2024 U.S. NXP Benefits Frequently Asked Questions

These frequently asked questions (FAQs) provide only an overview of benefit changes and clarifications effective January 1, 2024. The respective plan documents and policies govern your rights. You should rely on this information only as a general summary of some of the features of the plans and policies. In the event of any difference between the information contained here and the plan documents and policies, the plan documents and polices will supersede these FAQs. NXP reserves the right at any time to amend, modify or terminate one or more of the plans or policies described in these FAQs.

Table of Contents

Annual Enrollment Overview

1. When is NXP's Annual Enrollment?

Annual Enrollment is October 16 – October 27 with changes effective January 1, 2024.

2. Where can I find information about NXP benefits?

Visit NXP.com/benefits for information about NXP benefit changes. Call NXP Benefits Service Center, speak to a representative about the benefits and make your elections through them at (888) 375-2367. Representatives are available Monday through Friday from 7:00 a.m. to 7:00 p.m. U.S. Central time.

3. What are the key benefit changes for 2024?

- UnitedHealthcare Medical Plan 1 Deductible has changed to $1,600 Single / $3,200 Family to maintain IRS compliance
- Vision enhancements including: $0 copay for retinal imaging, frame coverage every calendar year, increased computer vision care frame allowance, and more. Find more details here
- Beginning Jan 1, 2025, the Health Care FSA funds will no longer roll over from year to year. You must use your funds by Dec. 31, 2024 or any remaining funds will be forfeited. You have until March 31, 2025 to reimburse yourself for any eligible expenses incurred in 2024
- The IRS has increased the maximum contribution limits for the Health Savings Account (HSA) to $3,650 Single / $7,300 Family
- Medical and Vision plan contributions will increase — for employees and NXP
- If you do not make new elections by October 27, 2023 your current 2023 enrollment elections will carry over to 2024 except for spending accounts. Your 2023 Flexible Spending Account elections and Health Savings Account elections will not automatically be renewed for 2024. You will be required to log in and make an election to contribute to the FSA and HSA again in 2024.

4. How do I enroll?

To enroll, visit nxp.bswift.com to make your elections. You can enroll online 24 hours a day, 7 days a week. If you would like to enroll through NXP Benefits Service Center, call (888) 375-2367. Representatives are available to assist you Monday through Friday from 7:00 a.m. to 7:00 p.m. U.S. Central time.

5. Will I receive new identification cards?

Yes, all UHC members will receive new ID cards.

6. How does the tobacco non-user discount work?

The tobacco non-user discount for medical is $50/month per adult tobacco user.

There are two ways for you and/or your spouse/domestic partner to qualify for this discount. You can certify being tobacco-free for the past twelve months, or you can enroll in a tobacco cessation program.

By qualifying, you and/or your spouse/domestic partner receive:

- A $50 per smoker monthly discount on the cost of medical coverage; and
- Eligibility for non-tobacco rates for supplemental life insurance and spouse/domestic partner life insurance.

Tobacco use status for medical coverage can be changed during the calendar year if you attest to being tobacco-free for twelve months. For supplemental life insurance and spouse life insurance, tobacco use status cannot change during the calendar year. To change tobacco, use status for the medical plan during the year for you or your spouse/domestic partner, call NXP Benefits Service Center at (888) 3752367.

7. Who is an eligible dependent?

For complete details on eligibility please review the NXP Summary Plan Description. In summary, your eligible dependents include:

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

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

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

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

8. What should I do if my covered dependent(s) doesn't have a Social Security number and are my dependent(s) eligible for health coverage if they don't have an identification number?

The IRS requires a taxpayer identification number on all returns, statements, and other tax-related documents. For most, this is a Social Security number (SSN). A foreign person, who does not have and is not eligible to get an SSN, must use an individual taxpayer identification number (ITIN). We aren't denying health coverage if your eligible dependent doesn't have an identification number. Please

contact NXP Benefits Service Center at (888) 375-2367 to assist with update to your dependent's account once you have the identification number.

9. If I drop a dependent/spouse/domestic partner during Annual Enrollment will they receive a COBRA packet?

No, Annual Enrollment is an open election time when you can make any changes but does not follow the Qualified Event Status rules for COBRA. If you have a qualified event such as a divorce, please make a separate election and the appropriate COBRA packet will be mailed.

10. When can I change my benefit elections?

You can make changes to your HSA annual goal amount **anytime** either online at nxp.bswift.com or by calling NXP Benefits Service Center at (888) 375-2367. Representatives are available Monday through Friday from 7:00 a.m. to 7:00 p.m. U.S. Central time.

You can make changes to your 401(k) contribution percentage anytime either online at www.netbenefits.com or by calling the NXP Retirement Service Center at (844) NXP-401K. Representatives are available Monday through Friday from 7:30 a.m. to 7:00 p.m. U.S. Central time.

If you experience a qualified status change (sometimes referred to as life event) that affects eligibility, you may be eligible to change some or all your health and wellness, spending account, life insurance or disability income elections. You may make the change in coverage by going online to nxp.bswift.com or by calling NXP Benefits Service Center at (888) 375-2367 within 30 days of the qualified status change.

Medical Plans

1. What NXP medical plans are available for me to choose from?

You can select one of four medical plans – Plan 1, Plan 2, or Plan 3. If you live in California, you will also have access to the Kaiser HMO.

Under Plan 3 you only have coverage for in-network providers and facilities, except in the case of a true emergency.

Know what "emergency" means: a life-threatening emergency is a condition or problem that, without immediate care, will result in the loss of life or limb. Examples include heart attack, stroke, poisoning, severe bleeding, severe burns, and unconsciousness. Detailed description found here.

2. What is Teladoc and Virtual Visits?

If you enroll in one of our 3 offered UnitedHealthcare medical plans, you will have access to doctors by video 24/7 through UnitedHealthcare's Virtual Visit Program. No additional accounts to set up or apps to download. Just log in at UnitedHealthcare.

Virtual Visit doctors can diagnose your symptoms and prescribe medicine, if needed, for everyday medical conditions like:

- Allergies
- Rashes
- Eye infections
- Sore throats
- Flu
- Stomachaches
- Headaches/migraines
- And more

Other virtual visit providers covered under United Healthcare include Teladoc, Amwell and Doctor on Demand.

This service is also ideal for employees on Medical Plan 1, as it allows those employees and their enrolled dependents to see a doctor for $49 or less per visit. Start your Virtual Visit at **myuhc.com/virtualvisits.**

2. Can I get a prescription through Virtual Visits?

Virtual Visits doctors can send prescriptions* to the pharmacy of your choice. Costs for prescription drugs are based on your pharmacy benefit and are not covered as part of the Virtual Visit. You'll only get a prescription if the doctor decides you need one. **Certain prescriptions may not be available, and other restrictions may apply.*

3. Is there an age minimum for Virtual Visits? In other words, does my child have to be a certain age for them to treat and prescribe?

There are no age restrictions for the Virtual Visit program. In general, a parent or legal guardian must be present during the Virtual Visit with a minor dependent who is covered under your plan.

4. How much will Virtual Visits cost me?

At $49 or less per consultation, Virtual Visits costs significantly less than urgent care and emergency room visits. Plus, you can use Virtual Visits from the convenience of home, allowing you to avoid the hassle of sitting in a waiting room.

- Plan 2 and Plan 3 enrollees pay a $10 copay.
- Plan 1 enrollees pay no more than $49.

5. I have coverage from my spouse's medical plan. How do I opt out of the NXP medical plan coverage?

If you choose to opt out, you can do so during Annual Enrollment at nxp.bswift.com. You do not have to provide proof of other coverage to opt out.

6. I want to learn more about the costs and benefits of the medical plans. Who is Emma and how can she help?

Emma is your virtual, personal benefits counselor. She can help you determine which medical plan can best serve your needs. You can access her during your enrollment at nxp.bswift.com.

7. How do I find an UHC network provider?

With all UHC medical plans, you will have access to an extensive network of UHC providers. To find out if your providers are in-network, use the UHC link

When you're asked to select a plan, click on Choice Plus network or call UHC Member Services at (844)210-5428 to ask about provider status.

8. I'm planning on having a procedure requiring anesthesia and would like to know how coverage is applied for anesthesiologists.

Facility charges are benefits for covered health care services that are billed by a network facility and provided under the direction of either a network or out-of-network physician or other provider. Benefits for non-emergency covered health care services include physician services provided in a network facility by a network or an out-of-network emergency room physician, radiologist, anesthesiologist, or pathologist.

9. If I'm enrolled in family coverage, do I just need to meet the individual deductible and out of pocket maximum to have the benefit? Or do I have to reach the family limits for benefits to begin?

Medical Plan 1 is a non-embedded deductible and out of pocket plan. When you have a non-embedded plan, your family must meet **the entire family limit** before anyone receives benefits. In other words, the Medical Plan 1 in-network family deductible of $3,200 must be reached (even if by just one member of that family) before the coinsurance benefit applies for that individual. The family deductible can be met by one family member or a combination of family members however there are no benefits until expenses equaling $3,200 (the in-network family deductible amount) have been incurred. This same accumulation strategy applies to the out-of-pocket limit for Plan 1. See Plan 1 deductible and out of pocket limits below.

Plan 1 (In-Network) Deductible and Out of Pocket Limits

- You Only: Deductible is $1,600 and Out of Pocket limit is $4,000
- You + Spouse: Deductible is $3,200 and Out of Pocket limit is $7,350
- You + Children: Deductible is $3,200 and Out of Pocket limit is $7,350
- You + Family: Deductible is $3,200 and Out of Pocket limit is $7,350

Medical Plan 2 and Plan 3 are embedded deductible and out of pocket plans. Having an embedded plan means that when expenses for any one family member reach the limit, the benefit starts for that individual. Once one member in the family reaches their individual deductible, their coinsurance benefit begins. The family deductible can be met by one family member or a combination of family members. Once the family deductible is met, the coinsurance benefit begins for everyone in the family. The same is true for the out-of-pocket limits for these plans - once an individual meets the individual out of pocket limit, their coverage is paid at 100%. If one or more members reach the family out of pocket limit, the entire family's coverage is paid at 100%.

Medical Plan 1 High Deductible Health Plan

1. What is Medical Plan 1 and how does it work?

This is a high deductible health plan (HDHP), and it's an NXP medical plan—just like NXP's other medical plans. It covers the same medical services as the other medical plans (including preventive care and preventive generic drugs at 100%) and offers the same quality care and provider network. You can see any provider you choose, and you pay for medical and pharmacy you receive through your deductible and coinsurance.

2. What makes the HDHP different from the other medical plans is that:

- There are no copays in this plan, i.e., you pay 100% of your medical and pharmacy costs until you meet your deductible. So, if your doctor charges $90 for a visit when you are ill, you pay the entire $90, instead of a copay.
- You receive funds initially from NXP to pay for your healthcare costs for the year, $500 for individual coverage and $1,000 for family coverage.
- You can contribute to a Health Savings Account (HSA) to pay for health care expenses, or you can save the funds for future use.
- You pay the lowest amount in paycheck contributions coverage in this plan. But again, you pay all upfront costs for medical and pharmacy until you meet your annual deductible.

3. Is NXP depositing funds for me to use towards qualified medical expenses if I enroll in Medical Plan 1?

Yes, NXP will fund $500 for employee-only (single) coverage and $1,000 for family (any coverage level other than employee-only) by the end of the first full week of the month after your enrollment to help you with the deductible, coinsurance, and qualified medical expenses. The amount you receive will be prorated based on the number of remaining months in the year after your enrollment is captured. Need help understanding the IRS limits for the HSA? You can read more here.

Turning 65

1. Will my current insurance expire when I turn 65?

No, as long as you're still an actively employee and enrolled in medical insurance through NXP, your coverage will remain active. Please note: Medicare eligibility begins on the first of the month in which you will turn age 65. If your birthday is on the first day of the month, your Medicare eligibility will become effective the first day of the prior month. If you are within three months of becoming eligible for Medicare, begin the process of enrolling as soon as possible. It can take six weeks to three months to be approved for coverage. We encourage employees to begin the enrollment process 60 days before retiring from NXP.

2. Will I be enrolled in Medicare and NXP provide Gap insurance?

Medicare is optional and only automatic when you turn 65, if you have already accepted Social Security benefits. If you would like to speak to someone about what the private Medicare exchange is and how to enroll, please contact the Aon Retiree Benefit advisors at 847.323.7886.

Before you can enroll in additional Medicare coverage, you must enroll in Medicare Parts A and B, here's how:

- Visit your local Social Security office
- Call Social Security at 1-800-772-1213 (TTY 1-800-325-0778)
- Apply on the Social Security website at ssa.gov

3. Will my spouse's coverage expire when he/she turns 65?

Your spouse will continue to stay covered on your plan, unless he/she chooses to enroll in Medicare. As long as you remain an active employee at NXP, their coverage as a dependent through UHC will remain primary.

4. If I keep the existing company insurance, will I pay a late enrollment penalty when I retire?

No, you will not pay a late fee if you continue to actively work and keep NXP's coverage, you won't have to pay the penalty that would otherwise apply for delaying your Medicare Part A or Part B enrollment. See more information around the special enrollment period.

What happens if I'm contributing to the Health Savings Account and turn 65?

To be able to contribute to an HSA after age 65, you must not enroll in Medicare, including Medicare Part A. If you are not enrolled in Medicare and are otherwise HSA eligible, you can continue to contribute to an HSA after age 65.

Prescription Drugs

1. Why can't I use drug coupons or "copay cards" when I fill my maintenance medications?

Copay cards and manufacturer coupons are not permitted for maintenance medications through the NXP pharmacy plan. Copay cards and coupons typically reduce or eliminate member copays for brand name drugs.

2. If I choose a brand name drug when a generic drug is available, will the full amount I pay apply towards my annual out-of-pocket maximum?

If you choose a brand name drug when a generic is available, the amount you spend on the brand name drug above the copay/coinsurance will not count towards your out-of-pocket maximum.

3. Do I have to get my short-term prescriptions filled at CVS Caremark? Can I have my prescriptions filled at my local pharmacy?

You do not have to fill your short-term prescriptions at a CVS Caremark pharmacy. You can fill your short-term prescriptions at any of the over 68,000 participating pharmacies in our plan. To view a list of participating pharmacies, visit https://caremarkrxplaninfo.com/NXPSemiconductors.

4. If I use maintenance medicines, do I have to use the CVS Caremark home delivery?

Yes. In addition to receiving maintenance medicines in the mail (home delivery), you have the option to fill a 90–day prescription at a retail CVS Caremark pharmacy while maintaining the same home delivery benefits and cost.

5. What is the purpose of the step therapy program for prescription drugs?

The step therapy program is designed to help patients and their doctors find the medicine that is most effective in terms of both cost and medical results for the certain conditions. For example, these conditions include, but are not limited to, allergies, depression, high blood pressure, high cholesterol, insomnia/sleep problems, migraine, osteoporosis, overactive bladder/incontinence, pain and inflammation, and stomach ulcers. You are required to try a generic drug for at least 30 days before using specific brand–name drugs. If you have questions about the treatments or drugs that are part of the step therapy program, contact CVS Caremark at (877) 505-8360, or visit caremark.com.

6. What is the difference between brand and generic drugs? Why are there copay/coinsurance differences for various medications?

The primary difference between a brand-name drug and a generic drug isn't in the drug itself, but in who makes it and how long it has been on the market. A generic drug is the chemical copy of a brand–name prescription drug, and generally costs less than 50 percent of the cost of the brand-name drug. Generic drugs are typically dispensed in the same dosage, taken in the same way, and packaged in the same unit strength as their brand–name counterparts.

For brand name drugs, preferred drugs are medications selected by clinical experts after meeting clinical and therapeutic criteria. These drugs help reduce overall out–of–pocket expenses without compromising quality. Preferred brand drugs are more expensive than generic drugs but less expensive than non-preferred, brand-name drugs. Use the Drug Formulary List .

Dental Plan

1. What does the dental plan cover?

Delta Dental is the NXP dental provider. To view a complete listing of the dental benefits and contributions, please visit the NXP.com/benefits website. You can also review a summary of the NXP dental coverage on NXP.com/benefits on the Dental page.

2. Will I get a Delta Dental ID card?

You will receive a Welcome kit from Delta Dental if you elect dental. Attached to the welcome kit will be your card to use for you and your family. Or you can log on to NXP.com/benefits for more information.

3. Can I use a dental provider that isn't in the Delta Dental network?

Yes. You are always free to select the dental provider of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. They haven't agreed to accept negotiated fees. You may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Vision Plan

1. What does the vision plan cover?

VSP is the NXP vision provider. To view a complete listing of the vision benefits and contributions, please visit the NXP.com/benefits website.

2. How can I find out if my vision provider is in the VSP Choice network?

Visit vsp.com/choice to see if your current eye doctor participates in this network or to find a Choice network doctor that's right for you. Please call VSP member services at (800) 877-7195 with any questions or concerns.

3. Will I receive a VSP card if I enroll in the vision plan?

VSP Vision doesn't issue ID cards. To access care, you simply need to share your employer's name and that you have VSP Vision insurance with your network provider. Your network provider will contact VSP and get the information they need to understand your benefit and file claims on your behalf. Our VSP group number is 12245206.

Health Care Flexible Spending Account (HCFSA)

1. What is a health care flexible spending account?

You can contribute up to $3,050 each year, pre-tax, to this account to pay for eligible health-related expenses incurred by you and your family. Beginning Jan. 1, 2025, the Health Care FSA funds will no longer roll over from year to year. You must use your funds by Dec. 31, 2024 or any remaining funds will be forfeited. You have until March 31, 2025 to reimburse yourself for any eligible expenses incurred in 2024

For details see Health Care FSA Roll Over Process below. Covered expenses typically include healthcare expenses that are not covered by your health plan, such as the following.

- Deductibles, copayments, and coinsurance for medical and dental services
- Prescription drug expenses
- Eyeglasses, contact lenses, and hearing aids
- Certain over-the-counter medications (when prescribed by a licensed health care professional)
- Medical supplies and equipment

The IRS publishes a complete list of eligible healthcare expenses.

2. What are the reimbursement options for the Health Care FSA?

You have two reimbursement options, automatic reimbursement (for medical claims only) or a Health Care FSA debit card. Every employee will automatically receive a Health Care FSA debit card in the mail to use for medical, pharmacy, dental and vision expenses. If you would like to sign up for automatic reimbursement (for medical claims only), please make sure you make that election on the UnitedHealthcare website at myuhc.com or call customer service at 1-844-210-5428. If you activate and use the Health Care FSA debit card, be sure to save all your receipts. You may be asked to provide copies to confirm your expenses. Visit irs.gov and refer to Publication 502 to learn more about your Health Care FSA reimbursement options.

Dependent Care Flexible Spending Account (DCFSA)

1. What is a Dependent Care Flexible Spending Account?

A dependent care flexible spending account is a way to set aside pre-tax contributions of up to $5,000 each year to care for your eligible dependents while you work. If you earn over $130,000 in 2023, you are limited to $2,500. The Dependent Care FSA can be used to pay for qualified dependent day care expenses such as:

- A licensed child or elder care center
- A babysitter, nanny, or nurse
- After-school care
- Nursery school tuition

For more information review the Flexible Spending Account page on NXP.com/benefits.

2. Does the carryover rule apply to my Dependent Care FSA?

No, the carryover does not apply to the Dependent Care FSA. Any money contributed to this account must be used for expenses incurred in the same calendar year or the money is forfeited.

3. Do overnight camps for my children count as an eligible expense?

The cost of sending your child to an overnight camp is not considered a work-related expense. For more details on eligible Dependent Care FSA expenses, visit IRS-eligible child and dependent care expenses at https://www.irs.gov/pub/irs-pdf/p503.pdf.

Life Insurance

1. What are the life insurance coverage options available?

Basic life and AD&D Insurance – coverage is 2 times your eligible compensation, up to a $1 million maximum benefit, at no cost to eligible employees. There is an additional option for a flat $50,000 in coverage for anyone whose eligible compensation exceeds $50,000*.

> *Tax Alert - Company-paid life insurance is tax-free if your coverage does not exceed $50,000. If your Basic Life Insurance coverage exceeds $50,000, the cost of the excess coverage will be imputed and included in your gross income. If enrolled, the cost of your Supplemental and Spouse/Domestic Partner Life Insurance coverage, less your after-tax contributions, will also be included. For this purpose, the cost is computed using a uniform premium table published by the IRS. The taxable amount, if any, is reported to you on your Form W-2 ("C" in Box 12) and on your paycheck ("Group Term Life"). Talk to your accountant or financial advisor for more information regarding taxation of life insurance coverage.

Supplemental Life Insurance – you can elect between one- and eight-times eligible compensation, with a $1.5 million maximum benefit.

Spouse/Domestic Partner Life Insurance – you can elect coverage for your spouse or domestic partner for as much as 100% of your total life insurance coverage (i.e., basic plus supplemental life insurance), up to a maximum of $250,000. You have coverage options of $25,000, $50,000, $100,000, $150,000, $200,000 or $250,000.

Child Life Insurance – life insurance for your child(ren) is offered at two coverage levels of $15,000 and $25,000. Your contributions for child life insurance are the same regardless of the number of eligible children you cover.

2. Are there maximum coverage limits that apply to basic, supplemental, and spouse/domestic partner life insurance?

The maximum dollar amount of coverage for basic life insurance is $1,000,000. The maximum dollar coverage for supplemental life insurance is $1,500,000. Spouse/domestic partner life insurance cannot exceed 100% of total employee life insurance (including employee basic and supplemental life) or $250,000, whichever is less.

3. What are "non-medical issue" and "evidence of insurability (EOI)"?

Non-medical issue is the amount of life insurance coverage that does not require satisfactory EOI to be provided by the applicant before the coverage takes effect. EOI is proof that the applicant qualifies for the requested coverage level based upon the acceptance standards for the type and amount of coverage. You and/or your spouse/domestic partner may be asked to provide EOI directly to MetLife. In most cases, satisfactory EOI can be established for the applicant by answering some questions. In some cases, a basic physical examination (paramedical) may be required (height, weight, pulse, blood pressure, brief questions, blood and urine).

If an examination by a qualified medical professional is required, MetLife's EOI Unit (Statement of Health) will notify you of the required examination and an approved vendor will contact you to schedule

an appointment at your convenience and at no cost to you. A copy of the examination and any necessary lab results are available to you at no cost.

A review of your medical records may be necessary to evaluate EOI. If so, MetLife will request these from your doctor or other health care provider by mail and give you a copy of that request. All medical records are considered confidential, and information is not released to anyone else without your consent or a court order.

Child life insurance does not require evidence of insurability.

During Annual Enrollment, participants currently enrolled in supplemental life insurance plan may increase their current coverage by one level up to the non-medical issue amount without EOI. All other choices require EOI.

4. I made a choice that requires EOI, what will my coverage be during the period in which my EOI is being evaluated or if my EOI is determined not to be satisfactory?

If you elect coverage above the non-medical issue amount for either supplemental or spouse/domestic partner life insurance, your coverage is limited to your current level of coverage or the non-medical issue amount, if higher, until an EOI determination is made. Once your EOI is approved, your coverage will be automatically increased to the level you chose.

If your EOI is not approved, your coverage is limited to your current level of coverage or the non-medical issue amount, if higher.

5. Is there a life insurance rate discount offered for employees and spouses/domestic partners who are tobacco–free?

Yes. If you or your spouse/domestic partner have been tobacco–free for at least the past six months, or are currently enrolled in a tobacco cessation program, a discounted rate for supplemental life insurance or spouse/domestic partner life insurance will apply. Tobacco use status can be changed during Annual Enrollment, but not during the calendar year for life insurance.

6. What will happen to my life insurance coverage if I leave NXP?

Your coverage ends on the last day of the month in which your employment ends. If you want to continue coverage after your employment ends, there are conversion and portability rights for basic, supplemental, spouse/domestic partner and child(ren) life insurance. This means that you or your dependent may convert NXP coverage into an individual policy under certain conditions. Some restrictions may apply. Applications are available by calling MetLife at (877) 275-6387.

MetLife Legal

1. What is the MetLife Legal program?

Your legal plan gives you easy, affordable access to experienced attorneys for an unlimited number of personal legal matters. When you use a MetLife Legal attorney for covered services, all attorney fees are paid for by your legal plan. In addition to representation, your plan provides consultation for virtually any personal legal matter. Plus, the cost of the plan is paid through convenient payroll deductions. It's like having an attorney on retainer.

2. How much does the MetLife legal program cost?

Sign up for a convenient payroll deduction of just $7.62 per pay period (every 2 weeks) for MetLaw or $9.92 per pay period for MetLaw Plus Parents.

3. How do I access the services once I'm enrolled?

To access service once you've enrolled visit www.legalplans.com or call MetLife Legal Plans' Client Service Center at (800) 821-6400. Use access code: NXP (Standard Legal Plan) or NXPPLUS (Parents Buy-Up Plan).

Dependent Verification

1. Who is an eligible dependent?

Click here for more information about dependent eligibility.

2. Why does NXP require documentation for covered dependents?

NXP requests documentation for covered dependents for two primary reasons:

- We want to confirm that our health care dollars are being spent appropriately. We believe that most enrolled dependents are eligible to participate; however, there may be some instances in which employees mistakenly cover ineligible dependents. When this occurs, each of us shares in the cost for the coverage of ineligible dependents.
- We want to ensure plan compliance with the Employee Retirement Income Security Act (ERISA) regulations and our Summary Plan Description.

3. If one of my dependents is found ineligible, where can I get insurance for him or her?

There are several individual plans available. One source of information for the plans that are available in your area is healthcare.gov. These plans are offered by individual carriers and not by NXP Benefits Service Center or NXP.

4. What will happen if I do not return the required documentation?

Any unverified dependents will not have access to NXP benefits. All dependents not verified by the deadline will lose all coverage, including health, dental, vision and life insurance.

Form 1095 Reporting for Benefits

Form 1095 is a tax form required under the Affordable Care Act (ACA). Beginning with the 2015 tax year and continuing through 2023, this form will play an important role in your annual tax filings. The following questions and answers will help you generally understand the form, why it's important, and how it affects you. These FAQs provide only summarized information about Form 1095; it does not cover all circumstances. The NXP Benefits Service Center does not give legal or tax advice. For specific information about Form 1095, see irs.gov and speak with your legal or tax advisor.

1. When should I expect to receive my form(s)?

Forms for the 2023 tax year must be mailed no later than February 1. Please allow seven to ten business days for delivery.

2. What if I lose my form or don't receive it? How can I get another one?

You will be able to access a copy of your form online at nxp.bswift.com. If you need assistance locating it, please contact the Benefits Service Center at (888)375-2367.

3. I received a letter asking for my dependent's Social Security number. Why?

The IRS requires that employers and medical carriers make their best effort to obtain the missing individual taxpayer identification number (ITIN) or SSN(s) of any covered individual or dependent(s).

4. What happens if I don't provide this information?

The IRS may impose a $50 tax penalty for each missing individual taxpayer identification number (ITIN) or SSN(s). Failing to provide this data may also negatively impact your dependent's coverage. Plus, you can expect to receive requests for the missing SSN(s) at least once a year.

5. How do I update this information?

Log on to your benefits website at nxp.bswift.com or contact NXP Benefits Service Center at (888) 375-2367 to edit your dependent information and add the required individual taxpayer identification number (ITIN) or SSN(s) to your account.

6. What should I do if my covered dependent(s) doesn't have a Social Security number and are my dependent(s) eligible for health coverage if they don't have an identification number?

The IRS requires a taxpayer identification number on all returns, statements, and other tax-related documents. For most, this is a Social Security number (SSN). A foreign person, who does not have and is not eligible to get an SSN, must use an individual taxpayer identification number (ITIN). We aren't denying health coverage if your eligible dependent doesn't have an identification number. Please contact the NXP Benefits Service Center at (888) 375-2367 to assist with update to your dependent's account once you have the identification number.

If you have any questions, contact NXP Benefits Service Center at (888) 375-2367.

401(k) Retirement Plan

1. What types of contributions are permitted?

You can elect to contribute on a pre-tax basis, Roth (after-tax) basis, traditional after-tax basis or in a combination of the three. You decide how much of your eligible compensation you would like to contribute to the Plan, in 1% increments, up to 75%, subject to the IRS limits.

The pre-tax and/or Roth limit is $22 ,500 in 2023 (the IRS has not officially published the 2024 limits). You can contribute even more with after-tax contributions. In 2023, total contributions to the plan, including your employee pre-tax, Roth and/or after-tax contributions and the NXP matching contributions, is limited to $66,000 (the IRS has not officially published the 2024 limits).

If you are age 50 or older, or will reach age 50 during the calendar year, you are eligible to make additional, catch-up contributions to your account. Your catch-up contributions will automatically start once you've reached the IRS limit of $22,500. You can contribute up to $7,500 in catch up contributions in 2023 (the IRS has not officially published the 2024 limits).

2. What are my investment options in the 401(k) Retirement Plan?

The 401(k) Retirement Plan allows you to make investment decisions that match your savings objectives and investment preferences. You have a choice of 13 core investment funds plus target date retirement funds, to which you can invest in 1% increments. These investment elections apply to your contributions and the NXP match. In addition, you have access to a self-directed brokerage account. You can learn more about each investment option and the fund managers at netbenefits.com.

3. When can I make changes to my 401(k) Retirement Plan elections?

You may increase or decrease the amount you contribute to the 401(k) Retirement Plan, change your type of contribution (pre-tax, Roth or after-tax), and change the way your future funds are invested at any time.

You may transfer balances in your account among investment options at any time, within the guidelines of the Trading Policy. You can view the Trading Policy and nxp.com/benefits.

4. How does the company match work in the 401(k) Retirement Plan?

You are eligible to receive company matching contributions to your account as soon as you begin contributing. NXP will match up to the first 5% of eligible compensation you contribute on a pre-tax and/or Roth basis, including catch-up contributions. To be eligible for the maximum company matching contribution, you must contribute at least 5% of your eligible compensation. NXP makes company matching contributions each pay period, based on your contributions for that pay period. NXP does not match traditional after-tax contributions.

5. What if I do not receive the maximum company match, I am eligible for during the year?

NXP makes company matching contributions each pay period, based on your contributions for that pay period. Currently, if, at the end of the year, you have not received the maximum company match you could have received on your contributions, NXP will make an additional "true-up" contribution to bring you up to the maximum match based on your actual annual contributions.

6. What is the vesting schedule in the 401(k) Retirement Plan?

The 401(k) Retirement Plan does not have a vesting schedule. You are fully vested in your 401(k) account, including the company matching contributions, regardless of your years of service. If you leave NXP at any time, you may take 100% of your account balance with you.

7. Do I pay fees in the 401(k) Retirement Plan?

Yes, participants pay fees to cover different types of services, including investment management fees, administrative fees and other participant paid individual fees. For more information on fees, review the NXP 401(k) Retirement Plan Fee Disclosure at netbenefits.com (under Plan Information and Documents).

8. Who do I contact if I have questions about the 401(k) plan or need assistance with my 401(k)-plan account?

For question regarding the NXP 401(k) plan, contact the NXP Retirement Service Center at 844-NXP-401K.