and Dismemberment (AD&D) Insurance coverage. This coverage provides financial protection if you suffer a covered loss as the result of a non-work-related accident. You don’t have to enroll, and there’s no cost to you for this coverage.

Your Principal Sum of Coverage

The company provides you with a Principal Sum of coverage as shown in the table below.

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Principal Sum of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD&amp;D Insurance</td>
<td>One times eligible compensation, rounded to the next higher $100</td>
</tr>
</tbody>
</table>
The maximum amount of AD&D coverage you may have is $3 million.

When Coverage Begins

As long as you meet the Life Insurance Plan’s eligibility requirements, your AD&D Insurance coverage begins on your first day of active work.

How the Plan Pays Benefits

The Life Insurance Plan pays a benefit to you or your designated beneficiary if you suffer a covered loss due to an accident. The covered loss must occur within 365 days of the accident.

The benefit is equal to your Principal Sum of coverage or a percentage of your Principal Sum, depending on the covered loss, as shown in the Schedule of benefits.

Schedule of Benefits

The Plan pays an AD&D benefit based on the following schedule.

<table>
<thead>
<tr>
<th>Covered loss</th>
<th>Benefit amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>Loss of any combination of the following:</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>▪ One hand</td>
<td></td>
</tr>
<tr>
<td>▪ One foot</td>
<td></td>
</tr>
<tr>
<td>▪ Sight in one eye</td>
<td></td>
</tr>
<tr>
<td>Loss of both:</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>▪ Speech</td>
<td></td>
</tr>
<tr>
<td>▪ Hearing in both ears</td>
<td></td>
</tr>
<tr>
<td>Loss of one of the following:</td>
<td>75% of Principal Sum</td>
</tr>
<tr>
<td>▪ Arm</td>
<td></td>
</tr>
<tr>
<td>▪ Leg</td>
<td></td>
</tr>
<tr>
<td>Loss of one of the following:</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>▪ Hand</td>
<td></td>
</tr>
<tr>
<td>▪ Foot</td>
<td></td>
</tr>
<tr>
<td>▪ Sight in one eye</td>
<td></td>
</tr>
<tr>
<td>▪ Speech</td>
<td></td>
</tr>
<tr>
<td>▪ Hearing</td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>Covered loss</td>
<td>Benefit amount paid</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25% of Principal Sum</td>
</tr>
<tr>
<td>Loss of thumb and index finger of the same hand</td>
<td>25% of Principal Sum</td>
</tr>
<tr>
<td>Paralysis of one arm or one leg</td>
<td>25% of Principal Sum</td>
</tr>
<tr>
<td>Coma</td>
<td>1% up to 60 months, less any other Principal Sum benefits paid after 7 days of continuous coma</td>
</tr>
<tr>
<td>Brain damage</td>
<td>100% if:</td>
</tr>
<tr>
<td></td>
<td>▪ Presented within 30 days of the accident;</td>
</tr>
<tr>
<td></td>
<td>▪ The accident resulted in hospitalization of 5 or more days; and</td>
</tr>
<tr>
<td></td>
<td>▪ The condition persists for 12 consecutive months</td>
</tr>
</tbody>
</table>

The Plan pays an AD&D Insurance benefit equal to the sum of all benefits up to a maximum of the Principal Sum of coverage, not to exceed 100 percent.

### Maximum Benefits

The maximum benefit applicable to your AD&D Insurance coverage is $3 million. This maximum is in addition to any other benefits you may receive under your AD&D Insurance coverage, including the following:

- Seat belt and air bag benefit
- Common carrier benefit
- Day care expense benefit
- Child tuition reimbursement benefit
- Spouse tuition reimbursement benefit
- Workplace felonious assault benefit
- Occupational HIV benefit
- Hospital confinement benefit

This maximum is separate from the maximum that applies to your Basic and Supplemental Life Insurance coverage.

### Exposure and Disappearance Benefit

If you die or suffer other covered losses as the result of exposure to the elements due to your accident, your death or loss will be considered a result of the accident for AD&D Insurance purposes. As a result, the Plan will pay benefits as detailed previously.
If your body hasn’t been found within one year of the disappearance, stranding, sinking or wrecking of any vehicle you occupied, then it shall be presumed for AD&D Insurance purposes, subject to all other provisions and conditions of the Plan, that you died as a result of the accident.

**Additional Accidental Death and Dismemberment (AD&D) Benefits**

If you die as a result of an accident, and the Plan pays your beneficiary an AD&D benefit, the Plan may pay additional benefits as shown in the table below.

<table>
<thead>
<tr>
<th>Additional benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seat belt use benefit</strong></td>
<td>If you die in an automobile accident, and are wearing a seat belt in the manner prescribed by the vehicle’s manufacturer, the Plan will pay an additional 10% of the Principal Sum to a maximum of $25,000 (minimum $1,000). The seat belt must meet published federal safety standards and must have been installed by the automobile manufacturer. In addition, it must not have been altered after such installation. Actual use at the time of the injury must be verified in an official report of the accident or be certified in writing by the investigating official.</td>
</tr>
<tr>
<td><strong>Air bag use benefit</strong></td>
<td>If you die in an automobile accident and the automobile is equipped with an air bag, the Plan will pay an additional benefit of 5% of the Principal Sum to a maximum of $10,000 (minimum $1,000). The air bag must meet published federal safety standards and must have been installed by the automobile manufacturer. In addition, it must not have been altered after such installation. Actual use at the time of the injury must be verified in an official report of the accident or be certified in writing by the investigating official.</td>
</tr>
<tr>
<td><strong>Common carrier benefit</strong></td>
<td>If you die as the result of an accidental injury that occurred while you were traveling in a common carrier, the Plan will pay your beneficiary an additional benefit equal to your Principal Sum.</td>
</tr>
<tr>
<td><strong>Child care benefit</strong></td>
<td>If you die in a covered accident, the Plan provides a benefit for child care expenses of a dependent child under age 12. The annual benefit is the least of the following:  - The actual cost charged by the day care center per year  - 12% of your coverage amount  - $5,000 a year, for up to four consecutive years The benefit applies only if the child is under age 12 and enrolled in a child care center on the date of your death. The benefit is paid to your spouse or the legal guardian of the child.</td>
</tr>
<tr>
<td><strong>Child education benefit</strong></td>
<td>If you die in a covered accident, and on the date of your death (or within 12 months after that date, with respect to a child at the 12th grade level) your child is enrolled as a full-time student at an accredited college, university or vocational school, the Plan pays a child education benefit. The person paying tuition for your child will receive reimbursement for tuition charges on an annual basis after your death (proof that tuition expenses have been paid is required), up to the least of the actual annual tuition, exclusive of room and board, charged by the school; 20% of your Principal Sum; or $10,000 per each</td>
</tr>
</tbody>
</table>

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Additional benefit | Description
--- | ---
| academic year up to four years.

**Spouse education benefit**
If you die in a covered accident, the Plan provides a spouse education benefit for a professional or trade program if your spouse is enrolled on your date of death or enrolls within 12 months after your death.

The benefit is the least of the following:
- 5% of your coverage amount
- $5,000

Enrollment in the program must occur within 12 months of your death.

If you suffer a covered loss or you sustain an accidental injury while performing your occupational duties, you may be eligible for an additional benefit. This is shown in the following table.

<table>
<thead>
<tr>
<th>Additional benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Workplace felonious assault benefit</strong></td>
<td>If you suffer a covered loss due to an assault committed during the commission of a felony at a company facility or your home while you’re engaged in company business, you (or your beneficiary, if you die) will receive 20% of your Principal Sum of coverage up to $20,000. The Plan does not pay this benefit if you or a member of your immediate family committed the assault, or if you were commuting to your regular place of employment when the assault occurred.</td>
</tr>
</tbody>
</table>
| **Human immunodeficiency virus (HIV) benefit** | If you sustain an accidental injury while performing your occupational duties, you (or your beneficiary, if you die) may receive an additional monthly benefit of 20% of the Principal Sum. The Plan pays this benefit if you:
- File a workers’ compensation claim and provide it to Motorola Solutions within 48 hours;
- Submit to a blood test for the human immunodeficiency virus (HIV) and AIDS-related complex (ARC) within 48 hours, and the results of those tests are negative; and
- Test positive for HIV or ARC within one year after the date of the injury. |

**When Coverage Ends**

Your AD&D Insurance coverage ends on the earliest of the following occurrences:

- The day your Basic Life Insurance coverage ends
- The last day of the month in which your employment ends
- The day you no longer meet the Plan’s eligibility requirements
- The last day of the month in which you begin a layoff or leave of absence (if you’ve been insured for less than six months)
- The last day of the sixth month after the month in which your layoff or leave of absence begins (other than a disability leave), provided you’ve been insured for at least six months
The last day of the ninth month after the month in which your disability leave of absence begins, provided you’ve been insured for at least six months

Exclusions

The Life Insurance Plan doesn’t pay an AD&D Insurance benefit for any loss that results from any of the following:

- A suicide or an attempted suicide, while sane or insane.
- Any infection, other than infection occurring in an external accidental wound.
- Intentionally self-inflicted injuries.
- Commission of, or attempt to commit, a felony.
- War, whether declared or undeclared; or act of war, insurrection, rebellion or riot.
- 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 in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision, “reserve forces” are defined 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.
- Physical or mental illness or infirmity, or the diagnosis or treatment of such 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 drug, medication or sedative taken as directed;
  - Alcohol in combination with any drug, medication or sedative; or
  - Poison, gas or fumes.
- Being legally intoxicated while operating a motor vehicle.
- Any incident related to:
  - Travel in an aircraft as a pilot, crew member or flight student or while acting in any capacity other than as a passenger;
  - Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation; or
  - Travel in an aircraft or device used:
    - For testing or experimental purposes;
    - By or for any military authority; or
    - For travel or designed for travel beyond the earth’s atmosphere.
Additional Facts about the Life Insurance Plan

Once you’ve reviewed your eligibility and coverage restrictions for the Life Insurance Plan, there are a few more things you’ll need to know. This section outlines some additional information related to the Plan, including tax alerts, key terms, coverage continuation information and where to access more resources in your life insurance planning.

An Important Tax Alert

If your Basic Life Insurance coverage exceeds $50,000, you must include in your gross income the cost of the excess coverage. This is called “imputed income.” For this purpose, Motorola Solutions computes the cost by using a uniform premium table published by the Internal Revenue Service. The taxable amount, if any, will be 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 adviser for more information regarding taxation of life insurance.

Key Terms for Coverage under AD&D Insurance

The following are key terms for your AD&D Insurance coverage.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemiplegia</td>
<td>Paralysis of both an arm and a leg on either side of the body.</td>
</tr>
<tr>
<td>Loss of hand</td>
<td>Permanently severed at or above the wrist but below the elbow.</td>
</tr>
<tr>
<td>Loss of a foot</td>
<td>Permanently severed at or above the ankle but below the knee.</td>
</tr>
<tr>
<td>Loss of an arm</td>
<td>Permanently severed at or above the elbow.</td>
</tr>
<tr>
<td>Loss of a leg</td>
<td>Permanently severed at or above the knee.</td>
</tr>
<tr>
<td>Loss of a thumb or index finger of the same hand</td>
<td>In the case of loss of a thumb, the thumb is permanently severed through or above the second joint from the tip of the thumb. In the case of a loss of an index finger, the index finger is permanently severed through or above the third joint from the tip of the index finger.</td>
</tr>
<tr>
<td>Loss of sight</td>
<td>Permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye, or the field of vision must be less than 20 degrees.</td>
</tr>
<tr>
<td>Loss of hearing</td>
<td>The entire and irrecoverable loss of hearing in both ears that continues for six consecutive months following the accidental injury.</td>
</tr>
<tr>
<td>Loss of speech</td>
<td>The entire and irrecoverable loss of speech that continues for six consecutive months following the accidental injury.</td>
</tr>
<tr>
<td>Loss of a member</td>
<td>A loss of one of the following:</td>
</tr>
<tr>
<td></td>
<td>- Hand</td>
</tr>
<tr>
<td></td>
<td>- Foot</td>
</tr>
<tr>
<td></td>
<td>- Sight</td>
</tr>
<tr>
<td></td>
<td>- Speech</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td>Loss of use of a limb, without severance. A physician must determine the paralysis to be permanent, complete and irreversible.</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>Paralysis of both legs or both arms.</td>
</tr>
<tr>
<td>Principal Sum</td>
<td>Your Accidental Death and Dismemberment (AD&amp;D) Insurance is twice your eligible compensation, rounded to the next higher $100. Note: Your Principal Sum of coverage is subject to maximums as noted in Accidental Death and Dismemberment (AD&amp;D) Insurance.</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>Paralysis of both upper and lower limbs.</td>
</tr>
</tbody>
</table>

**Living Benefit: Accelerated Benefit Option (ABO)**

If you have a life expectancy of 24 months or less, you may elect to receive 80 percent of your eligible Basic and Supplemental (if applicable) Life Insurance benefit. The combined Basic and Supplemental Life Insurance living benefit maximum is $1 million.

Additionally, if your spouse has a life expectancy of 24 months or less, you may elect to receive 80 percent (to a maximum of $160,000) of your eligible Dependent Life Insurance benefit.

In order to receive this benefit, you must submit a completed ABO claim form to MetLife. This benefit may be taxable. The Plan ultimately reduces the amount of your death benefit by any living benefit you may receive. This living benefit doesn’t apply to you if you’ve assigned your benefits to a third party.

Consult your tax adviser for more information. For details on the living benefit, contact the Motorola Solutions Employee Service Center.

**Continuation of Coverage during a Disability Leave of Absence**

You may continue certain coverage while you’re away from work on a disability leave of absence.

**DISABLED**

For purposes of continuing Supplemental Life Insurance, the Plan considers you to be disabled if, because of an injury or illness, you’re unable to perform the material duties of your regular job and are on an approved disability leave of absence.

**Continuing Basic Life Insurance Coverage**

The length of time for which you can continue your Basic Life Insurance coverage depends on how long your coverage has been in effect at the time your disability leave of absence begins.

**Less than six months:** If your Basic Life Insurance coverage has been in effect for less than six months when your disability begins, you may continue this coverage through the end of the month in which your disability begins.
**Six months or more:** If your Basic Life Insurance coverage has been in effect for at least six months when your disability begins, your coverage continues at no cost to you until the earlier of the following:

- the date your disability ends
- the date your employment ends with Motorola Solutions

Once your continuation of coverage ends, you may convert your Basic Life Insurance coverage to an individual policy. See Conversion rights for more details.

### Continuing Supplemental Life Insurance Coverage

The length of time for which you may continue your Supplemental Life Insurance coverage depends on how long your coverage has been in effect at the time your disability leave of absence begins.

#### Less than six months: If your Supplemental Life Insurance coverage has been in effect for less than six months when your disability begins, you may continue this coverage through the end of the month in which your disability begins.

#### Six months or more: If your Supplemental Life Insurance coverage has been in effect for at least six months when your disability begins, coverage can continue for up to nine months if you pay your contributions.

As long as coverage has continued, after seven continuous months of disability, you are eligible to apply for a waiver of your contribution, provided the disability began before age 65. If approved by MetLife, you will no longer be required to pay the contribution for the coverage. The Motorola Solutions Employee Service Center will notify you when you need to begin the application process. You must apply and provide proof of your disability as requested within 31 days of the day you receive notification from the Employee Service Center. Once you’ve been disabled for nine consecutive months (but no later than one year from the start of your disability), you must apply for a waiver.

### TOTAL DISABILITY

For purposes of continuing Supplemental Life Insurance, Dependent Life Insurance and AD&D Insurance coverage, the Plan considers you to have a “total disability” and to be “totally disabled” if, because of an injury or illness, you’re unable to perform:

- The material duties of your regular job; and
- Any other job for which you’re fit by education, training or experience.

The waiver of contribution ends on the earliest of the following:

- The date your total disability ends
- At age 65
- When you fail to provide proof of continuing disability
- When you fail to submit to a medical exam as required by MetLife
To verify that you continue to be totally disabled without interruption, you may be required, from time to time, to send proof that you continue to be totally disabled. You won’t be asked to provide proof more than once each year.

Once your coverage ends, you may convert your Supplemental Life Insurance coverage to an individual policy. See Conversion rights for more details.

**Continuing Dependent Life Insurance Coverage**

It’s possible for you to continue coverage for your eligible dependents. The length of time that the Plan continues Dependent Life Insurance coverage depends on how long the coverage has been in effect when your total disability begins.

**Less than six months:** If Dependent Life Insurance coverage has been in effect for less than six months when your total disability begins, the Plan continues this coverage through the end of the month in which your total disability begins.

**Six months or more:** If Dependent Life Insurance coverage has been in effect for at least six months at the time your total disability begins, coverage continues to the earlier of:

- The day your disability ends
- The day your Supplemental Life coverage ends
- The day your employment ends

When coverage ends, you may convert Dependent Life Insurance coverage to an individual policy. See Conversion rights for more details.

**Continuing Accidental Death and Dismemberment (AD&D) Insurance Coverage**

You may continue AD&D Insurance coverage for the same period of time in which you continue to be eligible for Basic Life coverage.

This coverage will continue at no cost to you. Conversion privileges aren’t available for this coverage.

**Reinstating Your Coverage**

Once you return from a leave of absence, your Basic Life Insurance coverage is automatically reinstated. The reinstatement of any Supplemental Life and Dependent Life Insurance coverage depends on when you return from the leave of absence.

If you return from a leave of absence within 12 months, the Plan reinstates any Supplemental Life and Dependent Life Insurance coverage you had in place when your leave of absence began. If your leave of absence extends more than 12 months, you’re considered a terminated employee according to the Medical Leave Policy. You may convert any appropriate coverage. If you return, you’re considered a rehired employee. In this event, you’ll need to provide an Evidence of Insurability form.

If you return to work and elect Supplemental Life or Dependent Life Insurance coverage for the first time, or you want to increase your coverage amount, you (or your spouse/domestic partner) must submit a completed Evidence of Insurability form, and this coverage must be approved by MetLife. A completed Evidence of Insurability form isn’t required for your eligible child(ren).
Conversion Rights

Conversion privileges apply for the following coverages:

- Basic Life Insurance
- Supplemental Life Insurance
- Dependent Life Insurance

This means that under certain conditions, you or your dependent may convert Motorola Solutions coverage to an individual policy without furnishing medical evidence of insurability. (There are no conversion rights for AD&D Insurance.)

There are times when a conversion policy may work best for you. However, a conversion policy isn’t the same as the coverage it replaces. For instance, your cost will be higher. You may choose any type of insurance except term insurance. The maximum amount you may convert is the total of the Basic and Supplemental Life Insurance coverage you had under the Plan. You must apply for the conversion by the later of 31 days after your coverage ends or the 15th day after notification of the right to convert by MetLife. In no case, however, will this time frame exceed 91 days from coverage termination. You'll pay the contribution that applies to your age, class of risk, and the type of policy that you apply to receive.

The same rules apply to Dependent Life Insurance if you leave Motorola Solutions or if you end your Supplemental Life Insurance coverage while you’re still employed. In addition, your covered dependent may apply for a conversion policy if you die while covered by Supplemental Life Insurance, or if he or she ceases to be an eligible dependent.

Please note that certain restricted conversion rights apply if the master policy is terminated or amended to eliminate your coverage. You'll be notified of such rights in the event of master policy termination or amendment.

Portability Option

As an alternative to life insurance conversion, you may want to apply to continue your Basic, Supplemental and Dependent Life Insurance coverage as term life insurance through a portable policy with MetLife. You must apply for the portability option within 31 days after your coverage ends. You'll pay for the entire cost of coverage.

The maximum amount you may take with you is your current coverage amount, with a minimum of $10,000 and a maximum of five times your annual earnings or $2 million. Benefits for you will automatically reduce to 50 percent of the insured amount at age 70 and terminate at age 100. Spouse/domestic partner coverage ends at age 70 and child coverage ends at age 25. Evidence of insurability is required for certain types of coverage and to pay reduced (preferred) premiums.

Please note that certain restricted portability option rights apply if the master policy is terminated or amended to eliminate your coverage. You'll be notified of such rights in the event of master policy termination or amendment.

For portability information, contact MetLife at (888) 252-3607.

Information for Survivors Filing a Claim

In the event of your death or the death of your covered dependent, survivors should call the Motorola Solutions Employee Service Center at (800) 585-5100 to file a claim.
When MetLife learns of the death, a life claim packet will be sent to the beneficiary. In addition, a Delivering The Promise (DTP) Specialist will contact the beneficiary by phone. DTP Specialists are MetLife employees who are specifically trained to assist survivors with the claim process. If your beneficiary prefers to meet in person, the DTP Specialist will make a home visit.

Assignments of life insurance benefits may be available under certain circumstances. If you’re interested in assignments of life insurance coverage to an individual or trust, or as a gift, call the Employee Service Center at (800) 585-5100 to obtain more information and appropriate forms.

Additional Life Insurance Services

Will Preparation

If you elect Supplemental Life, the Plan provides access to a will preparation service. This will preparation service provides employees and their spouses/domestic partners with face-to-face access to attorneys participating in the Hyatt Legal Plans network for preparing or updating a will, living will, and power of attorney. When you choose a participating Hyatt Legal Plans attorney, the attorney’s fees are fully covered and there are no claim forms to file.

Estate Resolution Services

If you elect Supplemental Life, the Plan provides access to estate resolution services. With estate resolution services, the participating plan attorney’s fees are covered for the administrator or executor of your estate for the following probate services:

- Face-to-face and telephone consultations to discuss matters related to probating the insured’s estate;
- Preparation of documents and representation at court proceedings needed to transfer the probate assets from the insured’s estate to heirs;
- The completion of forms and correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts, or a house; and
- Associated tax filings.

Terms of Life Insurance Policies

Certain life insurance benefits described previously may be provided by life insurance policies purchased by Motorola Solutions. These insurance policies are deemed a part of the Life Insurance Plan and, together with the Plan, shall determine the benefits to which you’re entitled.

All benefits and coverage described here are subject to the terms of the insurance policies under which the benefits are provided. If there’s any conflict between this information and the insurance policies, the insurance policies will always govern.

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of your Group Insurance Certificate.
How to Receive Your Life Insurance Benefits

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Information needed</th>
<th>Where to send your claim or appeal</th>
<th>Deadline and initial decision</th>
</tr>
</thead>
</table>
| Life Insurance  | Death certificate  | MetLife                           | **Deadline:** Within 90 days after the covered loss or as soon as reasonably possible  
|                 | (photocopies are acceptable) | Group Life Claims P.O. Box 6100 Scranton, PA 18505 | **Initial Decision:** Within 90 days after the claim is filed  
|                 |                     | Phone: (800) 638-6420 Fax: (570) 558-8645 | |

Once you apply for a specific benefit, you'll receive a decision from the Claims Administrator in writing. The Claims Administrator may either approve or deny your request. Motorola Solutions wants to make sure that you, your covered dependents and your beneficiaries all receive the full benefits that you and they are eligible to receive under the Plans.

**Your right to appeal:** If an initial claim for benefits is denied, in whole or in part, in a letter from the Claims Administrator or otherwise, you may request a review of the denial. Your request for review must be submitted in writing within 60 days, and it should contain the reasons why you believe you’re entitled to benefits, as well as any additional information or documentation to support your claim.

**DISABILITY**

**Your Disability Benefits**

Motorola Solutions provides you disability income replacement benefits if you suffer an illness or injury that prevents you from working. Coverage is automatic (as well as optional in some cases).

This section summarizes the different disability coverages available to employees. Read on to learn more about the eligibility requirements and how coverage and benefits are determined.

Unum Disability Management administers benefits for Short-Term Disability (including Short-Term Disability Supplemental Buy-Up) and Long-Term Disability claims.

**Disability Income Plan Coverage**

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Description</th>
<th>Who’s eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability</td>
<td>Pays a benefit to you if an illness, pregnancy, or non-work-related accident prevents you from working for up to 180 calendar days</td>
<td>You (automatic coverage)</td>
</tr>
<tr>
<td>Short-Term Disability</td>
<td>Pays you an additional benefit during your Short-Term Disability</td>
<td>You, if you enroll and pay for coverage</td>
</tr>
<tr>
<td>Supplemental Buy-Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Pays you a benefit beyond the 180-calendar-day period, provided your</td>
<td>You (automatic coverage)</td>
</tr>
</tbody>
</table>
Overview

Although it’s not pleasant to think about, accidents and illnesses happen. Sometimes, because of an accident or illness, you’re unable to work.

As long as you meet the Plan’s eligibility requirements, the Disability Income Plan provides you with Short-Term and Long-Term Disability coverage at no cost to you. You may increase your Short-Term Disability coverage by purchasing the Short-Term Disability Supplemental Buy-Up option. If eligible, you may also purchase additional Supplemental Long-Term Disability Income Insurance coverage. These extra coverage options may be available to you if you enroll and pay the required contribution through payroll deductions.

If you meet the Plan’s definition of disabled, the Plan pays Short-Term and Long-Term Disability benefits to you.

The Plan uses your compensation as of the last day you work, before your disability begins, to determine your benefit. The Plan enables you to receive income even though you’re unable to work.

Disability Coverage Options

Below is an overview of the various types of disability coverage options available.

<table>
<thead>
<tr>
<th>Coverage type</th>
<th>Coverage amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-Term Disability</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Coverage amount</strong></td>
<td></td>
</tr>
<tr>
<td>The first 90 calendar days* are paid at 75% of your compensation.</td>
<td></td>
</tr>
<tr>
<td>The next 90 calendar days are paid at 60% of your compensation.</td>
<td></td>
</tr>
<tr>
<td><strong>Short-Term Disability Supplemental Buy-Up</strong></td>
<td>If enrolled, you will receive an additional 15% of your compensation during the period in which you’re eligible to receive a Short-Term Disability benefit.</td>
</tr>
<tr>
<td><strong>Long-Term Disability</strong></td>
<td>You receive the lesser of:</td>
</tr>
<tr>
<td>60% of your compensation; or</td>
<td></td>
</tr>
<tr>
<td>$10,000 per month.</td>
<td></td>
</tr>
<tr>
<td><strong>Supplemental Long-Term Disability Income Insurance Program</strong></td>
<td>If eligible and enrolled, you may increase your Long-Term Disability benefit up to an additional $10,000 per month (or up to $20,000 if you’re eligible for an additional $10,000 benefit). Certain eligibility requirements apply for this</td>
</tr>
</tbody>
</table>
Short-Term Disability (STD) Coverage

This section summarizes the Disability Income Plan’s Short-Term Disability coverage, including eligibility, requirements to be qualified as disabled, and when coverage begins and ends, as well as other important information about Short-Term Disability coverage and benefits. In many cases, different rules apply to Long-Term Disability benefits, which are provided under an insured policy issued by Unum Disability Management. See Long-Term Disability (LTD) coverage for rules that apply to Long-Term Disability coverage.

As long as you meet the Plan’s eligibility requirements, Motorola Solutions provides you with Short-Term Disability coverage. If you’re unable to work because of an illness or injury not covered under workers’ compensation, and you meet the Plan’s definition of disabled, the Plan pays a portion of your compensation. The company provides this coverage at no cost to you.

As soon as you know that you are, or will be, physically unable to work, contact the Motorola Solutions Employee Service Center to begin your claim.

Who’s Eligible

You’re automatically enrolled for Short-Term Disability coverage under the Plan if:

- You’re a domestic employee of the company that participates in this Plan;
- You’re actively at work on the day your coverage becomes effective;
- You’re regularly scheduled to work at least 20 hours per week; and
- Your regular paycheck is processed by the company’s U.S. payroll department.

Note: If you’re a member of a group of employees who become employees of the company as a result of a merger, an acquisition, or the ending of a joint venture in which the company took part, you’ll be eligible only if, and to the extent that, Motorola Solutions expressly extends coverage under the Plan to your group.

Who’s Not Eligible

You’re not eligible for Short-Term Disability coverage under the Plan if:

- You provide services under an independent contractor, consultant or employee leasing agreement;
- You’re an intern or co-op student;
- You’re classified as a leased employee;
- You’re classified as contract labor;
- Your eligible compensation isn’t processed by the company’s U.S. payroll department; or
- You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in this Plan).
Definition of Disabled for Short-Term Disability Benefits

To be eligible for a Short-Term Disability benefit, you must meet the Plan’s definition of disabled, described below in Qualification requirements for a Short-Term Disability benefit. Your Short-Term Disability coverage doesn’t cover disabilities caused by an occupational illness or injury which are approved as a compensable claim by Motorola Solutions’ or another employer’s workers’ compensation carrier.

Qualification Requirements for a Short-Term Disability Benefit

You’re disabled when Unum Disability Management determines that:

- You’re limited from performing the material and substantial duties of your regular occupation because of your illness or injury; and
- You have a 20 percent or more loss in weekly compensation because of the same illness or injury.

To be considered disabled, you must be under the regular care of a physician.

“Regular care” means:

- You personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- You’re receiving the most appropriate treatment and care, which conforms with generally accepted medical standards for your disabling condition(s), by a physician whose specialty or experience is the most appropriate for your disabling condition(s).

UNUM DISABILITY MANAGEMENT

If you know in advance that you’ll need Short-Term Disability benefits – such as for childbirth or planned surgery – you can contact the Motorola Solutions Employee Service Center ahead of time to initiate your claim for disability benefits. When the time comes for you to be away from work, contact the Employee Service Center and your department manager or supervisor to report your last day of work.

Eligible Physician

An eligible physician who provides services within the scope of his or her license must certify your disability. An “eligible physician” for purposes of certifying a Short-Term Disability is:

- A person performing tasks that are within the limits of his or her medical license; or
- A person who is a legally qualified medical practitioner according to the laws and regulations of the governing jurisdiction and is:
  - A licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or Doctor of Dental Surgery (D.M.D. or D.D.S.);
  - A chiropractor (D.C.), physician assistant (P.A.) or nurse practitioner (N.P.), limited to 20 days of the initial period of disability;
  - A nurse midwife (C.N.M. or L.N.M.) limited to certifying only vaginal deliveries, including a six-week postpartum period;
  - A general practitioner or psychiatric nurse practitioner (PNP); or
A licensed psychologist (Ph.D. or Psy.D. whose primary practice is treating patients) if your disability is primarily mental, nervous or alcohol- or drug-related (a psychiatrist must certify your disability beyond 60 days).

**Note:** Under the Disability Income Plan, you, your spouse, your children, your parents and your siblings cannot be the physician certifying your disability for a claim.

If you’re receiving a Short-Term Disability benefit, be sure to notify Unum Disability Management if you engage in any employment. See **How to file a claim** for details and contact information.

**Rehabilitation and Return-to-Work Assistance**

If you become disabled, Unum Disability Management can help you return to your personal and work activities as soon as you’re medically able to do so.

Unum Disability Management’s rehabilitation specialists effectively manage your disability leave. These physicians and nurses work with your physician (when necessary) to establish a realistic program and timetable for your return to work, when that’s possible.

**When Coverage Begins — Benefit Waiting Period**

Your eligibility for Short-Term Disability coverage begins on the first of the month following the date you complete a waiting period of 90 consecutive calendar days as an active employee (provided you’re regularly scheduled to work at least 20 hours per week). If you’re not actively at work that day, your Short-Term Disability coverage begins on the day you return to work. If you joined Motorola Solutions as a result of a merger or acquisition, and the Company recognized your prior service with the selling company for benefit purposes under the Disability Income Plan, the 90 day waiting period will be waived.

If your employment ends and you’re rehired within 30 days, your previous work while in an eligible group will apply toward the waiting period. All other provisions of the plan apply.

**Pre-Existing Condition Rule**

For your Short-Term Disability coverage (including the Supplemental Buy-Up), you’re subject to a pre-existing condition rule during the first 180 days of coverage. This means that the Plan doesn’t pay a Short-Term Disability benefit or a Short-Term Disability Supplemental Buy-Up benefit for an illness, injury or pregnancy for which you received medical care or treatment, including prescription drugs, during the 90 days leading up to your coverage effective date. Eligibility for coverage for a disability related to this illness, injury or pregnancy begins once you’re covered under the Plan for 180 consecutive calendar days and have been actively at work. You must be disability-free from the pre-existing condition for those 180 consecutive calendar days.

The 180-day period will be waived if you were covered by another group disability plan sponsored by a related company immediately before you become a participant in the Plan. Also, if you joined Motorola Solutions as a result of a merger or acquisition, and the Company recognized your prior service for benefit purposes under the Disability Income Plan, the 180-day period pre-existing condition limitation, you will be waived.

**When Your Benefit Begins — Benefit Elimination Period**

After your coverage begins, if you become disabled, you may be eligible to receive Short-Term Disability benefits. The table below shows when your Short-Term Disability benefit begins. In some instances, a benefit elimination period applies.
Condition | When your Short-Term Disability benefit begins
---|---
Illness, pregnancy or injury not caused by accident | The eighth calendar day that you’re disabled
Injury caused by an accident | The day you become disabled

Definition of an Accident

The Plan defines an accident as an unexpected, unintentional and unforeseen traumatic experience by an outside force, specific to a time and place that results in your inability to work for a period of at least eight consecutive calendar days beginning within 30 days of the experience.

Your Benefit Amount

The Plan pays a Short-Term Disability benefit for up to 180 calendar days. The table below shows the Short-Term Disability benefit you receive for the first 90 calendar days. It also shows the benefit amount you receive for the next 90 calendar days.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>First 90 calendar days*</th>
<th>Next 90 calendar days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability benefit</td>
<td>75% of your compensation</td>
<td>60% of your compensation</td>
</tr>
</tbody>
</table>

*Excludes any benefit waiting period or elimination period that may apply. Your benefit may be reduced in accordance with the Integration of Benefits Rules and, in some cases, by the income you earn while disabled.

Your Short-Term Disability benefit is paid on a weekly basis. The Plan uses your compensation, determined as of the day you worked before you became disabled, to calculate your benefit amount. It also takes into account whether you’re receiving any other benefits and reduces your Short-Term Disability benefit in accordance with the Integration of Benefits Rules. See Integration of benefits — deductible sources of income for details.

Any benefit the Plan pays for a period of less than one week is paid by prorating a five-day workweek for each day you’re disabled. For example, if you return to work on Thursday, you receive three-fifths (3/5) of your weekly benefit for Monday through Wednesday, a total of three days.

Compensation and Your Short-Term Disability Benefit

Your compensation is a major factor when determining your Short-Term Disability benefit. Your compensation is determined as of the day you become disabled and includes all of the following:

- Your annual compensation
- Your prior year’s Sales Incentive Plan payments or commissions
- Any shift differential
- Lump-sum merit pay

The Plan then divides your annual compensation by 52 to determine your weekly rate of pay for Short-Term Disability benefit purposes. If at the time you become disabled you’ve worked for the company for less than 12 months, the Plan calculates your compensation by using figures from your actual period of employment.

Your compensation for Short-Term Disability benefit purposes doesn’t include any of the following:
- Overtime
- Annual Incentive Plan payments
- Bonuses
- Moving allowances
- Educational allowances
- Noncash payments
- Overseas allowances

Components of Compensation

The following table further defines certain components of your compensation, which depend on your employee status.

<table>
<thead>
<tr>
<th>Employee status</th>
<th>Compensation component</th>
<th>Additional detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-exempt employees</td>
<td>Annual compensation</td>
<td>Your annual compensation is your annualized base rate of pay.</td>
</tr>
<tr>
<td>Exempt employees</td>
<td>Annual compensation</td>
<td>Your annual compensation is your annualized compensation.</td>
</tr>
<tr>
<td>Shift differential employees</td>
<td>Shift premiums</td>
<td>If you receive a shift premium, your salary for Short-Term Disability benefit purposes includes your shift premium.</td>
</tr>
<tr>
<td>Lump-sum merit employees</td>
<td>Lump-sum merit</td>
<td>If you receive a lump-sum merit in lieu of an increase to your compensation, your salary for Short-Term Disability benefit purposes includes your lump-sum merit.</td>
</tr>
<tr>
<td>Sales Incentive Plan employees</td>
<td>Earnings plus prior year’s Sales Incentive Plan payments or commissions</td>
<td>The Plan determines your Short-Term Disability benefit based on your current year’s earnings plus your prior year’s Sales Incentive Plan payments or commissions.</td>
</tr>
</tbody>
</table>

How to File a Claim

As soon as you know that you are, or will be, physically unable to work, contact the Motorola Solutions Employee Service Center to initiate your claim.

Be sure to apply for a disability benefit as soon as possible, so that a claim decision can be made in a timely manner. Notice of a claim should be sent within 30 days of the onset of your disability.

Information Required as Proof of Your Claim

Your proof of claim, provided at your expense, must show:

- That you’re under the regular care of a physician;
 The cause of your disability;
 The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
 The name and address of any hospital, institution or other source where you received treatment, including all attending physicians’ names and addresses.

Unum Disability Management may request that you send proof of continuing disability, indicating that you’re under the regular care of a physician. This proof must be received within 45 days of Unum Disability Management’s request.

In some cases, you’ll be required to give Unum Disability Management authorization to obtain additional medical information, and to provide nonmedical information as part of your proof of claim or proof of continuing disability. Your claim may be denied or payments may stop if the appropriate information isn’t submitted.

If you wish to file a claim for benefits, you should follow the claim procedures described above. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum Disability Management.

When Your Benefit Ends

As long as you remain disabled and eligible for a Short-Term Disability benefit, you continue to receive your benefit for up to the maximum payment period of 180 calendar days.

Your Short-Term Disability benefit ends on the earliest of the following occurrences:

 When you’re able to work in your regular occupation on a part-time or full-time basis, but you choose not to
 At the end of the maximum payment period
 On the date you’re no longer disabled under the terms of the Plan
 On the date you fail to submit proof of continuing disability
 On the date your partial work compensation while disabled exceeds 80 percent of your predisability compensation
 On the date of your death

The Plan suspends your Short-Term Disability benefit during any period in which you’re incarcerated because you’ve been convicted of, or pled guilty or no contest to, a crime. Your benefits will also end if you become ineligible for coverage.

When Your Coverage Ends

Your Short-Term Disability coverage under the Plan ends on the earliest of the following dates:

 The day your employment ends (or the date you elect to voluntarily terminate employment under a Motorola Solutions individual or group voluntary separation program, regardless of your actual termination date) even if you’re disabled on such date; however, this provision doesn’t apply if:
  — You’re receiving Disability Plan benefits and terminate employment under a Motorola Solutions individual or group involuntary severance program (unless such program provides otherwise); or
— You’re on a disability leave of absence and your disability continues until your termination of employment under the Medical Leave Policy

- The day on which your employment is terminated for cause and/or gross misconduct, regardless of whether you’re disabled on such date
- The last day you work before a family, parental or personal leave of absence that isn’t based on your medical condition
- The last day you work before a medical leave of absence, unless within six months you’re determined to be disabled as a result of the illness or injury for which the leave was granted (then coverage will be retroactively reinstated as of the date the leave of absence began)
- The last day of the month in which you receive military service pay under the Military Service Pay Policy; however, if you’re a participant who returns to active employment within 31 days of entering military service, as described in the Uniformed Services Employment and Reemployment Rights Act, your coverage isn’t terminated as a result of such absence
- The last day of your leave classified under a Worker Adjustment and Retraining Notification (WARN) period
- The day your employment category changes to one under which you’re not eligible for coverage, other than due to a disability leave of absence
- The day your disability ends or the last day Motorola Solutions 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 or Motorola Solutions or a related company
- The day of your death
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

Disabilities Excluded From Short-Term Disability Coverage

The Plan doesn’t pay a Short-Term Disability benefit for a disability that’s caused by, contributed to by or results from any one of the following:

- Occupational illness or injury, meaning an illness or injury that was caused by or aggravated by any employment for pay or profit and was approved as a compensable claim by Motorola Solutions’ or another employer’s workers’ compensation carrier
- An occupational illness or injury for which you didn’t file a workers’ compensation claim within the Plan’s required 30-day period
- A self-inflicted injury for the purpose of obtaining disability benefits
- Active participation in a riot
- Service in the armed forces of any country
- A mental health condition that’s diagnosed solely by a general practitioner, psychiatric nurse practitioner or licensed psychologist beyond 60 days, if such condition isn’t thereafter certified by a psychiatrist
- A disability certified by a nurse midwife beyond a vaginal delivery and six-week postpartum period
- A health condition certified by a non-physician eligible provider (chiropractor, nurse practitioner or physician assistant) beyond the initial 20 days of disability
- A condition that's treated and diagnosed with test analysis, research studies, unconventional methods or procedures that aren't considered accepted medical practice in the medical industry
- A cosmetic or transsexual procedure that alters appearance but doesn't restore or improve impaired physical function, except when performed to repair defects that result from an accident, to replace diseased tissue that has been surgically removed or to treat a birth defect
- Commission of or engaging in a crime for which you've been convicted
- War, declared or undeclared, or any act of war
- Any illness or injury that arises while you're incarcerated or in a penal institution

The Plan won't pay a benefit for any period of disability during which you're incarcerated or for any condition that's determined to be ineligible during the pre-existing period of coverage.

The Plan also doesn't pay a Short-Term Disability benefit to cover physician or other service provider charges associated with completing forms, missed appointments, telephone consultations, examinations (unless the Plan Administrator orders the examination), copying and sending records, or telephone charges.

**Short-Term Disability Supplemental Buy-Up Option**

To help minimize the financial impact of a short-term disability, Motorola Solutions offers the Short-Term Disability Supplemental Buy-Up option ("Supplemental Buy-Up"). As long as you meet the Plan's eligibility requirements and are eligible for the Plan's Short-Term Disability coverage, you may purchase on a pretax basis Supplemental Buy-Up coverage. With Supplemental Buy-Up coverage, you increase your Short-Term Disability benefit by an additional 15 percent if you become disabled. As a result, you could be covered for up to 90 percent of your income for the first 90 days of disability benefits, and up to 75 percent of your income for the second 90 days of disability benefits. You pay for this additional coverage with pretax dollars deducted from your pay.

<table>
<thead>
<tr>
<th>ABOUT THE SUPPLEMENTAL BUY-UP OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>All rules governing your Short-Term Disability coverage (except those highlighted in this section) apply to the Supplemental Buy-Up option.</td>
</tr>
<tr>
<td>The Plan uses the same definition of disabled for both Short-Term Disability coverage and coverage under the Supplemental Buy-Up. See <strong>Definition of disabled for Short-Term Disability benefits</strong> for details.</td>
</tr>
<tr>
<td>If your disability is compensable under workers' compensation, the Supplemental Buy-Up benefit doesn't apply. At no time are you eligible for the Supplemental Buy-Up option and not eligible for Short-Term Disability coverage.</td>
</tr>
</tbody>
</table>

**Who’s Eligible**

If you meet the Plan’s eligibility requirements as outlined under **Who’s eligible**, you’re eligible for the Supplemental Buy-Up option.

**When Your Coverage Begins**

The date on which the Supplemental Buy-Up coverage begins depends on whether you’re an active employee, a new hire or an employee on a leave of absence.
**Active employee:** As an active, eligible employee, you may elect the Supplemental Buy-Up option only during annual enrollment. If you do, this option begins on the January 1 following your election and continues for one full calendar year.

**New hire:** You may elect the Supplemental Buy-Up option within 31 days of your hire date. The Supplemental Buy-Up option begins on the first of the month following the date you complete 90 consecutive calendar days as an active employee. If you’re not actively at work on that day, your Supplemental Buy-Up option begins on the day you return to work.

If you don’t enroll for the Supplemental Buy-Up option during the 31 days following your hire date, you may not elect coverage until the next annual enrollment period.

If you’re on a leave of absence, you may elect the Supplemental Buy-Up option during annual enrollment. If you do, the Supplemental Buy-Up option begins on the January 1 following your election and continues for one full year. However, if you’re not actively at work when the Supplemental Buy-Up option is scheduled to begin, your enrollment is void for the year. You may not enroll again until the next annual enrollment period.

**When Your Benefit Begins — Coverage Waiting Period**

You may have to satisfy a 90-day coverage waiting period before your Supplemental Buy-Up benefit begins. The table below shows when a coverage waiting period applies. The coverage waiting period doesn’t apply again unless you drop coverage and reenroll at a later date.

**Example of Coverage Waiting Period for Supplemental Buy-Up Option**

<table>
<thead>
<tr>
<th>Eligible participant</th>
<th>Election date</th>
<th>Option effective date*</th>
<th>Contributions begin</th>
<th>Pre-existing period</th>
<th>Coverage waiting period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active employee</td>
<td>Annual enrollment</td>
<td>January 1,</td>
<td>January 1,</td>
<td>None</td>
<td>January 1, – March 31,</td>
</tr>
<tr>
<td>New hire date:</td>
<td>Within 31 days</td>
<td>May 1,</td>
<td>May 1</td>
<td>January 31 – April 30,</td>
<td>None</td>
</tr>
<tr>
<td>New hire date:</td>
<td>Within 31 days</td>
<td>January 1, (following year)</td>
<td>January 1.</td>
<td>October 3, – December 31</td>
<td>None</td>
</tr>
<tr>
<td>New hire date:</td>
<td>Within 31 days</td>
<td>January 1,</td>
<td>January 1</td>
<td>None</td>
<td>January 1 – March 31</td>
</tr>
<tr>
<td>New hire date:</td>
<td>Within 31 days</td>
<td>January 1,</td>
<td>January 1</td>
<td>None</td>
<td>January 1 – March 31</td>
</tr>
<tr>
<td>Employee LOA (actively at work on January 1)</td>
<td>Annual enrollment</td>
<td>January 1 (if actively at work on January 1)</td>
<td>January 1</td>
<td>None</td>
<td>January 1 – March 31</td>
</tr>
<tr>
<td>Employee LOA (not actively at work on January 1)</td>
<td>Annual enrollment</td>
<td>Void (if on leave of absence on January 1)</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

*Must be actively at work on this date.

**Your Benefit Amount**

* Includes any consecutive period of employment with Motorola, Inc. immediately prior to January 1, 2011.
Your Supplemental Buy-Up benefit is 15 percent of your compensation at the time you become disabled. (See Definition of disabled for Short-Term Disability benefits for how the Plan defines compensation.) This Supplemental Buy-Up benefit is payable while you receive your Short-Term Disability benefit. The table below shows how the Plan calculates a Short-Term Disability benefit and how the Plan calculates a Short-Term Disability benefit with the Supplemental Buy-Up option.

<table>
<thead>
<tr>
<th>Benefit coverage</th>
<th>First 90 days* of your disability</th>
<th>Second 90 days of your disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability</td>
<td>You receive 75% of your compensation for the first 90 calendar days.</td>
<td>You receive 60% of your compensation for the next 90 calendar days.</td>
</tr>
<tr>
<td>Short-Term Disability with Supplemental Buy-Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You receive 90% (75% + 15%) of your compensation for the first 90 calendar days.</td>
<td>You receive 75% (60% + 15%) of your compensation for the next 90 calendar days.</td>
<td></td>
</tr>
</tbody>
</table>

*Excludes the benefit waiting period.

Your Supplemental Buy-Up benefit is combined and paid with your Short-Term Disability benefit on a weekly basis.

**Note:** See Integration of benefits — deductible sources of income for deductible sources of income that may affect your benefit amount.

Contributions for Coverage

You pay for your Supplemental Buy-Up coverage through pretax payroll deductions. Your cost is based on an amount per $100 of your compensation. (See Compensation and your Short-Term Disability benefit for how the Plan defines compensation.) Your monthly cost for this additional coverage may change each year. You’re notified of the next year’s cost during the annual enrollment period.

Your payroll contributions for Supplemental Buy-Up coverage are waived while you’re receiving a Supplemental Buy-Up benefit. Upon your return to work, your contributions resume through pretax payroll deductions at the rate in effect at the time of your return.

When Your Benefit Ends

As long as you remain disabled and are receiving a Short-Term Disability benefit, you continue to receive your additional Supplemental Buy-Up benefit for up to 180 calendar days. Your Supplemental Buy-Up benefit generally ends on the same day your Short-Term Disability benefit ends.

When your Coverage Ends

Your Supplemental Buy-Up coverage generally ends on the same date as your Short-Term Disability coverage.

You may not cancel your Supplemental Buy-Up coverage at any time during a year in which your coverage is in effect. If you terminate employment during the year in which your coverage is in effect, your Supplemental Buy-Up coverage ends on the last day that you’re actively at work.
Exclusions

The Plan doesn’t pay a Supplemental Buy-Up benefit in certain instances. The same exclusions that apply for Short-Term Disability benefits apply for Supplemental Buy-Up benefits. See Disabilities excluded from Short-Term Disability coverage for details.

Note: If you’ve elected the Supplemental Buy-Up option and you don’t cancel your election during annual enrollment, the Supplemental Buy-Up option automatically extends through the following year. If you choose to cancel this election during annual enrollment, your Supplemental Buy-Up option remains in effect through December 31 of the year for which you elected the option.

Disability Rehabilitation — A Special Return-to-Work Program

Disability rehabilitation is designed to help you if your condition forces you to work a reduced number of hours. Rehabilitation most often occurs after a disability. Therefore, if your physician certifies your return to work (with or without modified job duties) on a reduced-hour work schedule, the Plan may continue to pay you a Short-Term Disability Rehabilitation benefit. A similar program applies to Long-Term Disability.

Rehabilitative Employment

To be considered for rehabilitative employment, your return to work must include a plan to increase your work hours with the intent for you to ultimately return to your regular work schedule and duties.

The Unum Disability Management team reviews all requests for a Short-Term Disability Rehabilitation benefit and works with your physician and Occupational Health to establish a plan for your rehabilitative employment. This plan must be approved by your manager. If your manager determines that rehabilitative employment isn’t available to you, you may continue to receive a Short-Term Disability benefit (provided you meet the requirements for such benefit).

Note: Even if you’re working in rehabilitative employment before the eighth day of a period of disability, your Short-Term Disability Rehabilitation benefit doesn’t begin until the eighth day.

When Your Benefit Begins

You’re eligible for a Short-Term Disability Rehabilitation benefit when you’re approved for rehabilitative employment and:

- You’re disabled for seven or more consecutive calendar days; or
- You’re disabled but immediately approved for rehabilitative employment with a duration of at least two weeks; and
- You’re able to perform rehabilitative employment as approved by your physician; and
- You provide a statement from your physician certifying the above.

Be sure to apply for the Short-Term Disability Rehabilitation benefit as soon as you know your physician will release you to return to work (with or without modified job duties) on a reduced-hour work schedule. If you work part-time but wait until after you return to work full-time to apply, you don’t receive a retroactive Short-Term Disability Rehabilitation benefit. You must be approved for rehabilitative employment before you can receive a Short-Term Disability Rehabilitation benefit.

Your Benefit Amount
You may receive a weekly Short-Term Disability Rehabilitation benefit payment if you’re disabled and your reduced weekly disability compensation is from 20 percent to 80 percent of your pre-disability weekly compensation. Payments are based on the percentage of income you’re losing because of your disability and will be determined as follows:

1. Subtract your reduced weekly disability compensation from your pre-disability weekly compensation.

2. Divide by your pre-disability weekly compensation. This is your percentage of “lost compensation.”

3. Multiply your weekly disability benefit by the answer from step 2. This is the amount you’ll receive each week.

An Example of a Short-Term Disability Rehabilitation Benefit Calculation

To show how a Short-Term Disability Rehabilitation benefit is calculated, assume that before you became disabled you worked 40 hours each week and your weekly pre-disability compensation was $533. Then, let’s assume that your weekly disability benefit is $400 and your physician certifies that you’re able to return to work on a reduced schedule. Your reduced schedule is 20 hours each week with reduced weekly disability compensation of $266.50. Here’s how your Short-Term Disability Rehabilitation benefit is calculated.

Short-Term Disability Rehabilitation benefit calculation

<table>
<thead>
<tr>
<th>Gross weekly base rate of pay each week</th>
<th>$533</th>
<th>This is your predisability weekly compensation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross weekly disability benefit at 75% of pay (without Short-Term Supplemental Buy-Up coverage)</td>
<td>$400</td>
<td>This is your weekly disability benefit amount.</td>
</tr>
<tr>
<td>Reduced compensation earned</td>
<td>$266.50</td>
<td>This is the weekly amount you earned while working your reduced schedule while disabled.</td>
</tr>
<tr>
<td>Lost compensation percentage (gross weekly base rate of pay minus gross reduced weekly disability compensation divided by gross weekly base rate of pay)</td>
<td>($533 – $266.50) ÷ $533 = 50%</td>
<td>Results in a 50% loss in compensation.</td>
</tr>
<tr>
<td>How much you’ll receive (weekly disability benefit times lost compensation percentage)</td>
<td>$400 x 50% = $200</td>
<td>You’ll receive $200 as your Disability Rehabilitation benefit.</td>
</tr>
</tbody>
</table>

When Your Benefit Ends

Your Short-Term Disability Rehabilitation benefit ends on the earliest of the following dates:

- The date you exhaust the 180-calendar-day maximum period for Short-Term Disability benefits
- The date you’re no longer eligible for either Short-Term or Long-Term Disability coverage
- The date you’re no longer able, or otherwise cease, to perform rehabilitative employment
Administrative Practice for Medical Leaves

If you’re an exempt employee who — initially or within a two-week period or less — goes from active full-time employment to a “reduced schedule” based on your health care provider’s authorization, your first two weeks of reduced-hours employment is paid by payroll at 100 percent of your regular salary.

If you’re an exempt employee whose active full-time schedule is “reduced” for more than two weeks, your first two weeks of reduced-hours employment is paid by payroll at 100 percent of your regular salary. In the third week that you’re eligible for rehabilitation benefits, you’ll be subject to a one-week waiting period (no rehabilitation pay). You must have a minimum of two weeks of rehabilitation requested to qualify for a Short-Term Disability Rehabilitation benefit.

Additional Facts about Short-Term Disability and Short-Term Disability Supplemental Buy-Up Coverage

Physician’s Statement

The Plan pays benefits only while you’re under the regular care and treatment of a physician. Your physician must provide a confirmation of your disability before the Plan starts to pay benefits. Your physician’s periodic proof of your disability is required to confirm your continuing disability.

Taxes and Disability Benefits

Your Short-Term Disability and Short-Term Disability Supplemental Buy-Up benefits are considered to be taxable income. Applicable tax withholdings are taken from your disability payments as required by law.

Integration of Benefits — Deductible Sources of Income

Unum Disability Management will subtract from your gross disability payment the following deductible sources of income:

- The amount you receive, or are entitled to receive, under:
  - An occupational disease law; or
  - Any other act or law with similar intent.
- The amount you receive, or are entitled to receive, as disability income payments under any:
  - State compulsory benefit act or law;
  - Automobile liability insurance policy;
  - Other group insurance plan; or
  - Governmental retirement system as a result of your job with Motorola Solutions.
- The amount you, your spouse and your children (for whom you’re financially responsible) receive, or are entitled to receive, as disability payments because of your disability under:
  - The U.S. Social Security Act; or
  - Any similar plan or act.
- The amount you receive as retirement payments, or the amount your spouse and children receive as retirement payments because you’re receiving retirement payments, under:
— The U.S. Social Security Act; or
— Any similar plan or act.

▪ The amount you receive under Title 46, U.S. Code Section 688 (the Jones Act).
▪ The amount you receive from a third party (after subtracting attorney’s fees) by judgment, settlement or otherwise.
▪ Any severance pay received from Motorola Solutions.

With the exception of retirement and severance payments, Unum Disability Management will subtract only deductible sources of income that are payable as a result of the same disability.

**Nondeductible Sources of Income**

There are certain nondeductible sources of income that Unum Disability Management won’t subtract from your gross disability payment. These include, but are not limited to, the following:

▪ 401(k) plans
▪ A retirement plan from another employer
▪ Individual retirement accounts (IRAs)
▪ Individual disability income plans

**Overpayments**

Unum Disability Management has the right to recover any overpayments caused by any one of the following:

▪ Fraud
▪ Any error Unum Disability Management makes while processing a claim
▪ Your receipt of deductible sources of income

You must fully reimburse any overpayment. Unum Disability Management will determine the method by which the repayment is to be made and won’t recover more money than the amount paid to you.

**Special State Laws Regarding Disability Benefits**

Some states have special laws regarding disability benefits. For example, if you work in Hawaii, New Jersey, New York, California or Rhode Island, special provisions may apply to you. This list is not intended to be exhaustive as states continue to enact laws that affect this area and the list is subject to change.

**Hawaii, New Jersey and New York:** Benefits payable from this Plan are reduced by any benefits payable by any other plan or policy set up by the company to comply with that state’s disability benefits law.

**California and Rhode Island:** Benefits payable under this Plan are reduced by benefits paid to you by the state disability plan.

**If Your Injury or Illness is Work-Related**
If your injury or illness is work-related, you may still be eligible to receive a benefit under the Disability Income Plan until a determination is made on your workers’ compensation claim. You must provide proof that you’ve filed a workers’ compensation claim within 30 days after you file a disability claim. If you don’t file the workers’ compensation claim within this 30-day period, the Plan denies your disability claim.

If the company’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, the Plan denies you a disability benefit. If you receive both a disability benefit and payment from workers’ compensation, the Plan will require you to reimburse duplicate benefits.

Once a claim for an injury or illness is deemed payable under workers’ compensation, that injury or illness isn’t eligible for any future disability benefits from the Plan. Motorola Solutions’ workers’ compensation carrier notifies you if your claim is deemed payable under workers’ compensation at any point during this process.

**Recurring Disability**

A benefit maximum of 180 calendar days applies for any one Short-Term Disability period. All days you’re out of work because of the same (or a related) cause are considered one “period of disability.”

A current disability will be considered part of a prior claim if you were continuously covered and the recurrent disability (same or related) occurs within 30 consecutive days from the end of the prior claim. If more than 30 consecutive days pass since you were last disabled, your claim will be considered a new period of disability.

Different recurring disability benefit rules apply to the Long-Term Disability portion of the Plan. Long-Term Disability benefits are reduced by the amount of Short-Term Disability benefits paid for the same period to ensure that duplicate benefits aren’t paid.

**Insurance Fraud**

Unum Disability Management wants to ensure that you and the company don’t incur additional insurance costs as the result of the undermining effects of insurance fraud. Unum Disability Management promises to apply all means necessary to support fraud detection, investigation and prosecution.

It’s a crime to knowingly — and with intent to injure, defraud or deceive Unum Disability Management — provide information (including filing a claim) that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum Disability Management will pursue all appropriate legal remedies in the event of insurance fraud.

**Continuation and Conversion Rights**

Continuation and conversion rights don’t apply to Short-Term Disability (including Supplemental Buy-Up) coverage.

**Long-Term Disability (LTD) Coverage**

Long-Term Disability coverage may help minimize the financial impact if you’re still unable to work after the 180 days of the Short-Term Disability benefit period. You may be eligible for a Long-Term Disability benefit if you continue to meet the Plan’s definition of disabled and you’re not covered by workers’ compensation. Similar to Short-Term Disability coverage, the company provides Long-Term Disability coverage at no cost to you.
Note: If you were disabled before January 1, 2011, certain coverage details in this section may not apply to you. If this is the case, contact Unum for further details related to your Long-Term Disability claim.

Unum Disability Management

If your disability is expected to last more than 180 calendar days, your case is transitioned from your Short-Term Disability insurance case manager to a Long-Term Disability insurance case manager. You’ll be asked to provide additional information that will assist in determining your current eligibility for any Long-Term Disability benefits.

Who’s Eligible

You’re automatically enrolled for Long-Term Disability coverage under the Plan if:

- You’re a domestic employee (working in the U.S.) of the company that participates in this Plan;
- You’re actively at work on the day your coverage becomes effective;
- You’re working at least 20 hours per week; and
- Your regular paycheck is processed by the company’s U.S. payroll department.

Note: If you’re a member of a group of employees who become employees of the company as a result of a merger, an acquisition or the ending of a joint venture in which the company took part, you’ll only be eligible if, and to the extent that, Motorola Solutions expressly extends coverage under the Plan to your group.

Who’s Not Eligible

You’re not eligible for Long-Term Disability coverage under the Plan if:

- You provide services under an independent contractor, consultant or employee leasing agreement;
- You’re an intern or co-op student;
- You’re classified as a leased employee;
- You’re classified as contract labor;
- Your eligible compensation isn’t processed by the company’s U.S. payroll department; or
- You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in this Plan).

Definition of Disabled for Long-Term Disability Benefits

You must meet the Plan’s definition of disabled in order to be eligible for a Long-Term Disability benefit. You’re considered disabled when Unum Disability Management determines that:

- You’re limited from performing the material and substantial duties of your regular occupation because of your illness or injury; and
- You have a 20 percent or greater loss in your indexed monthly earnings because of the same injury or illness.
After 18 months of payments, you’re considered disabled when Unum determines that, because of the same injury or illness, you’re unable to perform the duties of any gainful occupation for which you’re reasonably fit by education, training or experience.

- To be considered disabled, you must be under the regular care of a physician.
- The loss of a professional or occupational license or certification does not, in and of itself, constitute disability.

Unum Disability Management may require that you be examined by a physician, other medical practitioner and/or vocational expert of their choice. Unum will pay for this examination and can require an examination as often as it is reasonable to do so. Unum may also require that you be interviewed by an authorized Unum representative.

### WHAT IS GAINFUL OCCUPATION?

“Gainful occupation” means an occupation that’s providing you, or can be expected to provide you, with an income that exceeds 80 percent of your indexed monthly earnings if you’re working, or 60 percent of your indexed monthly earnings if you’re not working, within 12 months of your return to work.

### IF TERMS OR PROVISIONS CONFLICT

For Long-Term Disability benefits, the Unum Disability Management insured contract is the prevailing document.

All benefit provisions described in this section are subject to review and approval by Unum. If the terms or provisions differ between this document and the insured contract, the insured contract will govern.

### Key Terms within the Definition of Disabled for Long-Term Disability Benefits

The following are key terms found within the definition of disabled for Long-Term Disability benefits.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited</td>
<td>What you are not allowed or are unable to do.</td>
</tr>
<tr>
<td>Material and substantial duties</td>
<td>Duties that:</td>
</tr>
<tr>
<td></td>
<td>- Are normally required for the performance of your regular occupation; and</td>
</tr>
<tr>
<td></td>
<td>- Can’t be reasonably omitted or modified, except that if you’re required to</td>
</tr>
<tr>
<td></td>
<td>work, on average, in excess of 40 hours per week, Unum Disability Management</td>
</tr>
<tr>
<td></td>
<td>the capacity to work, 40 hours per week.</td>
</tr>
<tr>
<td>Regular occupation</td>
<td>The occupation you’re routinely performing when your disability begins. Unum</td>
</tr>
<tr>
<td></td>
<td>Disability Management will look at your occupation as it’s normally performed</td>
</tr>
<tr>
<td></td>
<td>in the national economy, instead of how the work tasks are performed for a</td>
</tr>
<tr>
<td></td>
<td>specific employer or at a specific location.</td>
</tr>
<tr>
<td>Illness</td>
<td>Sickness or disease.</td>
</tr>
<tr>
<td>Injury</td>
<td>A bodily injury that’s the result of an accident.</td>
</tr>
</tbody>
</table>
### Indexed monthly earnings

Your monthly compensation adjusted on each anniversary of benefit payments by the lesser of 10 percent or the current annual percentage increase in the Consumer Price Index (CPI-U). Your indexed monthly earnings may increase or remain the same, but they never decrease. The CPI-U is published by the U.S. Department of Labor. Unum Disability Management reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while you're disabled and working, and in the determination of gainful occupation.

### Additional Qualification Requirements for a Long-Term Disability Benefit

To be eligible for a Long-Term Disability benefit, you must meet the Plan’s definition of disabled. Additional regulations and requirements are noted below.

You must provide proof of claim at your own expense. This proof of claim must show:

- That you're under the regular care of a physician;
- The date your disability began;
- The cause of your disability;
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

Unum Disability Management may request that you send proof of continuing disability, indicating that you’re under the regular care of a physician. This proof, provided at your expense, must be received within 45 days of Unum Disability Management’s request. In some cases, you’ll be required to give Unum Disability Management authorization to obtain additional medical information, and to provide nonmedical information, as part of your proof of claim or proof of continuing disability. Unum Disability Management will deny your claim or stop sending you payments if the appropriate information isn’t submitted.

If you're receiving a Long-Term Disability benefit from the Plan, be sure to notify Unum Disability Management before you engage in any employment. See Rehabilitation and Return-to-Work Assistance Program for details.

### When Coverage Begins

Your eligibility for Long-Term Disability coverage begins once you meet the definition of an eligible employee and satisfy the waiting period.

### When Your Benefit Begins

Your Long-Term Disability benefit begins after you’ve been continuously disabled through your elimination period. Unum Disability Management will treat your disability as continuous if your disability stops for 30 days or less during the elimination period for the same or a different covered illness or injury. The days that you’re not disabled won’t count toward your elimination period. Your elimination period is the later of:
- 180 days; or
- The date your Short-Term Disability benefit ends, if applicable.

**Note:** You can satisfy your elimination period if you're working while you're disabled; the days you're disabled will count toward satisfying your elimination period.

You'll begin to receive Long-Term Disability benefit payments when Unum Disability Management approves your claim, provided the elimination period has been met and you're disabled. Unum Disability Management will send you a payment for any period for which Unum Disability Management is liable.

**Your Benefit Amount**

The table below shows the Long-Term Disability benefit you receive. The Plan uses your compensation at the time you become disabled to determine your Long-Term Disability benefit amount. The Plan also considers any other income you may receive. As a result, your Long-Term Disability benefit may be reduced. See [Integration of benefits — deductible sources of income](#) for details.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Benefit amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-Term Disability benefit</td>
<td>The Plan pays the lesser of (minus any deductible sources of income):</td>
</tr>
<tr>
<td></td>
<td>▪ 60% of your compensation; or</td>
</tr>
<tr>
<td></td>
<td>▪ $10,000 per month.</td>
</tr>
</tbody>
</table>

Your Long-Term Disability benefit is paid by Unum Disability Management on a monthly basis. After the elimination period, if you're disabled for less than one month, Unum Disability Management will send you one-thirtieth of your payment for each day of disability.

**Compensation and Your Long-Term Disability Benefit**

Your eligible compensation is a major factor when determining your Long-Term Disability benefit. Your eligible compensation is determined as of the day before you become disabled and includes:

- Your monthly base pay;
- One-twelfth of your prior 12 months of Sales Incentive Plan payments or commissions;
- Your shift differential; and
- One-twelfth of your prior 12 months of lump-sum merit pay.

If, at the time you become disabled, you've worked for the company for less than 12 months, the Plan calculates your lump-sum merit pay, commissions and sales incentives using figures from your actual period of employment.

Your eligible compensation doesn't include any of the following:

- Overtime pay
- Annual Incentive Plan payments
- Bonuses
- Moving allowances
- Educational allowances
- Noncash payments
- Overseas allowances
- Any other extra compensation or income received from sources other than Motorola Solutions

**How Your Monthly Payment Is Calculated**

The following is how Unum Disability Management will calculate your monthly payment:

1. **Multiply** your pre-disability monthly compensation by 60 percent.
2. **Compare** the answer from step 1 with the maximum monthly benefit of $10,000. The lesser of these two amounts is your gross disability payment.
3. **Subtract** any deductible sources of income from your gross disability payment.
4. **Subtract** applicable taxes.

The amount figured in step 4 is your monthly payment.

**Note:** Federal income taxes won’t be withheld from your monthly benefit payment unless an IRS Form W-4 is completed and returned to Unum Disability Management indicating the desired amount you’d like withheld. You may also request that state income taxes be withheld. To do so, contact Unum Disability Management for the appropriate form to complete this request.

**Total Benefit Payable**

The total benefit payable to you on a monthly basis (including all benefits provided under this Plan) won’t exceed 100 percent of your monthly compensation. If, however, you’re participating in Unum Disability Management’s Rehabilitation and Return-to-Work Assistance Program, the total benefit payable to you on a monthly basis (including all benefits provided under this Plan) may be as much as 110 percent of your monthly compensation.

**Rehabilitation and Return-to-Work Assistance Program**

If your physician certifies you to work (with or without modified job duties) on a reduced-hour work schedule, the Long-Term Disability Plan may continue to pay you a disability benefit. While working, you’ll receive payments based on the percentage of income you’re losing due to your disability.

Unum Disability Management will send you a full monthly payment if you’re disabled (due to the same illness or injury) and your monthly disability earnings, if any, are less than 20 percent of your indexed monthly earnings.

**ADDITIONAL BENEFITS**

You may qualify for additional rehabilitation and return-to-work assistance benefits if you’re participating in the Return-to-Work Assistance Program. **Contact** Unum for additional information regarding your benefits described in the insured policy.

“Monthly disability earnings” means the earnings you receive while you’re disabled and working, plus the earnings you could receive if you were working to your maximum capacity.
“Indexed monthly earnings” means your pre-disability monthly compensation adjusted on each anniversary of benefit payments by the lesser of 10 percent or the current annual percentage increase in the Consumer Price Index (CPI-U). Your indexed monthly earnings may increase or remain the same but will never decrease. The CPI-U is published by the U.S. Department of Labor. Unum Disability Management reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-U. Indexing is only used as a factor in the determination of the percentage of lost earnings while you’re disabled and working and in the determination of gainful occupation.

If you’re disabled because of the same illness or injury, and your monthly disability earnings are less than 20 percent of your indexed monthly earnings, Unum Disability Management will pay you the full monthly disability benefit.

If you’re disabled because of the same illness or injury, and your monthly disability earnings are greater than 80 percent of your indexed monthly earnings, your Long-Term Disability payments end.

If you’re disabled because of the same illness or injury, and your monthly disability earnings are from 20 percent to 80 percent of your indexed monthly earnings, Unum Disability Management will figure your payment as follows:

1. **Subtract** your disability earnings from your indexed monthly earnings.
2. **Divide** the answer in step 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. **Multiply** your monthly payment by the answer in step 2.

The amount figured in step 3 is the amount Unum Disability Management will pay you each month.

**An Example of a Long-Term Disability Rehabilitation Benefit Calculation**

To show how a Long-Term Disability Rehabilitation benefit is calculated, assume that before you became disabled you worked 40 hours each week, and your monthly compensation prior to your disability was $5,000 and the current CPI-U is 3.85 percent. Your physician certifies that you’re able to return to work on a reduced schedule of 20 hours each week (50 percent work capacity). The table below shows how your Long-Term Disability Rehabilitation benefit is calculated.

<table>
<thead>
<tr>
<th>Long-Term Disability Rehabilitation benefit calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gross monthly earnings</strong></td>
</tr>
<tr>
<td><strong>Gross monthly disability benefit</strong></td>
</tr>
<tr>
<td>(60% of predisability compensation)</td>
</tr>
<tr>
<td><strong>Reduced wages earned (for example, $5,000 x 50%)</strong></td>
</tr>
<tr>
<td><strong>Indexed monthly earnings</strong></td>
</tr>
</tbody>
</table>
Long-Term Disability Rehabilitation benefit calculation

<table>
<thead>
<tr>
<th>Description</th>
<th>Calculation</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subtract monthly disability earnings from indexed</td>
<td>$5,192.50 – $2,500 =</td>
<td>$2,692.50</td>
</tr>
<tr>
<td>monthly earnings</td>
<td>$2,692.50</td>
<td></td>
</tr>
<tr>
<td>Amount from above divided by indexed monthly earnings</td>
<td>$2,692.50 ÷ $5,192.50 =</td>
<td>51.8%</td>
</tr>
<tr>
<td></td>
<td>51.8%</td>
<td>Results in a 51.8% loss in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>earnings.</td>
</tr>
<tr>
<td>Long-Term Disability Rehabilitation benefit</td>
<td>$3,000 x 51.8% = $1,554</td>
<td>You’ll receive $1,554 as your</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Long-Term Disability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rehabilitation benefit (51.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>of your gross monthly benefit).</td>
</tr>
</tbody>
</table>

*Indexing starts after one year of disability and continues each year thereafter.

When combined with your reduced-schedule work earnings, your total income is $4,054 each month ($1,554 benefit + $2,500 earnings = $4,054).

Unum Disability Management may require you to send proof of your monthly disability earnings, at least quarterly, and will adjust your payment based on your quarterly disability earnings. As part of your proof of disability earnings, you may be required to provide appropriate financial records that Unum Disability Management believes are necessary to substantiate your income.

After the elimination period, if you’re disabled for less than one month, Unum Disability Management will send you one-thirtieth of your payment for each day of disability.

When Your Disability Earnings Fluctuate

If your disability earnings fluctuate widely from month to month, Unum Disability Management may average your disability earnings over the most recent three months to determine whether your claim should continue.

If Unum Disability Management averages your disability earnings, your claim won’t terminate unless the average of your disability earnings from the last three months exceeds 80 percent of indexed monthly earnings.

Unum Disability Management won’t pay you for any month during which disability earnings exceed 80 percent of indexed monthly earnings.

Social Security Disability Claimant Advocacy Program

Unum Disability Management’s specialized program, the Social Security Disability Claimant Advocacy Program, can provide expert advice regarding your claim for Social Security Disability Income (SSDI) benefits and assist you with your application or appeal. Receiving Social Security Disability Income benefits may:

- Enable you to receive Medicare after 24 months of disability payments;
- Enable you to protect your retirement benefits; and
- Enable your family to be eligible for Social Security Disability Income benefits.

Unum Disability Management can assist you in obtaining Social Security Disability Income benefits by:

- Helping you find appropriate legal representation;
▪ Obtaining medical and vocational evidence; and
▪ Reimbursing preapproved case management expenses.

Contact Unum for more information about the Social Security Disability Claimant Advocacy Program.

Maximum Period of Payment and Your Claim End Date

As long as you remain disabled and eligible for a Long-Term Disability benefit, Unum Disability Management will send you a payment each month, up to the maximum period of payment. Your maximum period of payment is based on your age at disability as follows:

<table>
<thead>
<tr>
<th>Age at disability</th>
<th>Maximum period of payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than age 60</td>
<td>To age 65, but not less than five years</td>
</tr>
<tr>
<td>Age 60 through 64</td>
<td>Five years</td>
</tr>
<tr>
<td>Age 65 through 69</td>
<td>To age 70, but not less than one year</td>
</tr>
<tr>
<td>Age 70 and older</td>
<td>One year</td>
</tr>
</tbody>
</table>

*The maximum period of payment doesn’t include the 180 calendar days during which you received Short-Term Disability benefits.

Unum Disability Management will stop sending you payments and your claim will end on the earliest of the following:

▪ During the first 18 months of payments, when you’re able to work in your regular occupation on a part-time basis but you choose not to
▪ After 18 months of payments, when you’re able to work in any gainful occupation on a part-time basis but you choose not to
▪ If you’re working, the day your monthly disability earnings exceed 80 percent of your indexed monthly earnings
▪ The end of the maximum period of payment
▪ The day you’re no longer disabled under the terms of the Plan, unless you’re eligible to receive benefits under Unum Disability Management’s Rehabilitation and Return-to-Work Assistance Program
▪ The day you fail to submit proof of continuing disability
▪ After 24 months of payments if you’re considered to reside outside of the U.S. or Canada (i.e., you’ve lived outside of these countries for a total period of at least six months during any 12 consecutive months of benefits)
▪ The day of your death

Disabilities with a Limited Pay Period

The lifetime cumulative maximum benefit period for all disabilities caused by mental, nervous or alcohol- or drug-related conditions and disabilities based primarily on self-reported symptoms is 24 months.

Only 24 months of benefits will be paid for any combination of such disabilities even if the disabilities:

▪ Aren’t continuous; and
▪ Aren’t related.
Unum Disability Management will continue to send you payments beyond the 24-month period if you meet one or both of these conditions:

- If you’re confined to a hospital or institution at the end of the 24-month period, Unum Disability Management will continue to send you payments during your confinement. If you’re still disabled when you’re discharged, Unum Disability Management will send you payments for a recovery period of up to 90 days. If you’re reconfined at any time during the recovery period and remain confined for at least 14 consecutive days, Unum Disability Management will send payments during that additional confinement, and for one additional recovery period up to 90 more days.

- If, after the 24-month period for which you’ve received payments, you continue to be disabled and subsequently become confined to a hospital or institution for at least 14 consecutive days, Unum Disability Management will send payments during the length of the reconfinement.

Unum Disability Management won’t pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Unum Disability Management won’t apply the mental illness limitation to dementia if it’s the result of one of the following conditions:

- Stroke
- Trauma
- Viral infection
- Alzheimer’s disease
- Other conditions not listed, which aren’t usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment

When Coverage Ends

Your Long-Term Disability coverage under the Plan ends on the earliest of the following dates:

- The day the policy or Plan is cancelled
- The day you’re no longer in an eligible group
- The day your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you’re actively employed

Unum Disability Management will provide coverage for a payable Long-Term Disability claim that occurs while you’re covered under the Plan.

Dependent Care Expense Benefit

While you’re receiving Long-Term Disability benefits and participating in Unum Disability Management’s Rehabilitation and Return-to-Work Assistance Program, you may receive payments to cover certain dependent care expenses, limited to the following amounts:

- $350 per month, per dependent
- $1,000 per month maximum benefit amount for all eligible dependent care expenses combined
While you’re participating in this program, Unum Disability Management will pay a Dependent Care Expense benefit when you’re disabled and:

- You incur expenses to provide care for a child under the age of 15; and/or
- You incur expenses to provide care for a child age 15 or older or a family member who needs personal care assistance.

The payment of the Dependent Care Expense benefit will begin immediately after you start Unum Disability Management’s Rehabilitation and Return-to-Work Assistance Program.

To receive this benefit, you must provide satisfactory proof that you’re incurring expenses that entitle you to the Dependent Care Expense benefit.

Dependent Care Expense benefits will end on the earliest of the following:

- The date you’re no longer incurring expenses for dependent care
- The date you no longer participate in Unum Disability Management’s Rehabilitation and Return-to-Work Assistance Program
- Any other date that Long-Term Disability benefit payments stop in accordance with this Plan

**Recurrent Disability**

A recurrent disability means a disability that’s:

- Caused by a worsening of your condition; and
- Due to the same cause(s) as your prior disability for which Unum Disability Management made a Long-Term Disability payment.

If you have a recurrent disability, Unum Disability Management will treat your disability as part of your prior claim and you won’t have to complete another elimination period if:

- You were continuously insured under the Plan for the period between the end of your prior claim and your recurrent disability; and
- Your recurrent disability occurs within six months from the end of your prior claim.

Your recurrent disability will be subject to the same terms of the Plan as your prior claim and will be treated as a continuation of that disability. Any disability that occurs after six months from the date your prior claim ended will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period. If you become entitled to payments under any other group long-term disability plan, you won’t be eligible for payments under the Plan.

**Survivor Benefits**

When Unum Disability Management receives proof that you’ve died, Unum Disability Management will pay your eligible survivor(s) a lump-sum benefit equal to three months of your gross disability payment if, on the date of your death:

- Your disability had continued for 180 or more consecutive days; and
- You were receiving, or were entitled to receive, payments under the Plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. In that case, no payment will be made. However, Unum Disability Management will first apply the survivor benefit to any overpayment that may exist on your claim.
You may receive your three-month survivor benefit before your death if you've been diagnosed as terminally ill. Unum Disability Management will pay you a lump-sum amount equal to three months of your gross disability payment if:

- You've been diagnosed with a terminal illness or condition;
- Your life expectancy is less than 12 months; and
- You're receiving monthly payments. Your right to exercise this option and receive payment is subject to the following:
  - You must make this election in writing to Unum; and
  - Your physician must certify in writing that you have a terminal illness or condition and that your life expectancy is less than 12 months.

This benefit is available to you on a voluntary basis and will be payable only once, even if your life expectancy has been extended and you continue to receive a Long-Term Disability benefit. If you elect to receive this benefit before your death, no three-month survivor benefit will be payable upon your death.

Disabilities Excluded From Long-Term Disability Coverage

The Plan doesn't cover any disabilities caused by, contributed to by or resulting from:

- Occupational illness or injury (Unum Disability Management will, however, cover disabilities caused by occupational illnesses or injuries for partners or sole proprietors who can't be covered by a workers' compensation law)
- Intentionally self-inflicted injuries
- Active participation in a riot
- Loss of a professional license, occupational license or certification
- Commission of a crime for which you've been convicted
- Pre-existing conditions
- War, declared or undeclared, or any act of war

Unum Disability Management won't pay a benefit for any period of disability during which you're incarcerated.

You have a pre-existing condition if:

- You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines in the 90 days just before your effective date of coverage; and
- The disability begins in the first 180 days after your effective date of coverage.

Eligibility for coverage for a disability related to this illness, injury or pregnancy begins when you've been covered by the Plan for 180 consecutive calendar days and have been actively at work. You must be disability-free from the condition for those 180 consecutive calendar days.
Additional Facts about Long-Term Disability Coverage

Taxes and Disability Benefits

Your Long-Term Disability benefits are considered taxable income. Applicable tax withholdings are taken from your disability payments as required by law.

Integration of Benefits — Deductible Sources of Income

Unum Disability Management will subtract from your gross disability payment the following deductible sources of income:

- The amount that you receive, or are entitled to receive, under:
  - An occupational disease law; or
  - Any other act or law with similar intent.

- The amount that you receive, or are entitled to receive, as disability income payments under any:
  - State compulsory benefit act or law;
  - Automobile liability insurance policy;
  - Other group insurance plan; or
  - Governmental retirement system as a result of your job with Motorola Solutions.

- The amount that you, your spouse and your children (for whom you’re financially responsible) receive, or are entitled to receive, as disability payments because of your disability under:
  - The U.S. Social Security Act; or
  - Any similar plan or act.

- The amount that you receive as retirement payments, or the amount your spouse and children receive as retirement payments because you’re receiving retirement payments, under:
  - The U.S. Social Security Act; or
  - Any similar plan or act.

- The amount under any Motorola Solutions Retirement Plan that you:
  - Receive as disability payments;
  - Voluntarily elect to receive as retirement payments; or
  - Receive as retirement payments when you reach the later of age 62 or normal retirement age, as defined in the Motorola Solutions Retirement Plan.

(Note: Amounts received don’t include amounts rolled over or transferred to any eligible retirement plan. Unum Disability Management will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code, including any future amendments that affect the definition.)

- The amount that you receive under Title 46, U.S. Code Section 688 (the Jones Act).
- The amount that you receive from a third party (after subtracting attorney’s fees) by judgment, settlement or otherwise.
With the exception of retirement payments, Unum Disability Management will subtract only deductible sources of income that are payable as a result of the same disability.

“Law,” “Act” or “Plan” as used above means the original enactments of the law, act or plan, and all amendments.

“Retirement plan” means a defined contribution plan or defined benefit plan. These are plans that provide retirement benefits to employees and aren’t funded entirely by employee contributions. “Retirement plan” includes, but isn’t limited to, any plan that’s part of any federal, state, county, municipal or association retirement system.

Disability payments under a retirement plan will be those benefits that are paid because of a disability and do not reduce the retirement benefit that would have been paid if the disability had not occurred. Retirement payments will be those benefits that are based on your employer’s contribution to the retirement plan. Disability benefits that reduce the retirement benefit under the plan will also be considered as a retirement benefit. Regardless of how the retirement funds from the retirement plan are distributed, Unum will consider your and your employer’s contributions to be distributed simultaneously throughout your lifetime.

**Nondeductible Sources of Income**

There are certain nondeductible sources of income that Unum Disability Management won’t subtract from your gross disability payment. These include, but are not limited to, the following:

- 401(k) plans
- Profit-sharing plans
- Thrift plans
- Tax-sheltered annuities
- Stock ownership plans
- Nonqualified plans of deferred compensation
- Pension plans (excludes the Motorola Solutions Pension Plan)
- Military pension and disability income plans
- Credit disability insurance
- Franchise disability income plans
- A retirement plan from another employer
- Individual retirement accounts (IRAs)
- Individual disability income plans
- Salary continuation or accumulated sick leave plans

**Minimum Benefit**

If subtracting deductible sources of income would result in a zero benefit, Unum Disability Management will pay you a minimum monthly payment that’s the greater of:

- $100; or
■ 10 percent of your gross disability payment.

Unum Disability Management may apply this amount toward an outstanding overpayment.

Cost-of-Living Increases to a Deductible Source of Income

Once Unum Disability Management has subtracted any deductible source of income from your gross disability payment, Unum Disability Management won’t further reduce your payment because of a cost-of-living increase from that source.

Estimated Deductible Income Benefits

When Unum Disability Management determines that you may qualify for benefits under the first three items listed in Integration of benefits — deductible sources of income, Unum Disability Management will estimate your entitlement to these benefits. Unum Disability Management can reduce your payment by the estimated amounts if such benefits:

■ Haven’t been awarded; and
■ Haven’t been denied; or
■ Have been denied and the denial is being appealed.

Your Long-Term Disability payment will not be reduced by the estimated amount if:

■ You apply for the disability payments under the first three items listed in Integration of benefits — deductible sources of income, the benefits are denied, and you appeal the denial to all administrative levels Unum Disability Management feels are necessary; and
■ You sign Unum Disability Management's Payment Option form, which states that you promise to repay any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when Unum Disability Management receives proof:

■ Of the amount awarded; or
■ That benefits have been denied and all appeals Unum Disability Management feels are necessary have been completed. In this case, a lump-sum refund of the estimated amount will be made to you.

If you receive a lump-sum payment from any deductible sources of income, the lump sum will be prorated, on a monthly basis, over the time period for which the sum was given. If no time period is stated, Unum Disability Management will use one it deems reasonable.

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 are recognized if they comply with applicable state law and aren’t preempted by the Employee Retirement Income Security Act (ERISA).

Overpayments

Unum Disability Management has the right to recover any overpayments caused by any one of the following:

■ Fraud
- Any error Unum Disability Management makes while processing a claim
- Your receipt of deductible sources of income

You must fully reimburse any overpayment. Unum Disability Management will determine the method by which the repayment is to be made and won’t recover more money than the amount paid to you.

Special State Laws Regarding Disability Benefits

Some states have special laws regarding disability benefits. For example, if you work in Hawaii, New Jersey, New York, California or Rhode Island, special provisions may apply to you. This list is not intended to be exhaustive as states continue to enact laws that affect this area and the list is subject to change.

**Hawaii, New Jersey and New York:** Benefits payable from this Plan are reduced by any benefits payable by any other plan or policy set up by the company to comply with that state’s disability benefits law.

**California and Rhode Island:** Benefits payable from this Plan are reduced by benefits paid to you by the state disability plan.

Insurance Fraud

Unum Disability Management wants to ensure that you and the company don’t incur additional insurance costs as the result of the undermining effects of insurance fraud. Unum Disability Management promises to apply all means necessary to support fraud detection, investigation and prosecution.

It’s a crime to knowingly — and with intent to injure, defraud or deceive Unum Disability Management — provide information (including filing a claim) that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and they’re subject to prosecution and punishment to the full extent under state and/or federal law. Unum Disability Management will pursue all appropriate legal remedies in the event of insurance fraud.

Continuation and Conversion Rights

Continuation and conversion rights don’t apply to Long-Term Disability coverage.

How to Receive Your Disability Benefits

⚠️ If you’re eligible to receive Short-Term Disability (STD) benefits, benefits will be issued on a weekly basis and mailed by check to your home address on file. You may also set up a direct deposit option with Unum.

If you’re eligible to receive Long-Term Disability (LTD) benefits, benefits will be issued on a monthly basis. You have the option to request that Long-Term Disability payments be deposited directly into a U.S. bank account of your choice. Contact Unum to initiate this process.
Plan or Program | Where to send information for your claim | Deadline* and initial decision
---|---|---
Short-Term Disability (including Short-Term Disability Buy-Up) | For information needed to report a disability and to contact Unum to initiate your claim: Unum The Benefits Center** P.O. Box 100158 Columbia, SC 29202 Telephone: (866) 295-3009 Outside the U.S.: +1 (207) 575-3678 Fax: (800) 447-2498 | Deadline: Within 12 months of the date of the onset of your disability Initial decision: Within 45 days*** after the claim is filed

*If you wait any longer than this deadline, you won’t be eligible for benefits under the Plan related to those expenses.
**For physician use only to submit additional documentation to Unum upon request.
***Plus an extension of up to 45 days in special circumstances.

Once you apply for Short-Term or Long-Term Disability benefits, you’ll receive a decision from the Claims Administrator in writing. The Claims Administrator may either approve or deny your request. Motorola Solutions wants to make sure that you receive the full benefits that you’re eligible to receive under the Plans.

Your Right to Appeal

If your disability claim is denied, in whole or in part, in a letter from the Plan Administrator or applicable Claims Administrator, or otherwise, you may request a review of the denial. Your request for review must be in writing, and it should contain the reasons why you believe you’re entitled to benefits, as well as any additional information or documentation to support your claim.

**TIME LIMITS FOR LEGAL PROCEEDINGS**

You can start legal action regarding your claim 60 days after proof of claim has been given, and up to three years from the time proof of claim is required, unless otherwise provided under federal law.

You can start legal action regarding your claim 60 days after proof of claim has been given, and up to three years from the time proof of claim is required, unless otherwise provided under federal law.

You’ll be notified of the Claims Administrator’s decision within 45 days of receiving the 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. Should an extension be necessary, you’ll be notified before the end of the initial review period.
<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Send your request for review to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Short-Term Disability</td>
<td>Mail:</td>
</tr>
<tr>
<td>• Long-Term Disability</td>
<td>Unum</td>
</tr>
<tr>
<td></td>
<td>The Benefits Center</td>
</tr>
<tr>
<td></td>
<td>Appeals Unit</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 9548</td>
</tr>
<tr>
<td></td>
<td>Portland, ME 04104-5058</td>
</tr>
<tr>
<td></td>
<td>Fax: (207) 575-2354</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Deadline for submitting written request for review</th>
<th>180 days from notification of denial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date for final decision on appeal</td>
<td>Decision will be made within 45 days of receipt of your written appeal (plus an extension of up to 45 days in special circumstances)</td>
</tr>
<tr>
<td>Date for filing suit in federal court</td>
<td>180 days after final denial of appeal</td>
</tr>
</tbody>
</table>

You must exhaust all the internal administrative remedies described above before bringing an action for benefits under the Plans under Section 502(a) of ERISA.

**Supplemental Long-Term Disability Income Insurance Program**

If you’re eligible, you may purchase a portable individual disability income insurance policy through the Supplemental Long-Term Disability Income Insurance Program. This Program, offered through MassMutual and administered by Aon Hewitt, supplements the Plan’s Long-Term Disability coverage. When combined with your Long-Term Disability benefit, you may protect a greater percentage of your pre-disability earned income.

**About the Supplemental Long-Term Disability Income Insurance Program**

Policies may have exclusions and limitations. For costs and complete details regarding this coverage, contact Aon Hewitt. A dedicated Benefits Specialist is available to assist you. Massachusetts Mutual Life Insurance Company, Springfield, Massachusetts 01111, issues these policies.

**Applying for Coverage**

You can apply and be approved for the Supplemental Long-Term Disability Income Insurance Program at any time with medical evidence of insurability. You must meet the insurance carrier’s actively-at-work requirements. You may receive a policy with a pre-existing condition clause. A pre-existing condition clause limits coverage under certain circumstances. Employees residing in California who apply after the initial enrollment period may be asked to provide medical evidence of insurability.

A program enrollment period may be offered on occasion at the discretion of Motorola Solutions and MassMutual. If you meet the program eligibility requirements, the Program Administrator and MassMutual will contact you when and if there’s an enrollment period.
Who’s Eligible

You’re eligible to apply for this coverage if:

- The sum of your base pay, lump-sum merit bonuses, shift differential and average Sales Incentive Plan or commission pay is equal to at least $150,000;
- You’re a domestic employee of the company that participates in this Program;
- You’re actively at work (as defined by MassMutual); and
- You’re regularly scheduled to work at least 30 hours per week.

If you meet these eligibility requirements, MassMutual and Aon Hewitt will contact you directly regarding the application process.

When Coverage Begins

Coverage takes effect the first of the month following approval of your application.

Changes in Coverage

If your pay increases and you’re eligible for additional coverage, the Program Administrator will contact you during the next program enrollment period. Changes take effect the first of the month following approval of coverage, unless you elect not to increase your coverage.

Your Benefit Amount

The Supplemental Long-Term Disability Income Insurance Program provides coverage of 75 percent of your eligible compensation, less your Group Long-Term Disability coverage and any other long-term disability coverage you have in place. Based on your income, you may apply for coverage of up to $10,000 per month without evidence of insurability during a program enrollment period. You must meet the insurance carrier’s actively-at-work requirements. Some employees are eligible for up to an additional $10,000 benefit, available with additional underwriting, for a combined total benefit of up to $20,000. This increase of coverage must be applied for during an enrollment period. California residents are limited to a total of $15,000 of coverage. If you apply for a coverage increase outside of a program enrollment period, you’ll be required to provide medical evidence of insurability.

Your Contributions

You pay premiums for the Supplemental Long-Term Disability Income Insurance Program through after-tax payroll deductions. This means that the benefit you receive from this coverage isn’t taxable to you. Your cost (premium) is based on your age at initial application and changes only if your coverage increases.

Your premiums for Supplemental Long-Term Disability Income Insurance coverage are waived after you’ve been disabled for 90 days and while you’re receiving a Supplemental Long-Term Disability Income Insurance benefit. Upon your return to work, your contributions resume through after-tax payroll deductions at the same rate.

Compensation and Supplemental Long-Term Disability Income Insurance Coverage
Your eligible compensation is a major factor when determining your Supplemental Long-Term Disability Income Insurance coverage. Your eligible compensation includes all of the following:

- Your base pay
- Your two-year average of Sales Incentive Plan payments or commissions
- Your two-year average bonus compensation
- Lump-sum merit pay

Your eligible compensation doesn’t include any of the following:

- Overtime pay
- Moving allowances
- Educational allowances
- Noncash payments
- Overseas allowances
- Shift differential
- Annual Incentive Plan payments

**Evidence of Insurability Requirements**

Coverage up to $10,000 per month may be issued without medical evidence of insurability, provided you apply during the program enrollment period and meet the insurance carrier’s definition of “actively at work.” This definition is provided in your enrollment materials. Coverage in excess of $10,000 per month may require medical evidence of insurability, as determined by the insurance carrier.

You may initially decline to apply for the Supplemental Long-Term Disability Income Insurance Program but later decide to apply. If you do apply and are approved for coverage, your policy will contain a pre-existing condition clause. A pre-existing condition clause limits coverage under certain circumstances.

**Continuation and Conversion Rights**

Your Supplemental Long-Term Disability Income Insurance policy is portable. This means that you can continue your coverage if you leave the company. As long as you pay your premiums on time, your coverage continues at the same rate and benefit level, and MassMutual bills you directly.

For additional details regarding this coverage, contact Aon Hewitt and ask to speak to Motorola Solutions’ dedicated Benefits Specialist.

**WORK/LIFE**

**Overview**

This section summarizes the variety of different Work/Life programs we offer to our employees at Motorola Solutions. As long as you meet the Plan’s eligibility requirements, you can access programs such as our Adoption Assistance Program, Child Care Solutions and Motorola Solutions Assist. You may find that enrolling in one or more of these programs will provide you and your family with a long-term health benefit.
Use this section to read about all of these programs to learn which may be right for you. You’ll be able to locate information about eligibility, coverage, program details and any additional resources that may apply.

Work/Life Programs

Our Work/Life programs provide you with information, resources, financial assistance and benefits to help you balance work and personal responsibilities. Certain programs are automatic while others require you to enroll before you can participate. Here’s an overview of the programs available.

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
<th>Who’s eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption Assistance Program</td>
<td>Offers financial assistance to help with some of the expenses associated with adopting a child</td>
<td>You</td>
</tr>
<tr>
<td>Business Travel Assistance</td>
<td>Various assistance programs available for business travel</td>
<td>You</td>
</tr>
<tr>
<td>EAP</td>
<td>Offers counseling assistance and help with a variety of issues</td>
<td>You and your eligible family members</td>
</tr>
<tr>
<td>Motorola Solutions Assist</td>
<td>A comprehensive resource for international business travel assistance and services</td>
<td>You</td>
</tr>
<tr>
<td>Hospital Indemnity and Accident</td>
<td>Pays a benefit if you or a covered family member are hospitalized or suffer a covered accident</td>
<td>You and your eligible family members (voluntary benefit – requires enrollment)</td>
</tr>
<tr>
<td>Critical Illness</td>
<td>Pays a benefit if you or a covered family member is diagnosed with a critical illness.</td>
<td>You and your eligible family members (voluntary benefit – requires enrollment)</td>
</tr>
<tr>
<td>Long Term Care Insurance</td>
<td>Provides long term care assistance resulting from accident or illness.</td>
<td>You and your eligible family members (voluntary benefit – requires enrollment)</td>
</tr>
<tr>
<td>U.S. Commuter Benefit Program</td>
<td>Helps you with some of the expenses associated with your commute to work</td>
<td>You (may enroll any time)</td>
</tr>
</tbody>
</table>

About the Work/Life Programs

We offer a wide range of solutions and resources to help meet your life event needs, regardless of your stage in life — whether you need help locating a child care center, a nursing home facility for a loved one or scholarship resources for your college-bound child.

You may participate in the Work/Life programs as long as you meet certain eligibility requirements. The following eligibility requirements apply to all of the Work/Life programs except for long term care insurance.

Who’s Eligible

You’re eligible to participate in the Work/Life programs if:
You’re a domestic employee of Motorola Solutions (or a company that participates in the programs);
You’re actively at work;
You’re regularly scheduled to work at least 20 hours per week; and
The company’s U.S. payroll department processes your regular paycheck.

Who’s Not Eligible

You’re not eligible to participate if:

- You provide services under an independent contractor, consultant or employee-leasing agreement;
- You’re an intern or co-op student;
- You’re classified as a leased employee;
- You’re classified as contract labor;
- Your eligible compensation isn’t processed by the company’s U.S. payroll department; or
- You’re employed under a collective bargaining agreement (unless your union agreement provides for your participation in the Work/Life programs).
When Participation Begins and Ends

The table below shows when your participation begins and ends for each of the Work/Life programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Participation begins</th>
<th>Participation ends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption Assistance Program</td>
<td>Participation begins on the day you begin work.</td>
<td>Participation ends on the day your employment ends</td>
</tr>
<tr>
<td>Business Travel Assistance</td>
<td></td>
<td>EAP may be accessed for 30 days after employment ends.</td>
</tr>
<tr>
<td>EAP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Care Insurance</td>
<td>Participation begins once LifeSecure approves your enrollment application.</td>
<td>Coverage may continue even after your employment ends.</td>
</tr>
<tr>
<td>Motorola Solutions Assist</td>
<td>Participation begins on the day you begin work.</td>
<td>Participation ends on the day your employment ends</td>
</tr>
<tr>
<td>U.S. Commuter Benefit Program</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** If you’re no longer a participant, the Adoption Assistance Program doesn’t reimburse you for any adoption-related expense submitted more than 30 days after your participation terminates. This applies even if you incurred the eligible expense before the date your participation ended.

**Employee Assistance Program (EAP)**

The Employee Assistance Program (EAP) provides a variety of professional services that support Motorola Solutions employees. One key benefit is short-term, confidential counseling, referral and follow-up services for you and your eligible family members at no cost to you. The EAP can help you with a variety of issues, including anxiety, depression, marital and family problems, parenting concerns, alcohol and drug abuse, stress, grief, workplace and life coaching, and other emotional personal concerns that may affect personal well-being and work performance.

All records, including medical information, referrals and evaluations, are kept strictly confidential in accordance with federal and state laws. Motorola Solutions will not be told if you or one of your household members uses this benefit. Motorola Solutions receives participation data only in an anonymous aggregate format to assess the value of the program.

**Financial Assist**

Expert financial planning and consultation.

**Legal Assist**

Free telephonic or face to face legal consultation.

**Family Assist**

Consultation and referral services for daily living issues, such as dependent care, auto repair, pet care and home improvement

**Management Consultations and Management Referrals**
EAP consultation and referrals are also available through the EAP consultants for all levels of management to assist in resolving issues with individual employees, teams or businesses. Management referrals to the EAP may be based upon concern, behavior or performance issues.

Workplace Incidents

Workplace incidents, such as the death or serious injury of a co-worker, a natural disaster, domestic violence or a situation that threatens life or safety, can have a serious impact on individuals and the workplace. EAP consultants work with management and Human Resources to provide the most appropriate support when needed and to help you and your co-workers resolve issues in a timely manner, promoting well-being and facilitating your return to maximum functioning.

How the Program Works

You and your eligible family members are provided with up to five (5) no-cost counseling sessions per individual, per episode each calendar year. The EAP is available to you even if you don’t enroll in any of Motorola Solutions’ health care benefits. Your family members are eligible as long as they’re your dependents or members of your household, such as your spouse, domestic partner, parents or grandparents.

You can reach SupportLinc at 1-888-MSI-4474 (674-4474).

SupportLinc  www.supportlinc.com  Username: msi  Password: linc123

Adoption Assistance Program

The Adoption Assistance Program offers you financial assistance to help with some of the expenses associated with domestic and international adoptions. As an eligible employee, you may be reimbursed for up to $8,000 per child for eligible adoption expenses. If both you and your spouse/domestic partner are employees, your family is eligible for up to $8,000 per child.

Any benefit paid to you under the Motorola Adoption Assistance Program before January 1, 2011 has been applied to the Program limits under the Motorola Solutions Program, if the expenses are related to the adoption of the same child.

How the Program Works

You may receive reimbursement for many eligible adoption-related expenses, such as legal and medical fees. To receive reimbursement, submit the appropriate documentation and paid receipts to the Motorola Solutions Employee Service Center.

A NOTE ABOUT ELIGIBLE EXPENSES

An eligible expense is an expense that’s 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. For an expense to be considered eligible, you must incur the expense while you’re an eligible employee.
Eligible Expenses for Reimbursement

You may apply for reimbursement for the following eligible adoption-related expenses:

- Public or private adoption organization fees (including home study fees, where required)
- Foreign and international adoption fees
- Legal fees associated with the adoption legal guardianship — if 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 (adoptive parents’ physical exam, and in the case of a private adoption, the biological mother’s and child’s medical and professional counseling expenses) or
- Fees associated with temporary foster care (agency and legal fees associated with temporary foster care that results in a final [or failed] adoption)
- Reasonable travel expenses, such as airfare, hotel and meals, provided such expenses are directly related to, and necessary for, an adoption or a bona fide attempt to adopt
- Fees associated with the translation of documents into English

Failed adoption expenses are also considered eligible expenses. These are expenses you incur in the legal attempt to adopt a child, but the adoption terminates due to unforeseen circumstances.

Non-Eligible Expenses for Reimbursement

The following expenses aren’t eligible for reimbursement under the Program:

- Voluntary donations to adoption organizations or orphanages that aren’t a required fee for adoption
- Legal fees to obtain legal guardianship, unless legal guardianship is an integral part of a final (or failed) adoption
- Costs to obtain citizenship
- Cost of adoption when you or your spouse/domestic partner is the biological parent of the child
- Costs to have a child through a surrogate parent or to adopt a child born to a surrogate parent
- Expenses covered by any other plan, policy or program offered by the company or otherwise
- Legal retainer fees paid to an attorney
- Independent adoption networking fees and associated services
- Advertisement and soliciting fees
- General living expenses for the birth mother, such as rent, food and clothing
- Any service or expense incurred before the date you become eligible to participate in the Program
- Expenses incurred or submitted for reimbursement after your participation in the Program terminates
- Any expense not listed as an eligible expense
- Fees incurred by a public or private adoption organization that is not licensed

After You Adopt a Child
As soon as the placement or adoption of the child is complete, you may want to:

- File for any remaining Adoption Assistance Program reimbursement
- Add your child to your medical, vision and/or dental coverage
- Enroll your new dependent, if eligible, for Dependent Life Insurance coverage (provided you’re already enrolled for Supplemental Life Insurance coverage)
- Establish or change your contribution to the Flexible Spending Account (FSA)
- Establish or change your contribution to the Dependent Care Account (DCA)
- Change your beneficiary designations for your life insurance or the 401(k) Plan

### QUALIFIED ADOPTION EXPENSES (SECTION 23)

Qualified adoption expenses under Internal Revenue Code (IRC) Section 23 include reasonable adoption fees, court costs, attorney fees and other expenses directly related to, and the principal purpose of which is, the legal adoption of an eligible child.

Talk to your accountant or financial adviser, or see the instructions to IRC Form 8839 (available online at [www.irs.gov](http://www.irs.gov)) for detailed information regarding the adoption tax credit.

Also, certain expenses may be considered tax-free. Consult your tax adviser to determine which expenses apply.

### When Coverage Ends

Your coverage under the Adoption Assistance Program ends on the earliest of the following events:

- The day on which your employment ends
- The day you no longer meet the Work/Life program’s eligibility requirements, other than because of a leave of absence under the company’s Parental Leave Policy or a paid leave of absence
- The last day of the month in which you receive military service pay under the company’s Military Service Pay Policy, provided your coverage as a participant who returns to active employment within 31 days of entering military service (as described in the Uniformed Services Employment and Reemployment Rights Act) shall not be terminated as a result of such absence
- Ninety days after the Claims Administrator requests repayment from you or your covered dependent of amounts that are subject to reimbursement under any Motorola Solutions welfare plan, or overpayments or mistaken payments from any Motorola Solutions welfare plan, if you fail to repay or set up an acceptable payment schedule
- The day a Program amendment takes effect that eliminates such coverage
- The day the Program terminates

### Important Tax Information

Reimbursements from the Adoption Assistance Program are considered taxable income. Any reimbursement you receive is paid directly to you with applicable tax withheld. Reimbursements aren’t eligible for the adoption assistance income exclusion under IRC Section 137. Therefore, any reimbursements you receive are reported as wages in Box 1 of your Form W-2.

* Medical, vision and/or dental coverage becomes effective on either the date of adoption or date of placement of the child, as determined by the submitted court- or attorney-provided documents. Be sure to take action within 31 days of the date of adoption or placement to add your child to your health coverage.
You may be able to take a tax credit, allowed by IRC Section 36C, for qualified adoption expenses that aren’t reimbursed under this Program. A tax credit is an amount that you subtract from your tax liability. The tax credit is subject to change annually and is phased out for taxpayers with adjusted gross incomes above a certain level. **To determine whether you qualify for a tax credit, consult with your tax adviser.**

To consider your benefit as taxable income in the current calendar year, your claim should be received no later than December 1.

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**TAX ALERT**

You may be taxed on the value of any benefit you receive from a subsidized Work/Life program, including dependent care benefits. These benefits are taxable if their value, plus your Dependent Care Account (DCA) contributions, exceeds the maximum you may contribute to a DCA. See [Dependent Care Account (DCA)](Dependent_Care_Account_DCA) for more details.

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**Other Claim and Reimbursement Details**

**Documents Requiring Translation**

In cases of international adoption, adoption documents or receipts may not be written in English. Therefore, you must have these documents translated. For a smooth adoption reimbursement process:

- Locate a translator who’s proficient in the language of the documents and in English.
- Submit a signed, notarized letter or affidavit from the translator that:
  - Attests that he or she is proficient in the English language and the language being translated;
  - Attests that his or her translation accurately reflects the contents of the original documents;
  - Provides a list of each document translated;
  - Provides the native currency and amount of each receipt and the translated dollar equivalent; and
  - Contains the legibly printed name of the translator.

**TRANSLATED DOCUMENTS**

Documents translated into English should be accompanied by a notarized letter or affidavit from the translator, noting each of the documents he or she translated. For questions about the Adoption Assistance Program, **contact** the Motorola Solutions Employee Service Center.

**When You Can File for Reimbursement**

You can file for reimbursement of eligible expenses when:

- A child is placed in your home for adoption;
- The adoption is finalized; or
- Your attempt to adopt a child ends un成功fully.
Submission Deadlines for Reimbursement

You must submit an eligible expense for reimbursement by the earliest of the following applicable dates:

- One year from the date of the initial placement — for eligible expenses incurred on or before that date
- During the period after the initial placement of the child in your home but before the date of the final (or failed) adoption — for eligible expenses incurred during that same period (you may submit one or more requests for reimbursement)
- One year from the date of the final (or failed) adoption, or the date the eligible expense was incurred (whichever is later) — for all eligible expenses associated with a final (or failed) adoption
- Thirty days from the date you terminate participation in the Program

Documentation Required for Expense Reimbursement

To receive reimbursement for an eligible expense, you must submit an Adoption Reimbursement Request cover sheet and all relevant documents (translated into English, if the originals are in a non-English language), including the following:

- A copy of the adoption court order, or a notarized letter from an attorney or agency that either grants preliminary placement or documents a failed adoption attempt
- Paid itemized receipts for eligible adoption expenses

How to Receive Your Adoption Benefits

<table>
<thead>
<tr>
<th>Program</th>
<th>Information needed</th>
<th>Where to send your claim</th>
<th>Deadline* and initial decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption Assistance Program</td>
<td>Adoption Reimbursement Request form</td>
<td>Motorola Solutions Employee Service Center</td>
<td>Deadline: One year after the later of a final or failed adoption or the date the expense was incurred.</td>
</tr>
<tr>
<td></td>
<td>Required receipts and supporting documents</td>
<td>P.O. Box 785081 Orlando, FL 32878-5081</td>
<td>See submission deadlines for reimbursement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: (888) 211-9900</td>
<td>Initial decision: Within 45 days** after claim is filed.</td>
</tr>
</tbody>
</table>

*If you wait any longer than this deadline, you won't be eligible for benefits under the Program related to those expenses.

**Plus an extension of up to 45 days in special circumstances.

How to Make an Adoption Reimbursement Request and Submit Your Expenses

Access the Your Spending Account page from Your Benefits Resources and select “Adoption” from the “Request Reimbursement” option under the “Take Action” toolbar. Follow the instructions provided on the “About the Adoption Reimbursement Process” to create the required cover sheet. Indicate whether you will "Upload" your claim or “Send by fax or mail,” and then enter the required expense detail. After you complete the expense information, continue to follow the prompts to create a cover sheet. Complete your submission by following the prompts to upload your documentation or print the cover sheet to fax or mail with your required documentation.
If you don’t have online access, you can contact the Motorola Solutions Employee Service Center and follow the Your Spending Account prompts to request a cover sheet or to speak to a representative who will complete the cover sheet for you. The representative will mail you the completed cover sheet to attach to your required documentation when you mail or fax it.

After you apply for a specific benefit, you’ll receive a decision from the Claims Administrator in writing. The Claims Administrator may either approve or deny your request.

Your Right to Appeal

Motorola Solutions wants to make sure that you, your covered dependents and your beneficiaries all receive the full benefits that you and they are eligible to receive under the Program.

If an initial claim for benefits under the Adoption Assistance Program is denied, in whole or in part, in a letter from the Claims Administrator or otherwise, you may request a review of the denial. Your request for review must be in writing, and it should contain the reasons why you believe you’re entitled to benefits, as well as any additional information or documentation to support your claim.

If your appeal is denied, you’ll receive a Level II Claim Initiation form to submit a written second-level appeal of that denial. You’ll receive the final decision about your appeal in writing. This decision will give you the specific reasons for the decision and also provide you with the corresponding Program provision(s). The decisions are final and binding on all parties except as required by law. You or your covered dependents must exhaust all of the internal administrative remedies before bringing an action for benefits under the Program under Section 502(a) of ERISA.

Second Level of Review

Under the Adoption Assistance Program, if your appeal is denied, you may submit a written second-level appeal of that denial.

You’ll receive the final decision about your appeal in writing. This decision will give you the specific reasons for the decision and also provide you with the corresponding Program provision(s). The decisions are final and binding on all parties except as required by law.

You or your covered dependents must exhaust all of the internal administrative remedies described above before bringing an action for benefits under the Program under Section 502(a) of ERISA.

Where to Send Your Request for Review

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Send request for review to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption Assistance Program</td>
<td>First level of review</td>
</tr>
<tr>
<td></td>
<td>Contact: The Motorola Solutions Employee Service Center at (800) 585-5100 for a Claim Initiation form.</td>
</tr>
<tr>
<td></td>
<td>Second level of review</td>
</tr>
<tr>
<td></td>
<td>Contact the Employee Service Center for a Level II Initiation form. Your Level II appeal will be reviewed by the Motorola Solutions Benefit Review Committee.</td>
</tr>
</tbody>
</table>

U.S. Health and Welfare Benefits Book for Employees 133
Deadline for submitting written request for review | 180 days from notification of denial  
---|---  
Date for final decision on appeal | Decision will be made within 30 days of receipt of your written appeal  
Date for filing suit in federal court | 180 days after final denial of appeal  

### U.S. Commuter Benefit Program

The Motorola Solutions U.S. Commuter Benefit Program helps you with some of the expenses associated with your commute to work. Not only does it help the environment, it can save you money, too. If you travel to work on any form of public transportation (e.g., train, bus, subway, ferry or vanpool), you’re eligible to buy transportation vouchers and parking garage vouchers on a pretax basis. The vouchers you purchase will be mailed directly to your home before the beginning of each month.

### How the Program Works

The U.S. Commuter Benefit Program allows you to purchase vouchers with pretax dollars. The current benefit for 2018 allows up to a monthly maximum of $260 for parking and $260 for public transportation. The annual maximum benefit will be increased in future years with corresponding increases announced as the IRS. You can choose from more than 100,000 types of tickets and passes. If you pay for parking and transit, you can cover your expenses with both commuter benefits.

The monthly limits are set by the federal government and could change annually. For the current monthly limits, visit Your Benefits Resources. Click on “Other Benefits,” then “Your Spending Account.” You may also call a Your Spending Account Customer Service Representative, available through the Motorola Solutions Employee Service Center, at (800) 585-5100.

If you don’t see the voucher you need, contact the Your Spending Account team at (800) 585-5100, and they’ll add it to the website for you. In addition to enrolling in the program, you can use the Your Spending Account website to:

- Automatically renew your monthly transit and/or parking pass
- Track your order history
- Maintain your personal account information

You must place your order for the following month’s tickets, passes or vouchers by the tenth day of the previous month. If you don’t receive your pass by the first day of the month, you can be reimbursed for any out-of-pocket transit or parking purchases. To get a reimbursement, you’ll need to submit a refund form. You can find the form on Your Benefits Resources. Just sign in with your core ID and single sign-on password. Make sure you have your proof of purchase. Then, you can repurchase the parking pass.

You must place your order for the following month’s tickets, passes or vouchers by the tenth day of the previous month.

### Wired Commute

The Your Spending Account team has partnered with Wired Commute to administer the U.S. Commuter Benefit Program. Wired Commute has established relationships with transit authorities across the U.S. to
distribute transit passes and parking vouchers. You’ll receive your transportation vouchers through the mail from Wired Commute.

Buying Vouchers

To purchase your vouchers online:

1. Visit Your Benefits Resources.
2. Click on “Other Benefits,” then find the “Your Spending Account” link and follow the instructions for enrolling in the commuter program to gain access to the Your Spending Account website.
3. Once you submit your acknowledgement to enroll in the Commuter Benefit Program, you’ll need to click on the “Your Spending Account” link again and follow the instructions to manage your account to proceed with enrollment.
4. From here you can select your metropolitan area and choose your transit and/or parking provider and the type of pass or ticket you need. The vouchers will be mailed directly to your home before the beginning of each month.

Reasons to Enroll

You’re doing your part to save the environment while also saving money! Your payroll deduction for eligible commuter benefits is not subject to federal and FICA taxes, and in some areas, it’s also not subject to state or local taxes. So you’ll be saving money on commuting expenses every month.

Note: Mileage, tolls, fuel and carpooling aren’t eligible for the Commuter Benefit Program. All business travel and other reimbursable expenses are also excluded.

More Information

If you have questions or need more information about the U.S. Commuter Benefit Program, please click the “Your Spending Account” link on Your Benefits Resources. You can also speak with a Customer Service Representative at (800) 585-5100.

Long-Term Care Insurance

Long-Term Care Insurance, provided by LifeSecure, helps you and your eligible family members prepare now for rising health care costs and the potential need for professional long-term care services as the result of an accident or illness.

Long-Term Care Insurance covers the custodial long-term care services not usually covered under your group medical plan. If you become chronically ill and don’t have long-term care coverage, you must pay for care on your own or “spend down” financial resources until you qualify for Medicaid.

Participation in this program is completely voluntary. You pay LifeSecure a monthly premium for coverage. If you need long-term care services in the future, your insurance reimburses you for eligible expenses up to the limits you choose.

Who’s Eligible

LifeSecure offers Long-Term Care Insurance to individuals ages 18-79:
Active employees, their spouses/domestic partners and their surviving spouses/domestic partners;
Employees’ parents and grandparents; and
Employees’ parents-in-law and grandparents-in-law (parents and grandparents of spouses/domestic partners)
Adult children (18 and over) and siblings

If you’re an active employee and choose to purchase Long-Term Care Insurance, you will pay your premiums directly to LifeSecure.

Business Travel Assistance

Motorola Solutions Assist

The Motorola Solutions Assist program, administered by International SOS (Intl SOS), is a travel assistance program that provides international travel information and services for those traveling abroad on company business.

The following programs are available to you and your dependents to assist with your needs when you must travel on business, within the U.S. or abroad:

- Motorola Solutions Assist Program
- Business Travel Medical Insurance
- Business Travel Accident Insurance

**ONE-STOP SHOP**

<table>
<thead>
<tr>
<th>When traveling on business anywhere in the world, the Motorola Solutions Assist program offers the security and convenience of a one-stop shop for any and all health, safety and travel concerns.</th>
</tr>
</thead>
</table>

Such pre-trip and in-transit travel services include the following:

- Immunization services
- Automated health-related travel advisories
- 24-hour medical advice and referrals
- Emergency medical care

International SOS is the world’s largest provider of international assistance services and is available to you 24 hours a day.

How to Register for the Program

Registration for Motorola Solutions Assist is easy. All you need to do is complete the Emergency Record Profile, which you can obtain online at [www.internationalsos.com](http://www.internationalsos.com). Enter the membership number 11BCPA000173 for your Member Login.

International SOS keeps the information in your completed profile strictly confidential. This is an important document and must be available if you need medical attention while you're traveling. Be sure you complete at least the minimum recommended immunizations before an international trip plus any other
recommended immunizations based on where you're traveling and how long you're staying. See the Immunization Services below for details.

You’re not required to provide personal health information on the Emergency Record Profile to register for the program. However, having your health history on file will help International SOS provide critical information to physicians attending to your care if you require emergency medical assistance while you’re traveling.

If you have any questions regarding registration, contact International SOS. If you’re a current Motorola Solutions Assist member, you can access your records online, including your immunization history, health history and emergency contact information. When you need to update any of this information, access your Emergency Record Profile online at www.internationalsos.com, membership number: 11BCPA000173.

If you’re an international business traveler, you’re strongly encouraged to register for this program. Once you’re registered as a Motorola Solutions Assist member, you can access your records online at any time.

<table>
<thead>
<tr>
<th>PRIVACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motorola Solutions Assist is administered by a third party, International SOS. All personal information is secured and can only be accessed by you or a Motorola Solutions Assist health care professional if you need medical treatment in a foreign location.</td>
</tr>
<tr>
<td>For additional information regarding the International SOS privacy statement, please refer to its website at <a href="http://www.internationalsos.com/en/privacy.htm">www.internationalsos.com/en/privacy.htm</a>.</td>
</tr>
</tbody>
</table>

Immunization Services

If you’re an international traveler, your immunizations should always be kept up to date and be well-documented. There’s always the risk that you may be exposed to potentially dangerous diseases that you wouldn’t typically encounter in your own country. This is particularly true when traveling to developing countries.

At a minimum, you should ensure that your immunizations are up to date for the primary diseases listed below:

- Diphtheria
- Rubella
- Tetanus
- Hepatitis A
- Measles
- Polio
- Mumps

Other primary or secondary immunizations may be required depending on your international destination(s) and the amount of time you plan to spend there.

You’re encouraged to discuss your immunization records with your personal physician and determine what, if any, immunizations are required. Please note that access to immunizations necessary for international travel may not be available to your personal physician. However, Motorola Solutions Assist maintains a list of approved physicians who specialize in travel medicine and can provide the required
immunizations and documentation. Please call Motorola Solutions Assist for further information or if you need assistance.

As a registered member, you can receive email reminders when follow-up doses or boosters are required.

**Note:** Motorola Solutions Assist doesn’t pay for immunizations. You’re responsible for the initial cost. However, since these immunizations are business-travel expenses, they’re eligible for reimbursement through your department.

**Automated Health-Related Travel Advisories**

Before you leave on any international trip, you should be knowledgeable about potential health and safety risks in the countries you’ll be visiting. Automatic health-related travel advisories, when warranted, will be emailed to employees who book international business trips through recognized business travel booking systems. For current security travel advisory information, visit the Global Security travel information web page at [my.mot-solutions.com/go/benefits](http://my.mot-solutions.com/go/benefits).

**Access to Medical and Immunization Records**

Each traveler’s Emergency Record Profile is maintained in a secure database. This ensures that treating physicians where you’re traveling have the most up-to-date information available should they need to diagnose or treat you or a family member in an emergency. The profile includes records of your immunizations, medical conditions, allergic reactions to certain drugs and other information. You and your personal physician have access to these files at any time to ensure that all relevant information is kept current.

Your authorization is required before a treating physician can access any record. Also, whenever you’re treated by a Motorola Solutions Assist referral physician, a follow-up form is automatically sent and added to your medical profile.

<table>
<thead>
<tr>
<th>PRIVACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your privacy is assured; all information is secured and can be accessed only by you, your physician or a Motorola Solutions Assist (International SOS) health care professional in case of an emergency.</td>
</tr>
</tbody>
</table>

**Business Travel Medical Assistance**

When traveling internationally on company business, there’s always the chance that you might experience an illness or injury. In an emergency, Motorola Solutions Assist, through International SOS, will help facilitate the medical attention you require. In a non-emergency, where you’d like medical consultation, Motorola Solutions Assist can provide the following services:

**24-hour medical advice:** A Motorola Solutions Assist health care professional can answer your questions or arrange for you to speak with a physician and learn about recommended treatment practices.

**Physician referrals:** From a database of more than 3,000 physician and hospital referrals worldwide, Motorola Solutions Assist can arrange for you to see a local English-speaking physician.
If you experience an urgent medical situation, Motorola Solutions Assist can help you obtain appropriate medical care, and, if medically necessary, a private jet with medical escort can accompany you to the nearest facility best equipped to handle the medical emergency.

Regardless of the reason or severity, you can contact Motorola Solutions Assist for any medical issue you may have while on business travel — whether it's a toothache or a potentially life-threatening situation.

**Business Travel Accident (BTA) Insurance**

All full-time employees of the Policyholder who are domiciled in the United States, citizens of the United States and living abroad, or on U.S. payroll and are living abroad, who are in Active Service have BTA Insurance provided by Chubb (formerly known as ACE American.).

This coverage, provided to you under the Motorola Solutions Global Business Travel Accident Program, provides financial protection to you (and in some instances, to your spouse/domestic partner and dependent children) in case of an accidental death or dismemberment while you’re traveling on company business. You don’t have to enroll, and there’s no cost to you for this coverage.

For a specific business trip, coverage begins when you leave your home, place of employment or other location on company business. Coverage for that trip ends once you return to your home or regular place of employment (whichever occurs first). The Program also provides coverage if you’re traveling on company business as a passenger, pilot or crew member in an aircraft owned, leased or operated by Motorola Solutions.

A BTA Insurance benefit may be available to you if your spouse/domestic partner or dependent child suffers a covered loss (while traveling in the course of company business) that results from hijacking, air piracy, an injury in connection with a Motorola Solutions-leased aircraft, terrorism or an injury incurred when that individual is traveling on a relocation trip at the expense and direction of Motorola Solutions.

For detailed coverage information, visit [https://converge.motorolasolutions.com/community/hr](https://converge.motorolasolutions.com/community/hr) and review the BTA policy on the Policies page.

**Your Principal Sum of Coverage**

The company provides you, your spouse/domestic partner and your dependent children with a Principal Sum of coverage as shown in the table below for Business Travel Accident Insurance.

<table>
<thead>
<tr>
<th>Business Travel Accident Insurance</th>
<th>Principal Sum of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Three times eligible compensation, rounded to the next higher $100</td>
</tr>
<tr>
<td>Spouse/domestic partner</td>
<td>$50,000 (for some specified hazards, and if traveling on a relocation trip at the expense and direction of Motorola Solutions)</td>
</tr>
<tr>
<td>Dependent child</td>
<td>$25,000 (for some specified hazards, and if traveling on a relocation trip at the expense and direction of Motorola Solutions)</td>
</tr>
</tbody>
</table>

The minimum amount of Business Travel Accident Insurance coverage you may have is $50,000. The maximum amount of coverage you may have is $3 million. This is separate from the maximum allowed for Basic and Supplemental Life Insurance coverage.
When Coverage Begins

As long as you meet the Life Insurance Plan’s eligibility requirements, your Business Travel Accident Insurance coverage begins on your first day of active employment with Motorola Solutions. For a specific business trip, coverage begins when you leave your home, place of employment or other location on company business.

Coverage for that trip ends once you return to your home or regular place of employment (whichever occurs first). The Plan also provides coverage if you’re traveling on company business as a passenger, pilot or crew member in an aircraft owned, leased or operated by Motorola Solutions.

How the Plan Pays Benefits

The Life Insurance Plan pays a benefit to you or your designated beneficiary if you suffer a covered loss caused by an accident while traveling on company business. The covered loss must occur within 365 calendar days of the accident. The benefit that the Plan pays equals your Principal Sum of coverage or a percentage of your Principal Sum, depending on the covered loss. This is shown in the schedule of benefits below.

COVERED LOSS THAT RESULTS FROM WAR AND TERRORISM

The Plan pays a benefit for a covered loss that results from:
- An act of war outside the U.S. and your country of residence or permanent assignment; or
- Acts of terrorism, hijacking or air piracy, whether inside or outside the U.S.

Schedule of Benefits

The Plan pays a Business Travel Accident Insurance benefit based on the following schedule.

<table>
<thead>
<tr>
<th>Covered loss</th>
<th>Benefit amount paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>Two or more of the following:</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>- Hand</td>
<td></td>
</tr>
<tr>
<td>- Foot</td>
<td></td>
</tr>
<tr>
<td>- Sight in one eye</td>
<td></td>
</tr>
<tr>
<td>- Speech</td>
<td></td>
</tr>
<tr>
<td>- Hearing</td>
<td></td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100% of Principal Sum</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>50% of Principal Sum</td>
</tr>
<tr>
<td>Hemiplegia or paraplegia</td>
<td>75% of Principal Sum</td>
</tr>
</tbody>
</table>
Total paralysis of both upper limbs | 50% of Principal Sum
Loss of thumb and index finger of the same hand | 25% of Principal Sum

The Plan pays a Business Travel Accident Insurance benefit only for the greatest loss that results from any one accident.

Maximum Benefits

There’s a maximum benefit of $3 million that applies to Business Travel Accident Insurance. This maximum is separate from the maximum that applies to your Basic and Supplemental Life Insurance coverage.

Here are some additional things to keep in mind regarding this maximum:

- If more than one employee is involved in a single accident while traveling on company business, the Plan pays a combined maximum aggregate Business Travel Accident Insurance benefit of $15 million.
- If you’re traveling on company business to a war-risk area, the Plan limits your Business Travel Accident Insurance benefit to three times your eligible compensation, up to a maximum of $1 million.
- The maximum benefit includes any additional benefits you may receive under your Business Travel Accident Insurance coverage, including any of the following:
  - Permanent, total disability benefit
  - Coma benefit
  - Emergency medical evacuation benefit
  - Emergency medical expenses benefit
  - Rehabilitation benefit
  - Repatriation benefit
  - Air bag benefit
  - Seat belt benefit
  - Special adaptation benefit

How the Plan Pays Dependent Travel Benefits

The Life Insurance Plan pays a Business Travel Accident Insurance benefit if your spouse/domestic partner or dependent child suffers a covered loss (while traveling in the course of company business) that results from hijacking, air piracy, an injury in connection with a Motorola Solutions-owned aircraft, terrorism or an injury in connection with relocating.

The Plan pays a benefit equal to the Principal Sum of coverage. The Principal Sum for a dependent spouse/domestic partner is $50,000. The Principal Sum for a dependent child is $25,000.

The Plan provides Business Travel Accident Insurance coverage for relocation travel for your spouse/domestic partner or dependent child when that individual is traveling on a relocation trip at the expense and direction of Motorola Solutions.
## Additional Business Travel Accident Insurance Benefits

If you suffer a covered loss while traveling on company business, the Plan pays the following additional benefits in accordance with your Business Travel Accident Insurance coverage:

<table>
<thead>
<tr>
<th>Additional benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Permanent, total disability benefit</strong></td>
<td>If you suffer a covered loss that results in permanent, total disability, and the disability continues for 365 consecutive days, you’ll receive your Principal Sum of coverage.</td>
</tr>
<tr>
<td><strong>Coma benefit</strong></td>
<td>You’ll receive 1% of your Principal Sum of coverage each month for up to 11 months, if you:</td>
</tr>
<tr>
<td></td>
<td>▪ Become comatose, as determined by the Plan Administrator, within 31 days of a covered accident; and</td>
</tr>
<tr>
<td></td>
<td>▪ Remain comatose for at least 31 days.</td>
</tr>
<tr>
<td></td>
<td>If you remain comatose for the entire 11-month period, the Plan pays the remainder of the Principal Sum (less the amount already paid over the 11-month period) at the end of that period. The Plan may require proof of your comatose state. Benefits cease upon your death or recovery.</td>
</tr>
<tr>
<td><strong>Emergency medical evacuation benefit</strong></td>
<td>If you suffer a covered loss while traveling more than 100 miles away from your home on company business, the Plan pays 100% of covered expenses for necessary, immediate transportation to the nearest hospital or medical facility for treatment purposes, or to your home for recovery purposes.</td>
</tr>
<tr>
<td><strong>Emergency medical expense benefit</strong></td>
<td>Benefits are payable to a maximum of $10,000 if you suffer a medical emergency during the course of your trip and are traveling 100 or more miles away from your place of permanent residence.</td>
</tr>
<tr>
<td></td>
<td>Covered expenses include a:</td>
</tr>
<tr>
<td></td>
<td>▪ Medical expense guarantee: Expenses for guarantee of payment to a medical provider; and</td>
</tr>
<tr>
<td></td>
<td>▪ Hospital admission guarantee: Expenses for guarantee of payment to a hospital or treatment facility.</td>
</tr>
<tr>
<td></td>
<td>Benefits for these covered expenses won’t be payable unless:</td>
</tr>
<tr>
<td></td>
<td>▪ The charges incurred are medically necessary and don’t exceed the charges for similar treatment, services or supplies in the locality where the expense is incurred; and</td>
</tr>
<tr>
<td></td>
<td>▪ They don’t include charges that would not have been made if there were no insurance.</td>
</tr>
<tr>
<td><strong>Rehabilitation benefit</strong></td>
<td>If your doctor prescribes a rehabilitation program due to a spinal cord, nervous system or closed head injury, the Plan pays up to $50,000 to a facility that provides such rehabilitation program. This benefit also applies to any expenses your immediate family members may incur for travel to and from the program’s location.</td>
</tr>
<tr>
<td><strong>Repatriation benefit</strong></td>
<td>The Plan 100% of covered expenses for preparation and return of your body to your home after death. This benefit covers embalming, cremation and</td>
</tr>
</tbody>
</table>
### Additional benefit

**Description**

transportation expenses.

The expenses must be authorized in advance before the Plan pays this additional benefit.

<table>
<thead>
<tr>
<th>Additional benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air bag benefit*</td>
<td>The Plan pays $10,000 if you suffer a covered loss while operating or riding as a passenger in a vehicle with functioning air bags. If the air bag functionality can’t be determined, the default benefit is $1,000.</td>
</tr>
<tr>
<td>Seat belt benefit*</td>
<td>The Plan pays $25,000 if you suffer a covered loss while you’re wearing a seat belt and operating or riding as a passenger in an automobile. Proper use of the seat belt must be either part of the official police report or certified in writing by the investigating officer.</td>
</tr>
<tr>
<td>Special adaptation benefit*</td>
<td>The Plan will pay 10% of the Principal Sum to a maximum of $10,000 for home alteration and vehicle modification needed if you suffer a covered loss.</td>
</tr>
</tbody>
</table>

*These additional benefits are also payable if your covered dependent suffers a covered loss because of an accident (as described under the [How the Plan pays dependent travel benefits](#)).

### Defining a Permanent, Total Disability Benefit

For purposes of the Permanent, Total Disability benefit, “permanent, total disability” means that because of a covered loss that results from an accident while traveling on company business, you:

- Are unable to do any work for which you currently are, or may become, qualified by reason of education, experience or training (if you’re employed); or
- Are unable to perform the normal and customary activities of a healthy person of like age and sex (if you’re not employed); and
- Are expected to remain so disabled, as certified by a doctor, for the rest of your life.

### When Coverage Ends

Your Business Travel Accident Insurance coverage ends on the earliest of the following occurrences:

- Your last day of employment
- The day you enter the military service of any country
- The day you no longer meet the Plan’s eligibility requirements
- The day you begin a leave of absence, including a disability leave of absence or layoff
- The day a Plan amendment takes effect that eliminates such coverage
- The day the Plan terminates

### Exclusions

The Plan doesn’t pay a Business Travel Accident Insurance benefit for any loss that results from any of the following:

- Travel in an aircraft without a valid certificate of airworthiness
- Travel in an aircraft that’s flown by a pilot without a valid license
- Travel while on vacation or a leave of absence
- Commuting to and from your regular place of employment
- Travel while you’re acting as a pilot or crew member in any vehicle or device for aerial flight, except in a company aircraft
- Suicide, attempted suicide or an intentionally self-inflicted injury while sane or insane
- Service in the military, naval or air service of any country
- An illness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof (except for any bacterial infection) that results from an accidental external cut or wound or an accidental ingestion of contaminated food
- A war, or any act of war, declared or undeclared, on U.S. soil, or in your country of residence or permanent assignment

**Business Travel Accident Insurance Coverage: Life Events Chart**

The chart below shows how different life events can affect your participation in Business Travel Accident Insurance Program benefits. You’ll see the changes you can make based on specific life events.

**Note:** If your work schedule changes (for example, you’re scheduled to work less than 20 hours per week), this change may affect your eligibility for coverage. Be sure to discuss the impact of these changes with the Motorola Solutions Employee Service Center.

**Business Travel Accident Insurance Coverage**

<table>
<thead>
<tr>
<th>Life event</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New employee</td>
<td>Coverage is automatic.</td>
</tr>
<tr>
<td>Marriage or establishment of a domestic</td>
<td>No action is necessary.</td>
</tr>
<tr>
<td>partnership</td>
<td></td>
</tr>
<tr>
<td>Birth or adoption</td>
<td>No action is necessary.</td>
</tr>
<tr>
<td>Divorce or end of a domestic partnership</td>
<td>No action is necessary.</td>
</tr>
<tr>
<td>Child no longer qualifies as an eligible</td>
<td>No action is necessary.</td>
</tr>
<tr>
<td>dependent</td>
<td></td>
</tr>
<tr>
<td>Personal leave (non-disabled)</td>
<td></td>
</tr>
<tr>
<td>- If you’ve had coverage for less than six</td>
<td>Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td>months</td>
<td></td>
</tr>
<tr>
<td>- If you’ve had coverage for six months or</td>
<td>Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td>more</td>
<td></td>
</tr>
<tr>
<td>Disabled leave of absence</td>
<td>Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td>Reinstatement (from leave)</td>
<td>Coverage begins on the first day of reinstatement.</td>
</tr>
<tr>
<td>Death</td>
<td>Full benefit is payable to beneficiary(ies).</td>
</tr>
<tr>
<td>Death of a spouse/domestic partner or child</td>
<td>No action is necessary.</td>
</tr>
<tr>
<td>Termination of employment</td>
<td>Coverage ends on the date your employment</td>
</tr>
<tr>
<td></td>
<td>ends.</td>
</tr>
</tbody>
</table>

**Key Terms for Coverage under Business Travel Accident Insurance**
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hijacking and air piracy coverage</td>
<td>Coverage in the event that an accident takes place during the hijacking of an aircraft, air piracy or an unlawful seizure or attempted seizure of an aircraft. A covered accident that occurs in the course of hijacking or air piracy due to acts of terrorism, whether war-related or not, must meet the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• Take place in the course of company business</td>
</tr>
<tr>
<td></td>
<td>• Be caused by, or result directly and independently from, terrorism or a terrorist act</td>
</tr>
<tr>
<td>Loss of a thumb or index finger of the same hand</td>
<td>Complete severance through or above the metacarpophalangeal joints of the same hand.</td>
</tr>
<tr>
<td>Owned aircraft</td>
<td>If an accident takes place in an owned aircraft, the covered loss must take place in either of the following instances:</td>
</tr>
<tr>
<td></td>
<td>• While you or your covered dependent is riding in, or getting on or off, a covered aircraft</td>
</tr>
<tr>
<td></td>
<td>• As a result of you or your covered dependent being struck by a covered aircraft</td>
</tr>
<tr>
<td>Principal Sum</td>
<td>Your Business Travel Accident Insurance coverage in effect:</td>
</tr>
<tr>
<td></td>
<td>• Three times your eligible compensation, rounded to the next higher $100</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Your Principal Sum of coverage is subject to maximums as noted in the Business Travel Accident Insurance section.</td>
</tr>
</tbody>
</table>

**GENERAL ADMINISTRATION**

**Overview**

This section gives you additional tools and resources to help you understand how our health and welfare plans work. You'll be able to locate specific plan details and contact information for all of our benefit partners. Here's a list of what's included in this section:

- Information about how to take advantage of your benefits as your situation changes
- Guidance on procedures for filing claims and appeals for your benefits
- Details about your rights under the Employee Retirement Income Security Act of 1974 (ERISA) and other important plan information

This section also includes definitions of terms and phrases commonly used throughout this book and a list of telephone numbers, websites and other resources available to you for additional benefit plan information.
Keep this information in a convenient place and refer to it often as your source of information. The more you know regarding these plans and programs, the more you’ll be able to take full advantage of the benefits offered.

### How Life Events Affect Your Coverage

#### Health Care Plans and Flexible Spending Account (FSA): Life Events Chart

The chart below shows how different life events can affect your participation in the Health Care Plans and the FSA. You’ll see the changes you can make based on specific life events.

**Note:** If your work schedule changes (for example, if you’re scheduled to work less than 20 hours per week), this change may affect your eligibility for coverage. Be sure to discuss the impact of these changes with the Motorola Solutions Employee Service Center.

#### Health Care Plans and FSA

<table>
<thead>
<tr>
<th>Life event</th>
<th>Coverage</th>
<th>Dental and/or Vision</th>
<th>FSA</th>
<th>COBRA continuation coverage option</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New employee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New employee</td>
<td>- Choose Coverage on Aon Active Health Exchange or;</td>
<td></td>
<td></td>
<td>Not applicable.</td>
</tr>
<tr>
<td></td>
<td>- Opt Out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marriage or establishment of domestic partnership</strong></td>
<td>Add spouse/ domestic partner and/or make change to coverage (optional).</td>
<td>Add child to your current coverage (optional).</td>
<td>Change amount of pretax pay you contribute (optional).</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Birth or adoption</strong></td>
<td>Add child and/or make change to coverage (optional).</td>
<td>Add child to your current coverage (optional).</td>
<td>Change amount of pretax pay you contribute (optional).</td>
<td>Not applicable.</td>
</tr>
<tr>
<td><strong>Divorce or end of a domestic partnership</strong></td>
<td>Coverage ends on the last day of the month of the divorce or end of partnership.</td>
<td>Coverage ends on the last day of the month of the divorce or end of partnership.</td>
<td>FSA does not reimburse health care expenses incurred after the date the spouse/domestic partner is no longer an eligible dependent.</td>
<td>For medical, vision and dental coverage, a spouse/domestic partner and covered dependents are eligible for up to 36 months if the Plan is timely notified and contributions are paid.</td>
</tr>
<tr>
<td>Child no longer</td>
<td>Coverage ends on the</td>
<td>FSA does not</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Life event</th>
<th>Coverage</th>
<th>Dental and/or Vision</th>
<th>FSA</th>
<th>COBRA continuation coverage option</th>
</tr>
</thead>
<tbody>
<tr>
<td>qualifies as an eligible dependent</td>
<td>last day of the month.</td>
<td>last day of the month.</td>
<td>reimburse health care expenses incurred after the date the child is no longer an eligible dependent.</td>
<td>dental coverage, a child is eligible for up to 36 months if the Plan is timely notified and contributions are paid.</td>
</tr>
<tr>
<td></td>
<td>• Drop child from coverage.</td>
<td>• Drop child from coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Make change to coverage (optional).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal leave (non-disabled)</td>
<td>last day of the month.</td>
<td>last day of the month.</td>
<td>reimburse health care expenses incurred after the date the child is no longer an eligible dependent.</td>
<td>dental coverage, a child is eligible for up to 36 months if the Plan is timely notified and contributions are paid.</td>
</tr>
<tr>
<td></td>
<td>• If you’ve had coverage for less than six months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>last day of the month in which your leave begins.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If you’ve had coverage for six months or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to six months if monthly contributions (at the employee active rate) are paid.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to six months if monthly (at the employee active rate) contributions are paid.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled leave of absence</td>
<td>Coverage continues until termination of employment under the Medical Leave Policy if monthly contributions (at the employee active rate) are paid.</td>
<td>Coverage continues until termination of employment under the Medical Leave Policy if monthly contributions (at the employee active rate) are paid.</td>
<td>Coverage continues until termination of employment under the Medical Leave Policy if monthly contributions (at the employee active rate) are paid.</td>
<td>Medical, vision and dental coverage may be continued for up to an additional 18 months if contributions are paid; FSA coverage may be extended to the end of the calendar year.</td>
</tr>
<tr>
<td>Reinstatement (from leave)</td>
<td>Coverage begins on the first day of the reinstatement if previously covered.</td>
<td>Coverage begins on the first day of the reinstatement if previously covered.</td>
<td>Coverage is reinstated with the last election choice, and, if leave was covered by FMLA, an option to make up missed contributions applies.</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Death of employee</td>
<td>Dependents may continue survivor coverage for up to 36 months if contributions (at the employee active rate) are paid.</td>
<td>Dependents may continue survivor coverage for up to 36 months if contributions (at the employee active rate) are paid.</td>
<td>Coverage ends on the last day of the month in which your death occurs.</td>
<td>After survivor coverage ends, medical, vision and dental coverage may be continued for up to an additional 36 months if contributions are paid; FSA coverage may be extended to the end of the calendar year.</td>
</tr>
<tr>
<td>Death of a</td>
<td>Coverage for that</td>
<td>Coverage for that</td>
<td>Change amount of pay</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>
Life Insurance Coverage: Life Events Chart

The charts below show how different life events can affect your participation in Life Insurance Plan benefits. You’ll see the changes you can make based on specific life events.

Note: If your work schedule changes (for example, if you’re scheduled to work less than 20 hours per week), this change may affect your eligibility for coverage. Be sure to discuss the impact of these changes with the Motorola Solutions Employee Service Center.

Basic Life, Accidental Death and Dismemberment (AD&D), and Supplemental Life Insurance (SLI)

<table>
<thead>
<tr>
<th>Life event</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Basic Life Insurance</td>
</tr>
<tr>
<td>New employee</td>
<td>Choose level of coverage (optional) and designate beneficiary(ies).</td>
</tr>
<tr>
<td></td>
<td>• In the absence of an election, coverage will default to one times eligible compensation.</td>
</tr>
<tr>
<td>Marriage or establishment of a domestic partnership</td>
<td>Change beneficiary designation (optional).</td>
</tr>
<tr>
<td>Life event</td>
<td>Coverage</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Birth or adoption</td>
<td>Change beneficiary designation (optional).</td>
</tr>
<tr>
<td></td>
<td>No action is necessary.</td>
</tr>
<tr>
<td></td>
<td>Change beneficiary designation (optional).</td>
</tr>
<tr>
<td>Divorce or end of a domestic partnership</td>
<td>Change beneficiary designation (optional).</td>
</tr>
<tr>
<td></td>
<td>No action is necessary.</td>
</tr>
<tr>
<td></td>
<td>Change beneficiary designation (optional).</td>
</tr>
<tr>
<td>Child no longer qualifies as an eligible dependent</td>
<td>No action is necessary.</td>
</tr>
<tr>
<td></td>
<td>No action is necessary.</td>
</tr>
<tr>
<td></td>
<td>No action is necessary.</td>
</tr>
<tr>
<td>Personal leave (non-disabled)</td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>If you’ve had coverage for less than six months</td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to six months at no cost.</td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to six months.</td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to six months if monthly contributions are paid.</td>
</tr>
<tr>
<td>Disabled leave of absence</td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>If you’ve had coverage for less than six months</td>
</tr>
<tr>
<td></td>
<td>Coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to nine months if contributions are paid.</td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to nine months if contributions are paid.</td>
</tr>
<tr>
<td></td>
<td>Coverage may continue for up to nine months if contributions are paid.</td>
</tr>
<tr>
<td></td>
<td>As long as coverage is continued after seven months of disability, you’re eligible to apply for a waiver of contribution, provided the disability began before age 65. If</td>
</tr>
<tr>
<td>Life event</td>
<td>Coverage</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Basic Life Insurance</td>
</tr>
<tr>
<td></td>
<td>approved by MetLife, coverage continues for the duration of the approved disability.</td>
</tr>
<tr>
<td>Reinstatement (from leave)</td>
<td>Available on your first day of reinstatement.</td>
</tr>
<tr>
<td>Death of employee</td>
<td>Full benefit is payable to beneficiary(ies).</td>
</tr>
<tr>
<td>Death of spouse/domestic partner or child</td>
<td>Change beneficiary designation.</td>
</tr>
<tr>
<td>Termination of employment</td>
<td>Coverage ends on the last day of the month in which your employment ends; you may convert to an individual policy, or apply for a portability option (if eligible).</td>
</tr>
</tbody>
</table>
## Business Travel Accident and Dependent Life Insurance (DLI)

<table>
<thead>
<tr>
<th>Life event</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New employee</strong></td>
<td><strong>Business Travel Accident Insurance</strong> Automatic coverage.</td>
</tr>
<tr>
<td><strong>Marriage or establishment of a domestic partnership</strong></td>
<td>No action is necessary. Add spouse/domestic partner to coverage (optional, and available only if you elect SLI).</td>
</tr>
<tr>
<td><strong>Birth or adoption</strong></td>
<td>No action is necessary. Add child to coverage (optional, and available only if you elect SLI).</td>
</tr>
<tr>
<td><strong>Divorce or end of a domestic partnership</strong></td>
<td>No action is necessary. Drop spouse/domestic partner and any other covered dependents no longer eligible for coverage.</td>
</tr>
<tr>
<td><strong>Child no longer qualifies as an eligible dependent</strong></td>
<td>No action is necessary. Coverage for that dependent ends; dependent can apply to convert to individual coverage.</td>
</tr>
<tr>
<td><strong>Personal leave (non-disabled)</strong></td>
<td><strong>If you’ve had coverage for less than six months</strong> Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td></td>
<td><strong>If you’ve had coverage for six months or more</strong> Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td><strong>Disabled leave of absence</strong></td>
<td><strong>If you’ve had coverage for less than six months</strong> Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td></td>
<td><strong>If you’ve had coverage for six months or more</strong> Coverage ends on the date your leave begins.</td>
</tr>
<tr>
<td><strong>Reinstatement (from leave)</strong></td>
<td>Coverage begins on the first day of reinstatement.</td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td>Full benefit is payable to beneficiary(ies).</td>
</tr>
<tr>
<td><strong>Death of a spouse/domestic partner or child</strong></td>
<td>No action is necessary.</td>
</tr>
</tbody>
</table>
### Disability Income Plan: Life Events Chart

The chart below shows how different life events can affect your participation in the Disability Income Plan. You’ll see the changes you can make based on specific life events.

**Note:** If your work schedule changes (for example, if you’re scheduled to work less than 20 hours per week), this change may affect your eligibility for benefits. Discuss the impact this type of change may have on your benefits with the Motorola Solutions Employee Service Center.

## Disability Income Plan

<table>
<thead>
<tr>
<th>Life event</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Termination of employment</strong></td>
<td>Business Travel Accident Insurance: Coverage ends on the date your employment ends.</td>
</tr>
<tr>
<td></td>
<td>Dependent Life Insurance (DLI): Coverage ends on the last day of the month in which your employment ends; dependents may convert their coverage to individual policies (and under some conditions apply for a portability option).</td>
</tr>
</tbody>
</table>

### New employee

- **Life event:** New employee
- **Coverage:**
  - **Short-Term Disability:** Automatic coverage on the first day of the month following 90 consecutive calendar days of active employment.
  - **Short-Term Disability Supplemental Buy-Up:** Elect coverage within 31 days of your hire date (optional); coverage becomes effective on the first day of the month following 90 consecutive calendar days of active employment.
  - **Long-Term Disability:** Automatic coverage on the first day of the month following 90 consecutive calendar days of active employment.

### Personal leave (non-disabled)

- **Coverage:**
  - Coverage ends on the date your leave begins.
  - Coverage ends on the date your leave begins.
  - Coverage ends on the date your leave begins.

### Disabled leave of absence, including maternity

- **Coverage:**
  - Call Unum Disability Management Program.
  - If enrolled, contributions are waived while you’re receiving benefits.
  - Coverage continues in accordance with the Long-Term Disability Policy.

### Reinstatement (from leave)

- **Coverage:**
  - If initial eligibility requirements are met, coverage begins on the first day of reinstatement.
  - If initial eligibility requirements are met, coverage begins on the first day of reinstatement (if previously enrolled).
  - If initial eligibility requirements are met, coverage begins on the first day of reinstatement.

### Parental leave

- **Coverage:**
  - Coverage ends on the date your leave begins.
  - Coverage ends on the date your leave begins.
  - Coverage ends on the date your leave begins.
<table>
<thead>
<tr>
<th>Life event</th>
<th>Short-Term Disability</th>
<th>Short-Term Disability Supplemental Buy-Up</th>
<th>Long-Term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>Coverage ends on the date of your death.</td>
<td>Coverage ends on the date of your death.</td>
<td>Coverage ends on the date of your death.</td>
</tr>
<tr>
<td>Termination of employment</td>
<td>Coverage ends on the date your employment ends.</td>
<td>Coverage ends on the date your employment ends.</td>
<td>Coverage ends on the date your employment ends unless you’re disabled and still eligible to receive benefits under the Plan.</td>
</tr>
</tbody>
</table>

Work/Life and Dependent Care Account (DCA) Programs: Life Events Chart

The chart below shows how different life events can affect your participation in Work/Life and Dependent Care Account programs. You’ll see the changes you can make based on specific life events.

**Note:** If your work schedule changes (for example, if you’re scheduled to work less than 20 hours per week), this change may affect your eligibility for these programs and benefits. Discuss the impact this type of change may have on your benefits with the Motorola Solutions Employee Service Center.

**Adoption Assistance and Dependent Care Account (DCA)**

<table>
<thead>
<tr>
<th>Life event</th>
<th>Adoption Assistance</th>
<th>DCA</th>
</tr>
</thead>
<tbody>
<tr>
<td>New employee</td>
<td>Benefit is available on your first day of active employment.</td>
<td>Choose the amount of pre-tax pay you want to contribute (optional).</td>
</tr>
<tr>
<td>Marriage or establishment of a domestic partnership</td>
<td>Not applicable.</td>
<td>If applicable, enroll or change the amount of pre-tax pay you contribute (optional).</td>
</tr>
<tr>
<td>Birth or adoption</td>
<td>Benefit is available when the child is placed in your home for adoption, the adoption is finalized, or your attempt to adopt ends unsuccessfully.</td>
<td>Enroll or change the amount of pre-tax pay you contribute (optional).</td>
</tr>
<tr>
<td>Divorce or end of a domestic partnership</td>
<td>Not applicable.</td>
<td>If applicable, enroll or change the amount of pre-tax pay you contribute (optional).</td>
</tr>
<tr>
<td>Child no longer qualifies as an eligible dependent</td>
<td>Not applicable.</td>
<td>If applicable, change the amount of pre-tax pay you contribute (optional).</td>
</tr>
<tr>
<td>Personal leave (non-disabled)</td>
<td>Benefit is available only when you’re actively at work (except if you’re on a leave of absence under the Parental Leave Program). Contributions end with the last pay period before your leave occurs; you can request reimbursement for eligible expenses incurred through the end of your leave.</td>
<td>Contributions end with the last pay period before your leave occurs; you can request reimbursement for eligible expenses incurred through the end of your leave.</td>
</tr>
<tr>
<td>Life event</td>
<td>Coverage</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>Leave Policy).</td>
<td></td>
</tr>
<tr>
<td>Disabled leave of absence</td>
<td>Benefit is available only when you’re actively at work.</td>
<td></td>
</tr>
<tr>
<td>Reinstatement (from leave)</td>
<td>Available on your first day of reinstatement.</td>
<td></td>
</tr>
<tr>
<td>Death</td>
<td>Benefit ends on the date of your death.</td>
<td></td>
</tr>
<tr>
<td>Death of a spouse/domestic partner or child</td>
<td>Not applicable.</td>
<td></td>
</tr>
<tr>
<td>Termination of employment</td>
<td>Benefit ends when your employment terminates.</td>
<td></td>
</tr>
</tbody>
</table>

**More Work/Life Programs**

<table>
<thead>
<tr>
<th>Life events</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New employee</td>
<td>EAP</td>
</tr>
<tr>
<td>Marriage or establishment of a domestic partnership</td>
<td>Benefits are available immediately for your spouse/domestic partner.</td>
</tr>
<tr>
<td>Birth or adoption</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Divorce or end of a domestic partnership</td>
<td>Spouse/domestic partner’s eligibility ends on the date of the divorce or end of the domestic partnership.</td>
</tr>
<tr>
<td>Life events</td>
<td>Coverage</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>Child no longer qualifies as an eligible dependent</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Personal leave (non-disabled)</td>
<td>Benefit is available during your leave.</td>
</tr>
<tr>
<td>Disabled leave of absence</td>
<td>Benefit is available during your leave.</td>
</tr>
<tr>
<td>Reinstatement (from leave)</td>
<td>Benefit is available on your first day of reinstatement.</td>
</tr>
<tr>
<td>Death</td>
<td>Benefit ends on the date of your death.</td>
</tr>
<tr>
<td>Death of a spouse/domestic partner or child</td>
<td>Not applicable.</td>
</tr>
<tr>
<td>Termination of employment</td>
<td>Benefit ends 30 days after you terminate employment.</td>
</tr>
</tbody>
</table>

**How a Leave of Absence Affects Your Plan Coverage**

Under certain conditions, you can continue your medical, dental, vision and life insurance coverage (including dependent coverage) if you’re 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 as the result of a disability (see the **Disability** section), there are six types of leaves of absence. They are as follows:

- **Medical leave of absence**: For your own serious health condition or as necessitated by a workplace injury or illness
- **Parental leave of absence**: To care for a child after the birth, foster-care placement or adoption of the child
- **Family illness leave of absence**: To care for a covered family member or domestic partner with a qualifying serious health condition
- **Leave of absence under the Family and Medical Leave Act** (including the following):
  - For the birth of a son or daughter and in order 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/domestic partner, child or parent with a serious health condition
  - Because of your own serious health condition that renders you unable to perform the functions of your position
- **Personal leave of absence**: To attend to personal matters
- **Military service leave of absence**: For employees called to active duty or temporary active duty by the U.S. Armed Forces, or who are on temporary training duty with the U.S. Armed Forces
Leave of Absence Impact

Below you’ll see how taking a leave of absence will affect your participation in the Motorola Solutions benefit plans and programs.

<table>
<thead>
<tr>
<th>Leave of absence impact</th>
<th>If you have six months or more of service</th>
<th>If you have less than six months of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Plans</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical Plan</td>
<td>You may continue coverage at the active employee contribution rate for up to six months after the last day of the month in which your leave begins. You must continue your monthly contributions for this coverage. You may further continue coverage under COBRA.</td>
<td>Coverage ends as of the last day of the month in which your leave begins. You may further continue coverage under COBRA.</td>
</tr>
<tr>
<td>• Vision Care Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental Plan</td>
<td>If you’re on military service leave, your coverage continues at the active employee contribution rate until the last day of the last month in which you receive military service pay under the Military Service Pay Policy.</td>
<td></td>
</tr>
<tr>
<td>Spending Accounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• FSA</td>
<td>You may continue coverage for up to six months. You must continue your monthly contributions for this coverage. You may cease contributions at the end of the month in which your leave occurs. Your claims for eligible expenses incurred through the last day of the month must be received by the Motorola Solutions Employee Service Center and postmarked no later than March 31 of the following year. You may further continue coverage under COBRA.</td>
<td>Coverage ends as of the last day of the month in which your leave begins. Your claims for eligible expenses must be received by Motorola Solutions Employee Service Center and postmarked no later than March 31 of the following year. You may further continue coverage under COBRA.</td>
</tr>
<tr>
<td>• DCA</td>
<td>Even though you aren’t permitted to make pretax contributions to your DCA while you’re on leave status, you may submit eligible expenses incurred during the year and postmarked no later than March 31 of the following year.</td>
<td></td>
</tr>
<tr>
<td>Life Insurance Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>If you’ve been covered under</td>
<td>If you’ve been covered under</td>
</tr>
<tr>
<td>Leave of absence impact</td>
<td>If you have six months or more of service</td>
<td>If you have less than six months of service</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Basic Life Insurance for at least six months, coverage continues at no cost to you for up to six months after the last day of the month in which your leave begins. If you’re on military service leave, your coverage continues until the last day of the last month in which you receive military service pay under the Military Service Pay Policy. When you’re no longer eligible for this continuation of coverage, you may elect to convert this group coverage to an individual policy or apply for a portability option (if eligible). (See the Conversion rights or Portability option sections for details.)</td>
<td>Basic Life Insurance for less than six months, coverage ends as of the last day of the month in which your leave begins. You may elect to convert this group coverage to an individual policy or apply for a portability option (if eligible). (See the Conversion rights or Portability option sections for details.)</td>
</tr>
</tbody>
</table>

- **Supplemental Life Insurance (SLI)**
- **Dependent Life Insurance (DLI)**

  If you’ve been covered under SLI or DLI for at least six months, coverage continues for up to six months after the last day of the month in which your leave begins. You must make monthly contributions for this coverage. If you’re on military leave, your coverage continues until the last day of the last month in which you receive military service pay under the Military Service Pay Policy. When you’re no longer eligible for this continuation of coverage, you may elect to convert your SLI and/or DLI coverage to an individual policy or apply for a portability option (if eligible). (See the Conversion rights or Portability option sections for details.)

  If you’ve been covered under SLI or DLI for less than six months, coverage ends as of the last day of the month in which your leave begins. You may elect to convert this group coverage to an individual policy or apply for a portability option (if eligible). (See the Conversion rights or Portability option sections for details.)

**Disability Income Plan**
### Leave of absence impact

<table>
<thead>
<tr>
<th></th>
<th>If you have six months or more of service</th>
<th>If you have less than six months of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Disability (STD)</td>
<td>Coverage ends on the last day of your active employment that precedes your leave of absence. However, if your leave is based on a medical condition and within the first six months of the leave you’re determined to be disabled under the Disability Income Plan, your coverage under the Disability Income Plan will be reinstated retroactive to the date your leave began.</td>
<td></td>
</tr>
<tr>
<td>Short-Term Disability Supplemental Buy-Up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-Term Disability (LTD)</td>
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</tr>
</tbody>
</table>

### Disability Leave Impact

Below you’ll see how taking a disability leave of absence will affect your participation in the Motorola Solutions benefit plans and programs.

<table>
<thead>
<tr>
<th>Disability leave impact</th>
<th>If you have six months or more of service</th>
<th>If you have less than six months of service</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Care Plans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Plan</td>
<td>Medical, vision and dental coverage continues as long as you remain employed and eligible for Disability benefits, provided you continue to pay monthly contributions at the active employee rate for coverage. Coverage ends when your employment ends.</td>
<td></td>
</tr>
<tr>
<td>Vision Care Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Spending Accounts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSA</td>
<td>Coverage may continue as long as you remain employed and disabled, provided you continue to pay your contributions. You may cease contributions at the end of the month in which your leave occurs. You’re eligible for FSA reimbursement of eligible expenses incurred through the date your contributions end if your claim is postmarked no later than March 31 of the following year.</td>
<td></td>
</tr>
<tr>
<td>DCA</td>
<td>Even though you aren’t permitted to make pretax contributions to your DCA while you’re on leave status, you may submit eligible expenses incurred during the year as long as your claim is postmarked no later than March 31 of the following year.</td>
<td></td>
</tr>
<tr>
<td><strong>Life Insurance Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Coverage ends on the last day of the 12th month after the month in which your disability LOA begins unless you qualify for an extension period.</td>
<td>If you’ve been covered for less than six months, coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td>Disability leave impact</td>
<td>If you have six months or more of service</td>
<td>If you have less than six months of service</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Supplemental Life Insurance (SLI)</strong></td>
<td>If you’ve been covered under SLI for at least six months, coverage may continue for up to nine months if contributions are paid. As long as coverage is continued after seven months of disability, you’re eligible to apply for a waiver of contribution, provided the disability began before age 65. If approved by MetLife, coverage continues for the duration of the approved disability with a waiver of contribution (up to the same limits set forth for Basic Life Insurance).</td>
<td>If you’ve been covered for less than six months, coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td><strong>Dependent Life Insurance (DLI)</strong></td>
<td>If you continue Basic Life Insurance and SLI, coverage may continue until your termination of employment under the Medical Leave Policy if contributions are paid.</td>
<td>If you’ve been covered for less than six months, coverage ends on the last day of the month in which your leave begins.</td>
</tr>
<tr>
<td><strong>Accidental Death and Dismemberment Insurance (AD&amp;D)</strong></td>
<td>If you’ve been covered under AD&amp;D Insurance for at least six months, coverage may continue for up to nine months if you become totally disabled.</td>
<td>If you’ve been covered for less than six months, coverage ends on the last day of the month in which your leave begins.</td>
</tr>
</tbody>
</table>

**Administration Information**

Once you’ve reviewed all of your benefit options, you’ll need to make sure you understand how to receive these benefits and locate other key Plan information. This section addresses information you may need to know regarding the Plans and Programs.

**Your Plan Rights and Responsibilities**

**No Alienation, Sale or Assignment**

To the extent permitted by law, and except as specified under the terms of the Plans, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind. Any attempt to do so will be void. However, benefits under certain Plans may be subject to a Qualified Medical Child Support Order or a Qualified Domestic Relations Order. If you would like a copy of the Plans’ Qualified Medical Child Support Order or Qualified Domestic Relations Order procedures, you may request it in writing from the Plan Administrator.
Recovery of Payments Made By Mistake

If you receive under any of the Plans any benefits or portion of benefits by mistake of fact or law, you'll be required to return any such benefits or portion of benefits to Motorola Solutions or the applicable Claims Administrator or insurer.

No Contract of Employment

Your participation in the Plans isn't a guarantee of your continued employment with Motorola Solutions or rights to benefits, except as specified under the terms of the Plans. Nothing in the Plans or in this Benefits Book confers any right of continued employment to any employee.

Severability

If a court of competent jurisdiction finds, holds or deems any Plan provision described in this Benefits Book to be void, unlawful or unenforceable under any applicable statute or other controlling law, the remainder of the Plan will continue in full force and effect.

Your Health Care Plan Administration

The Plan Administrator has the sole and complete discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plans, including the making of factual determinations. The Plan Administrator shall have the discretionary authority to grant or deny benefits under the Plans. These Plan benefits will only be paid if the Plan Administrator decides that the applicant is entitled to receive them. The Plan Administrator's decisions shall be final and conclusive with respect to all questions related to the Plans.

The Plan Administrator may delegate responsibilities to others for performing certain duties under the terms of the Plans. The Plan Administrator may also seek such expert advice deemed reasonably necessary with respect to the Plans. The Plan Administrator shall be entitled to rely upon the information and advice furnished by such delegates and experts, unless the Plan Administrator actually knows such information and advice to be inaccurate or unlawful.

In addition, the Plan Administrator may adopt uniform rules for the administration of the Plans from time to time, as is deemed necessary or appropriate.

Amendment and Termination

Motorola Solutions reserves the sole discretionary right to modify, amend or terminate any of the Motorola Solutions benefit Plans, in any respect, at any time and from time to time.

If a Plan is modified, amended or terminated, you'll be notified about how your Plan benefits or coverage will change. Motorola Solutions doesn't require the consent of any employee or any other person in order to modify, amend or terminate any of the Plans described in this book.

Representations Contrary to the Plans

No employee, director or officer of Motorola Solutions 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 the terms of the Plans are binding upon the Plan, the Plan Administrator or Motorola Solutions.
Subrogation

If benefits are payable or have been paid by any of the Plans other than the Group Life Insurance Plan, as a result of an action by a third party or organization, the Plan will be subrogated to your right and your dependent’s right (including legal representatives) to recover these funds from the third party or organization. The Plan’s right to subrogation provides the Plan with priority over any funds paid by a third party or insurer, without regard to whether you or your covered dependent has been made whole.

If the Plan is precluded from exercising its right of subrogation or chooses not to exercise that right, the Plan has the discretion of whether or not to pay benefits. Also, the Plan has the discretion to exercise only its right of reimbursement.

If you’re considering initiating an action against a third party or organization, ask the Plan Administrator if any subrogation (or reimbursement) requirements apply to you. You must notify the Plan Administrator in advance of initiating (or a third party’s initiating on your behalf) any type of action against a third party or organization regarding the third party’s or organization’s involvement in the incident that resulted in your injury.

Reimbursement to the Plan

If you or your covered dependent is injured as a result of the act of a third party and you or your covered dependent’s legal representative files a claim for benefits under the Health Care Plans or Disability Income Plan, that same person must, as a condition of receipt of Plan benefits, reimburse the Plan for those benefits received from all recoveries (including future medical expenses) from the third party or organization, or any insurer, to the extent of the amount paid by this Plan on the claim (adjusted by the participant’s reasonable share of attorneys’ fees and costs to obtain payment, not to exceed 30 percent of the benefits the participant received from the Plan). The right of reimbursement provides the Plan with priority over any funds paid by a third party or insurer, without regard to whether you or your covered dependent has been made whole, and the Plan claims a lien on such funds, whether or not designated as payment for medical expenses. The Plan will be reimbursed from your future benefits to the extent necessary. Settlement proceeds, assets collected from judgments, and recoveries are subject to the imposition of constructive trust. You must notify the Plan Administrator in advance of any recovery, to the extent feasible, and within seven days after receipt of amounts from a third party, organization or insurer.

Plan Funding

Some benefits are self-insured and paid with the general assets of Motorola Solutions and other benefits are insured. Motorola Solutions may fund benefits through and a trust that’s intended to be a tax-exempt organization under IRC Section 501(c)(9). The details are listed below on “Information about the Plan.”

The Health Care Plans, as well as, the Life Insurance, and Disability Plans, may require you to contribute toward the cost of coverage depending upon the option selected. For the Health Care Plans, you and Motorola Solutions pay a contribution for you to participate, and the insurers of the Health Care Plans pay the cost of all benefits.

Statute of Limitations

You or your covered dependents must exhaust all of the internal administrative remedies described above before bringing an action for benefits under the Plans under Section 502(a) of ERISA. Any civil suit must be brought within one year of the date you or your covered dependents are notified that the claim on review has been denied.
Applicable Law

The Plans described here shall be governed and construed in accordance with the laws of the state of Illinois to the extent not preempted by the laws of the U.S. All disputes arising with regard to the Plan are to be litigated in Cook County, Illinois.

Employer Identification Number and Agent for Legal Service

The following table includes important information regarding the Employer Identification Number and identifies the agent for legal service.

<table>
<thead>
<tr>
<th>Employer/Plan Sponsor</th>
<th>Agent for legal service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motorola Solutions, Inc.</td>
<td>CT Corporation System</td>
</tr>
<tr>
<td>500 W Monroe</td>
<td>208 S. LaSalle Street</td>
</tr>
<tr>
<td>Chicago, IL 60661</td>
<td>Chicago, IL 60604</td>
</tr>
<tr>
<td>(847) 576-5000</td>
<td>(312)345-4336 or (800)475-1212)Service of legal process</td>
</tr>
<tr>
<td></td>
<td>may also be made on the Plan Administrator or Trustee.</td>
</tr>
<tr>
<td>Employer Identification Number: 36-1115800</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Plan Administrator</th>
<th>Plan Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Committee</td>
<td>Motorola Solutions Health and Welfare Plan</td>
</tr>
<tr>
<td>Motorola Solutions, Inc.</td>
<td>Plan Number: 510</td>
</tr>
<tr>
<td>500 W Monroe 43rd Floor</td>
<td>Last Day of the Plan Year: December 31</td>
</tr>
<tr>
<td>Chicago, IL 60661</td>
<td></td>
</tr>
<tr>
<td>(847) 576-5000</td>
<td></td>
</tr>
</tbody>
</table>

Information about the Plan

<table>
<thead>
<tr>
<th>Program type</th>
<th>Funding and claims administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Benefits Program</td>
<td>Fully-insured through the AON Active Health Exchange.</td>
</tr>
<tr>
<td>Vision Benefits Program</td>
<td>Fully-insured through the AON Active Health Exchange.</td>
</tr>
<tr>
<td>Dental Benefits Program</td>
<td>Fully-insured through the AON Active Health Exchange.</td>
</tr>
<tr>
<td>Motorola Solutions Pretax</td>
<td>Self-insured by Motorola Solutions and administered by</td>
</tr>
<tr>
<td>Contributions and Health</td>
<td>Alight</td>
</tr>
<tr>
<td>Care Flexible Benefits Program</td>
<td></td>
</tr>
<tr>
<td>Motorola Solutions Group Life</td>
<td>Life insurance fully insured by:</td>
</tr>
<tr>
<td>Insurance Benefit Program</td>
<td>MetLife</td>
</tr>
<tr>
<td></td>
<td>Group Life Claims</td>
</tr>
<tr>
<td>Program type</td>
<td>Funding and claims administration</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Life and AD&amp;D</td>
<td>P.O. Box 6100 \ Scranton, PA 18505</td>
</tr>
<tr>
<td>Business Travel Accident Insurance</td>
<td>Ace American Insurance Co. \ 1601 Chestnut St. \ Philadelphia, PA 19192 Administered by Chubb</td>
</tr>
</tbody>
</table>
| Motorola Solutions Disability Income Program | Short-Term Disability (STD) self-insured by Motorola Solutions and administered by Unum. 
Long-Term Disability (LTD) insured by Unum. |
| Motorola Solutions Dependent Care Plan    | Self-insured by Motorola Solutions and administered by Alight. Note this plan is not subject to ERISA. |
| Motorola Solutions Adoption Assistance Program | Self-insured by Motorola Solutions and administered by Alight. Note this program is not subject to ERISA. |

Statement of ERISA Rights

As a Motorola Solutions Plan participant, you're entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that you're entitled to:

Receive Information about Your Plan and Benefits

- Examine without charge, at the Motorola Solutions offices, 500 W. Monroe, Chicago, IL 60661 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.
- Obtain copies of documents governing the operation of the Plans, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Descriptions 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 summaries are prepared and distributed to Plan participants each year. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

Continue Group Health Plan Coverage

- Under a group health plan, you’ll continue health care coverage for yourself, your spouse or your dependents if there’s a loss of coverage under the group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage.
- You can review this Summary Plan Description and the documents governing the Plan regarding the rules governing your COBRA continuation coverage rights.
• You'll have the exclusionary periods for coverage of pre-existing conditions under your group health plan reduced or eliminated if you have creditable coverage from another plan. Your group health plan or health insurance issuer should provide a certificate of creditable coverage, free of charge, when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plans. 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 obtaining 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 obtain copies of documents related 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 don't 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. This won't occur if the reason for the materials not being sent was beyond the control of the Plan Administrator.

If you have a claim for benefits that's denied or ignored, in whole or in part, you may file suit in a state or federal court once you've exhausted the Plan's claims procedures. 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 after you've exhausted the Plan's claims procedures. If it should happen that Plan fiduciaries misuse the Plan's money, or if you're 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're successful, the court may order the person you've sued 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 general questions about the Health Care or Welfare Plans, contact the Motorola Solutions Employee Service Center. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Glossary

Defined Terms

This section defines many of the terms used throughout this Health and Welfare Benefits Book.

Accident

An unexpected, unintentional and unforeseen traumatic experience caused by an outside force and that happens at a specific time and place.

For purposes of the Disability Income Plan, an “accident” also means that the experience results in your inability to return to work for a period of at least eight consecutive calendar days, beginning within 30 days of the experience. The accident must not include a strain or injury that’s caused by overexertion of the body or pregnancy.

Accidental Death and Dismemberment (AD&D) Insurance

An insurance coverage that pays benefits in the event of certain losses, including (but not limited to) the loss of any of the following as a result of an accident:

- Life
- Limb(s)
- Eyesight

Actively at Work

To be considered actively at work, you must currently be performing the essential functions of your job at your assigned place of employment during assigned working hours. You’re considered to be actively at work on a day that’s not a regularly scheduled workday or a day that’s eligible for pay under the company's paid time off policies, provided you performed, in the customary manner, all of the regular duties of your job on the last preceding scheduled workday.

Adoption Assistance

A benefit program that reimburses you up to $8,000 (on an after-tax basis) for eligible adoption-related expenses.

Annual Enrollment

A period of time each year when you may enroll yourself and your eligible dependents for medical, vision and/or dental coverage. During each annual enrollment period, you may also do the following:

- Establish an HSA, if enrolled in high deductible medical coverage
- Enroll for the Short-Term Disability Supplemental Buy-Up option
- Establish, cancel or modify contribution amounts to the Health Care Flexible Spending Account for the next calendar year
Establish, cancel or modify contribution amounts to the Dependent Care Account for the next calendar year

Annual Out-of-Pocket Maximum

A cap on how much you have to pay for eligible medical expenses in a calendar year. Once you reach the annual out-of-pocket maximum, the Plan pays 100 percent of remaining eligible expenses for that year.

Basic Life Insurance

An insured program that provides a benefit to your beneficiary(ies) in the event of your death.

Beneficiary

For certain plans, you must name a beneficiary. You can name a primary beneficiary and a contingent beneficiary.

- **Primary beneficiary:** The person, trust or estate you choose to receive the proceeds from your life insurance following your death
- **Contingent beneficiary:** The person, trust or estate 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.

Business Travel Accident Insurance

Insurance coverage that pays benefits if you have an accident while traveling on company business and that accident results in certain loss, such as the loss of life, limb(s) or eyesight.

Claim

If you file a claim, you make a request for a Plan benefit in accordance with the Plan’s reasonable procedure for filing benefit claims. All claims, except urgent care claims, must be in writing and contain the information as described under the [How to file a claim](#) section. Urgent care claims may be made orally or in writing.

Claims Administrator

The entity to whom authority to decide claims and/or appeals has been delegated.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that extends group Health Care Plan coverage to terminated employees and their continuation coverage beneficiaries. COBRA requires employers to offer covered individuals 18, 29 or 36 months (for the FSA, through the end of the calendar year) of continued coverage. The contribution for such coverage is based on the cost of the coverage plus a 2 percent administration fee (or a 50 percent administration fee for a qualifying 11-month disability extension).
Coinsurance and Copayment

A percentage or flat dollar amount of an expense that you pay for eligible medical, vision or dental expenses under a Health Care Plan (e.g., the Plan pays a benefit of 90 percent and you pay 10 percent as coinsurance; or you pay $20 as a copayment for a service).

Covered Dependent

An eligible dependent whom you enroll for medical, vision, dental and/or dependent life insurance coverage.

Deductible

The amount of eligible expenses you pay before a Health Care Plan begins to pay benefits for medical, vision or dental expenses covered by the Plan (e.g., a $100 deductible for single coverage must be met before the Dental Plan begins to pay benefits for covered dental care services).

Dependent Care Account (DCA)

An account to which you can contribute pretax dollars and later use these dollars to reimburse yourself for eligible dependent care expenses.

Dependent Life Insurance (DLI)

An optional life insurance coverage that pays benefits for the loss of life of your covered spouse/domestic partner and/or a dependent child(ren). You pay for this coverage with monthly contributions deducted from your paycheck. The amount you pay depends upon your selected coverage level.

Domestic Partner

An adult who is the same or opposite sex as you and also:

- Has registered with you as domestic partners, or has entered into a civil union in accordance with the applicable city, county or state laws; or
- In the absence of domestic partner registration, all of the following requirements must be met:
  - You and your domestic partner are at least 18 years of age.
  - You and your domestic partner aren’t related to one another to a degree that would prevent marriage under the law of the state where you reside.
  - Neither you nor your domestic partner is married to another person under statutory or common law, and neither of you is in another domestic partnership.
  - You and your domestic partner are in a single, dedicated relationship with each other and have been in such relationship for a minimum of six consecutive months and intend to remain in the relationship indefinitely.
  - You and your domestic partner share the same residence and have shared the same residence for a minimum of six consecutive months.

In the case of life insurance benefits, the following additional requirement applies:
- You and your domestic partner have an exclusive mutual commitment to share the responsibility for each other’s welfare and financial obligations and have had such commitment for at least six months. In addition, two or more of the following exist as evidence of your joint responsibility for basic financial obligations:
  - A joint mortgage or lease
  - Designation of the domestic partner as beneficiary for life insurance or retirement benefits
  - Joint wills or designation of the domestic partner as executor and/or primary beneficiary
  - Designation of the domestic partner as durable power of attorney or health care proxy
  - Ownership of a joint bank account or joint credit cards or other evidence of joint financial responsibility
  - Other evidence of economic interdependence

Employee Assistance Program (EAP)

A program that provides short-term, confidential counseling, referral and follow-up for you and your family members. This type of program addresses a variety of issues that may affect personal well-being, including the following:
- Marital and family problems
- Alcohol and drug concerns
- Stress
- Grief
- Other emotional or personal concerns
- Work-Life Balance Programs

Employee Discount Program

A service designated to provide Motorolans with access to national discounts on products and services in the U.S.

ERISA

The Employee Retirement Income Security Act of 1974, as amended, which establishes certain rights and protections for participants and rules for employers.

Explanation of Benefits (EOB)

A printed or electronic statement addressed to the employee or provider that itemizes services performed and the benefit information related to those services.

Flexible Spending Account (FSA)

An account to which you can contribute pretax dollars, which you can then use to reimburse yourself for eligible health care expenses that you and your eligible dependents incur while you’re contributing. You can participate in the FSA regardless of whether you enroll for medical, vision and/or dental coverage.
under the Health Care Plans. However, if you’re a high deductible health coverage participants, eligible expenses are limited to dental and vision care expenses only.

Gainful Occupation

Gainful occupation means an occupation that, within 12 months of your return to work, is providing you, or can be expected to provide you, with an income that exceeds:

- 80 percent of your indexed monthly earnings if you’re working; or
- 60 percent of your indexed monthly earnings if you’re not working.

Generic Drug

A chemical copy of a brand-name prescription drug.

Health Care Plans

Term within the Health and Welfare Benefits Book referencing the coverage provided under the Motorola Solutions Medical Plan, Vision Care Program and Dental Plan.

Health Maintenance Organization (HMO)

A medical benefits plan that provides comprehensive benefits, including preventive care, and typically requires small copayments for most services. You must receive all care from network providers who are associated with the HMO.

Health Savings Account (HSA)

A special account that you own, provided you’re covered by a high-deductible health plan and elect to open an HSA. Contributions to the account can be used to pay for qualified medical expenses on a tax-free basis.

Illness or Injury

A disease, disorder or condition that affects any structure or function of the body that requires treatment by a physician or other medical care provider. For a female patient, illness or injury also includes childbirth, pregnancy or any related medical condition.

Incurred Expense

An expense is considered incurred at the time the service is rendered — not when an invoice for the service is issued or when the invoice is paid.

Leave of Absence

There are six types of leaves of absence available to eligible employees:

- **Medical leave of absence**: For your own serious health condition or as necessitated by a workplace injury or illness
- **Parental leave of absence**: To care for a child after the birth, foster-care placement or adoption of the child
- **Family illness leave of absence**: To care for a covered family member or domestic partner with a qualifying serious health condition
- **Leave of absence under the Family and Medical Leave Act including the following**:  
  - For the birth of a son or daughter and in order 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/domestic partner, child or parent with a serious health condition  
  - Because of your own serious health condition that renders you unable to perform the functions of your position
- **Personal leave of absence**: To attend to personal matters
- **Military service leave of absence**: For employees called to active duty or temporary active duty by the U.S. Armed Forces, or employees who are on temporary training duty with the U.S. Armed Forces

### Life Insurance

Death-benefit protection that provides benefits to your beneficiary following your death. Life insurance benefits include:

- Basic Life Insurance;  
- Supplemental Life Insurance (SLI);  
- Dependent Life Insurance (DLI);  
- Accidental Death and Dismemberment (AD&D) Insurance; and  
- Business Travel Accident Insurance.

### Long-Term Disability (LTD)

A benefit that provides a percentage of your base pay provided you’re an eligible employee under a doctor’s care who is continuously unable to engage in substantial and gainful employment because of a medically determinable physical or mental impairment. The duration of benefits depends on your age when you become disabled, how long you continue to be disabled and, in some cases, the primary cause of your disability.

### Mental, Nervous, or Alcohol- or Drug-Related Condition

Conditions subject to the 24-month maximum Long-Term Disability benefit under the Disability Income Plan.

### Military Service

Service (active duty, active duty training, inactive duty training or full-time National Guard duty) in:

- The U.S. Armed Forces; or  
- The U.S. Army National Guard or Air National Guard; or  
- The U.S. Public Health Service Commissioned Corps; or  
- Any other U.S. category of persons designated by the President in time of war or emergency.
Any period of time when you’re absent from your position of employment for the purpose of an examination to determine your fitness to perform any such duty is also considered military service.

Motorola Solutions Assist

A business-travel assistance program that provides international travel information and services.

Motorola Solutions Employee Service Center (Employee Service Center)

The entity responsible for Motorola Solutions benefits eligibility and customer service.

Out-of-Area

A term that describes you if you live in an area within the U.S. that’s outside of the designated U.S. network areas.

Plan Administrator

The entity with overall responsibility for the administration of a benefit plan described in this book, or the person or entity to whom such responsibility has been delegated.

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.

Preventive Care

The steps you take to prevent disease and injuries, rather than curing or treating them.

Provider

Any person or facility that provides covered health care services under one of Motorola Solutions’ Health Care Plans or Programs. Providers may include hospitals, physicians, counselors and technicians.

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.

Qualifying Child

A “qualifying child” is a tax dependent under Section 152 of the Internal Revenue Code. A “qualifying child” must:

- Bear one of the following relationships to you:
  - Your child or a descendant of your child
  - Your brother, sister, stepbrother, stepsister or a descendant of any such relative; and
- Be under age 19 (except a full-time student through age 23).
Older dependents may still qualify for coverage if they meet the Plan’s incapacitated dependent requirements.

**Qualifying Relative**

A “qualifying relative” is a tax dependent under Section 152 of the Internal Revenue Code. A “qualifying relative” must:

- Bear one of the following relationships to you:
  - Your child or a descendant of your child
  - Your brother, sister, stepbrother or stepsister
  - Your father or mother, or an ancestor of either
  - Your stepfather or stepmother
  - A son or daughter of your brother or sister
  - A brother or sister of your mother or father
  - Your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law
  - Any other individual who has the same principal residence as you and is a member of your household; and

- Receives more than one-half of his or her support from you; in addition, he or she isn’t a qualifying child of you or of any other taxpayer for the year (not applicable for a non-custodial parent covering a qualifying relative)

**Note:** Motorola Solutions’ definition of “dependent” for purposes of medical, vision and dental coverage is different from the definition of dependent for tax purposes under the Internal Revenue Code. Therefore, several of the “qualifying relatives” indicated above (such as your brother, sister or parents) aren’t eligible for coverage under the Motorola Solutions Plans.

**Short-Term Disability (STD)**

A benefit that provides a percentage of base pay paid for up to 180 calendar days to an eligible employee who is under a physician’s care and is continuously unable to perform the essential duties of his or her usual occupation because of a medically determinable physical or mental impairment.

**Short-Term Disability (STD) Supplemental Buy-Up**

An optional program that enables you to increase your Short-Term Disability coverage by an additional 15 percent. You pay for this increased level of coverage through pretax payroll deductions.

**Spouse**

For the purpose of coverage under the Health Care Plans, a spouse is a person to whom you’re legally married if the marriage is recognized in the jurisdiction in which you are married. See **Domestic partner eligibility requirements** subsection for details regarding eligibility for domestic partners.

**Unum Disability Management Program**
A program designed to effectively manage disabilities and return Motorola Solutions employees to work as soon as they’re able.

Contact Information

General Administration

<table>
<thead>
<tr>
<th>Plan or Program</th>
<th>Telephone and fax numbers</th>
<th>Web and mailing address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motorola Solutions Employee Service Center</td>
<td>Telephone: (800) 585-5100 Outside U.S.: +1 (646) 254-3472 Fax: (847) 883-8281 Fax Outside U.S.: +1 (847) 883-8281</td>
<td>Online: my.mot-solutions.com/go/ybr (Use your core ID and web applications password.)</td>
</tr>
<tr>
<td>Advocacy</td>
<td>Current employees: <a href="http://www.yourbenefitsresources.com/mot-solutions">www.yourbenefitsresources.com/mot-solutions</a> (Use your unique user ID and password for Your Benefits Resources.)</td>
<td></td>
</tr>
<tr>
<td>COBRA</td>
<td>Mail: Motorola Solutions P.O. Box 0742 Carol Stream, IL 60132-0742</td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td></td>
<td>Mail: Motorola Solutions P.O. Box 0743 Carol Stream, IL 60132-0743</td>
</tr>
<tr>
<td>When coverage ends</td>
<td></td>
<td>All premium payments (except COBRA and severance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>COBRA and severance premium payments</td>
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You can visit the U.S. Retiree website for benefit and contact information regarding Motorola Solutions U.S. retiree health care.

Health Care Plans

<table>
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<tr>
<th>Aon Exchange Plan Name</th>
<th>Telephone</th>
<th>Website</th>
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<tbody>
<tr>
<td>Aetna</td>
<td>1.855.496.6290</td>
<td><a href="http://www.aetna.com/">http://www.aetna.com/</a></td>
</tr>
<tr>
<td>Medical, Dental</td>
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<tr>
<td>Medical</td>
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<tr>
<td>Aon Exchange Plan Name</td>
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<td>Website</td>
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<tr>
<td>Cigna</td>
<td></td>
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</tr>
<tr>
<td>Medical, Dental</td>
<td>(855) 694-9638</td>
<td><a href="http://www.cigna.com">http://www.cigna.com</a></td>
</tr>
<tr>
<td>Dean/Prevea360</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical (WI)</td>
<td>(877) 232-9375</td>
<td><a href="http://aon.deanhealthplan.com/">http://aon.deanhealthplan.com/</a></td>
</tr>
<tr>
<td>Delta Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delta Dental – Illinois</td>
<td>(800) 323-1743</td>
<td><a href="http://www.deltadentalil.com">http://www.deltadentalil.com</a></td>
</tr>
<tr>
<td>(Bronze, Silver, Gold)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DeltaCare USA (Platinum)</td>
<td>(800) 471-8073</td>
<td><a href="http://www.deltadentalins.com">http://www.deltadentalins.com</a></td>
</tr>
<tr>
<td>EyeMed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>(844) 739-9837</td>
<td><a href="http://www.eyemed.com/">http://www.eyemed.com/</a></td>
</tr>
<tr>
<td>Geisinger</td>
<td></td>
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</tr>
<tr>
<td>Medical (PA)</td>
<td>(844) 390-8332</td>
<td><a href="https://www.thehealthplan.com">https://www.thehealthplan.com</a></td>
</tr>
<tr>
<td>HealthNet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical (OR, CA, AZ, WA)</td>
<td>(888) 926-1692</td>
<td><a href="https://www.healthnet.com">https://www.healthnet.com</a></td>
</tr>
<tr>
<td>Kaiser</td>
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<tr>
<td>Medical CA</td>
<td>(800) 464-4000</td>
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<tr>
<td>Medical CO</td>
<td>(303) 338-3800</td>
<td><a href="http://www.kp.org">http://www.kp.org</a></td>
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<tr>
<td>Medical GA</td>
<td>(404) 504-5712</td>
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<tr>
<td>Medical HI</td>
<td>(808) 432-5955</td>
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<tr>
<td>Medical MAS</td>
<td>(800) 777-7902</td>
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<tr>
<td>Medical NW</td>
<td>(800) 813-2000</td>
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<tr>
<td>Aon Exchange Plan Name</td>
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<tr>
<td>MetLife</td>
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</tr>
<tr>
<td>Dental, Vision</td>
<td>(888) 309-5526</td>
<td><a href="https://www.metlife.com/">https://www.metlife.com/</a></td>
</tr>
<tr>
<td>UHC</td>
<td></td>
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<tr>
<td>Medical</td>
<td>(888) 297-0879</td>
<td><a href="https://www.myuhc.com">https://www.myuhc.com</a></td>
</tr>
<tr>
<td>Medical – CA HMO</td>
<td>(877) 365-4199</td>
<td><a href="https://www.uhcwest.com/">https://www.uhcwest.com/</a></td>
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<tr>
<td>Dental</td>
<td>(888) 571-5218</td>
<td><a href="https://www.myuhc.com">https://www.myuhc.com</a></td>
</tr>
<tr>
<td>Vision</td>
<td>(888) 571-5218</td>
<td><a href="https://www.myuhc.com">https://www.myuhc.com</a></td>
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<tr>
<td>UPMC</td>
<td></td>
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<tr>
<td>Medical</td>
<td>(844) 252-0691</td>
<td><a href="http://www.upmchealthplan.com">http://www.upmchealthplan.com</a></td>
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<th>Health Care Plans</th>
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<tr>
<td>AON Active Health Exchange</td>
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<tr>
<td>Employee Assistance Program (EAP)</td>
<td>Telephone: (888) 674-4474</td>
<td>Online:</td>
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<td></td>
<td>TTY: (866) 228-2809</td>
<td>Click: SupportLinc</td>
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<td>Outside U.S.: Access by placing a</td>
<td>or <a href="http://www.supportlinc.com/">http://www.supportlinc.com/</a></td>
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<td>collect call to the toll-free number;</td>
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<td>if unable to call collect, dial the</td>
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<td>AT&amp;T USADirect® access number for the country you’re calling from.</td>
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### Your Spending Accounts

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<th>Account Type</th>
<th>Telephone and Fax Numbers</th>
<th>Web and Mailing Address</th>
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</table>
| Health Care Flexible Spending Account (FSA) | **Telephone:** (800) 585-5100  
**Outside U.S.:** +1 (646) 254-3472 | **Online:** [www.yourbenefitsresources.com/mot-solutions](http://www.yourbenefitsresources.com/mot-solutions)  
**Mail:**  
Your Spending Account  
P.O. Box 785040  
Orlando, FL 32878-5040 |
| Health Savings Account (HSA) |  |  |
| Dependent Care Account (DCA) |  |  |

### Life Insurance

#### MetLife

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<tr>
<th>Plan or Program</th>
<th>Telephone and Fax Numbers</th>
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</table>
| Claim submission and status | **Telephone:** (800) 638-6420  
**TTY:** (800) 855-2880  
**Fax:** (570) 558-8645 | **Online:** [www.metlife.com](http://www.metlife.com)  
**Mail:**  
MetLife Group Life Claims  
P.O. Box 6100  
Scranton, PA 18505 |
| Requests for review and appeals |  |  |
| Statement of Health review and termination |  |  |
| Portability or conversion information |  |  |
| Beneficiary management | **Telephone:** (800) 585-5100 | **Online:** [www.yourbenefitsresources.com/mot-solutions](http://www.yourbenefitsresources.com/mot-solutions) |
| Premium payments  
(Supplemental Life and Dependent Life Insurance) |  | **Send your premium, made payable to Motorola Solutions:**  
**Mail:**  
Motorola Solutions  
P.O. Box 0742  
Carol Stream, IL 60197-0742  
**Wire:**  
ABA#: 0210-0002-1  
JPMorgan Chase  
New York, NY  
Bank Acct.: 304231088  
Bank Acct. Name: MetLife Group Insurance Concentration  
Account Reference Info.:  
Control #50711, due date MMDDYY |
## Disability Plan

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<th>Plan or Program</th>
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<tr>
<td><strong>Unum</strong></td>
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<tr>
<td>- Claims submission</td>
<td>Telephone: (866) 295-3009</td>
<td>Unum</td>
</tr>
<tr>
<td></td>
<td>TTY: (800) 887-2180</td>
<td>The Benefits Center</td>
</tr>
<tr>
<td></td>
<td>Outside U.S.: +1 (207) 575-3678</td>
<td>P.O. Box 100158</td>
</tr>
<tr>
<td></td>
<td>Fax: (800) 447-2498</td>
<td>Columbia, SC 29202</td>
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<tr>
<td>- Management of Short- and Long-Term Disability claims</td>
<td>Fax: (207) 575-2354</td>
<td>Unum</td>
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<td></td>
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<td>The Benefits Center Appeals Unit</td>
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<td></td>
<td></td>
<td>P.O. Box 9548</td>
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<td></td>
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<td>Portland, ME 04104-5058</td>
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<tr>
<td>- Claim denial: Requests for review and appeals</td>
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<td>Telephone: (800) 585-5100</td>
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<td>- Report disability</td>
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<td>The Benefits Center</td>
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<td><strong>Supplemental Long-Term Disability Income Insurance Program</strong></td>
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<tr>
<td>- Aon Hewitt Benefits Specialist</td>
<td>Telephone: (877) 236-3073</td>
<td>Unum</td>
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<tr>
<td></td>
<td>Fax: (404) 240-6079</td>
<td>The Benefits Center Appeals Unit</td>
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## Work/Life and Other Programs

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<td><strong>Adoption Assistance Program</strong></td>
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<tr>
<td><strong>Business Travel Assistance</strong></td>
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<tr>
<td>- Motorola Solutions Assist Program</td>
<td>Telephone: (800) 767-1590</td>
<td>Unum</td>
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<tr>
<td></td>
<td>Outside U.S.: +1 (215) 942-8226</td>
<td>The Benefits Center</td>
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<tr>
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<td>P.O. Box 100158</td>
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<td>Columbia, SC 29202</td>
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<td>- Business Travel Medical Insurance</td>
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<td>- Business Travel Accident Insurance</td>
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<tr>
<td><strong>LifeSecure Long-Term Care Insurance</strong></td>
<td>Telephone: (855) 568-6235</td>
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<td><a href="http://www.groupltci.com/motorolasolutions">www.groupltci.com/motorolasolutions</a></td>
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<td>Email:</td>
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<tr>
<td></td>
<td><a href="mailto:hllopsmed@internationalsos.com">hllopsmed@internationalsos.com</a></td>
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<td>11BCPA000173)</td>
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<tr>
<td><strong>EAP</strong></td>
<td>Telephone: (888) 674-4474</td>
<td>Online: Click: SupportLinc</td>
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<tr>
<td>Plan or Program</td>
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<td><a href="http://www.supportlinc.com">http://www.supportlinc.com</a></td>
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<tr>
<td>U.S. Commuter Benefit Program</td>
<td><strong>Telephone:</strong> (800) 585-5100</td>
<td><strong>Online:</strong></td>
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<td></td>
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<td><a href="http://www.yourbenefitsresources.com/mot-solutions">www.yourbenefitsresources.com/mot-solutions</a></td>
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<td>P.O. Box 785040</td>
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