Tower Semiconductor

2025 Employee Benefits

Hello!

This guide provides important information about the benefits available to you and your dependents; please review the materials carefully. The programs detailed in this Benefits Guide provide quality choices that are comprehensive and cost-effective, both for the company and employees.

Providing comprehensive compensation and benefits programs is important to Tower Semiconductor because your overall wellness is important to the company's success. We know that you have a choice where you work and we are proud you continue to choose Tower Semiconductor – every day.

TOWER SEMICONDUCTOR BENEFITS ADMINISTRATION

For all 2025 Benefits Administration and 2025 Annual Enrollment activity, the Tower Semiconductor Benefits Center can be contacted online or by phone. Contact details are on page 33 of this booklet. The Tower Semiconductor Benefits Service Center is provided by PlanSource.

BENEFIT PLANS FOR 2025

Medical Insurance: Self-Insured plans using Anthem Blue Cross network for CA. These plans will continue to be administered by Collective Health.

Kaiser: The Kaiser plan is a closed plan and is only available for employees in CA who enrolled in the plan prior to 2020. There will be no new enrollments allowed on the Kaiser plan in 2025.

Prescription (Rx): CVS will continue to be the Pharmacy Benefit Administrator through Rx Benefits. Tria Health is available to help support members with chronic conditions. PrudentRx will continue to be available for Anthem members.

Dental Insurance: Dental plans will continue to be offered through Guardian and administered by Collective Health.

Vision Insurance: EyeMed plan will continue with no plan design changes and will now be administered by Collective Health.

Life and AD&D Insurance: All company provided and voluntary life and AD&D insurance coverage will continue to be offered through Reliance Standard.

Disability Insurance: Long Term Disability insurance is still insured through Reliance Standard.

Voluntary Benefits: Voluntary Critical Illness and Accident will continue to be offered through MetLife. A new enhanced MetLife legal plan now provides 4 hours of non-covered Legal services. Pet Benefit Solutions will continue to be the pet care discount plan for 2025.

Employee Assistance Program: ACI Specialty Benefits will continue being the EAP vendor.

Lyra Health: Anthem Blue Cross members will have up to 12 coaching and therapy sessions at no cost!

Health Savings Account and Flexible Spending Account: For those enrolling in the High Deductible Health Plan (HDHP), Tower will fund up to $500 annually towards the HSA. HealthEquity will continue to be the administrator for all Health Savings Account and Flexible Spending Accounts for 2025 and will require re-election.

As you can imagine, designing an employee health and welfare program that meets the broad needs of all of our employees is difficult, however, we believe we have succeeded. A list of insurance carrier contact phone numbers and websites may be found in the Benefits Directory on page 33 of this booklet.

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Welcome to the 2025 Benefits Plan Year.

Tower Semiconductor is proud to offer a range of employee benefit plans to help protect you and your family in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year.

If you have any questions regarding your benefits, please contact PlanSource or Human Resources.

Collective Health

What is Collective Health?

Collective Health is a one-stop-shop platform that brings together your medical, dental, Health Savings Account (HSA) and Flexible Spending Account (FSA) to create a single point of contact for you. **And new for 2025, Collective Health will now be managing your vision benefit, expanding them as your resource for almost all your benefits.** When you're trying to understand and use your benefits, we are here for you. From choosing your plan, to using it, Collective Health is your first point of contact on your care journey.

1

SELECT A PLAN

The Collective Health Open Enrollment website, ***join.collectivehealth.com/towersemiconductor***, guides you through your plan options in clear, human language so you can choose what's best for you and your loved ones.

2

RECEIVE YOUR WELCOME PACKAGE

Unwrap your cards, get information on how to use and download the Collective Health app, and more.

3

SIGN IN

Register to track your care, better understand your plan, submit claims, and more.

4

FIND A DOCTOR

The Collective Health "Get Care" tool is an easy and quick way to find in-network doctors in your area.

5

TALK TO A MEMBER ADVOCATE

Have a question that just needs a human? Call the Member Advocate team at 833-440-1639 for compassionate, knowledgeable help.

Collective Health

Who is Collective Health?

Collective Health's platform creates an all-in-one experience you deserve. They bring together technology, design, and humans to redefine how you experience benefits. Questions on how a benefit is covered? Need an in-network provider? Having a problem with your claim? Collective Health is here to help. They are here to help you manage your benefits and care with ease. Simple as that.

Explore more details at ***join.collectivehealth.com/TowerSemiconductor***

The Member Advocate team is on hand to answer any questions you may have from 4 a.m. to 6 p.m. PST, Monday through Friday and Saturday 7 a.m. to 11 a.m. PST. You may contact the Member Advocate team at 833-440-1639 or by signing into Collective Health to send a message.

Eligibility and Enrollment

Who can Enroll?

Regular full-time employees working a minimum of 30 hours per week are eligible to participate in the benefits program. Eligible employees may also choose to enroll eligible family members, including a legal spouse/registered domestic partner. Employees are required to provide documentation to validate a dependent's eligibility for coverage. Please contact Tower Semiconductor's Benefits Service Center at 877-284-5077 for additional information.

Children are considered eligible if they are:

- You or your spouse's/registered domestic partner's biological children, stepchildren, adopted child or foster child under the age of 26
- You or your spouse's/registered domestic partner's children of any age if they are incapable of self-support due to a physical or mental disability

Please Note: As of January 1, 2020, unregistered domestic partners will no longer be eligible for benefits. Tower Semiconductor will require proof of registered domestic partnership for enrollment in benefits for 2025. Employees will have until January 31, 2025 to submit proof of registered domestic partnership to PlanSource, or they will be terminated from the plans retroactive to January 1, 2025.

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a qualifying life event during the plan year. Please review details on IRS qualified change in status events for more information.

When Does Coverage Begin?

Your enrollment choices remain in effect for the benefits plan year, January 1, 2025 through December 31, 2025. Benefits for eligible new hires will commence as follows:

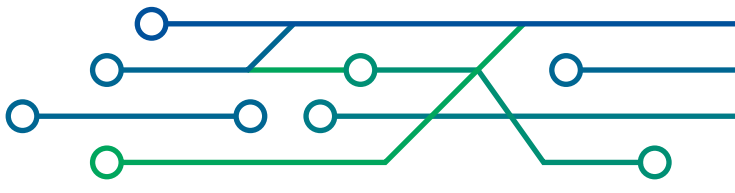
ELIGIBILITY DATE

- Your coverage is effective after **30 days** from your **date of hire** and must be actively at work to enroll. You must enroll within 30 days from your hire date.
- **PPO eligibility for Union employees requires 2 years of service. Service requirement must be met before January 1, 2025.**

BENEFIT PLANS

- Anthem Medical EPO, PPO, and HDHP
- Guardian Dental DHMO and PPO
- EyeMed Vision
- Reliance Standard Basic Life/AD&D, Long-Term Disability, Voluntary Long-Term Disability (Buy-Up), and Voluntary Life/AD&D
- MetLife Business Travel Accident
- HealthEquity Flexible Spending Account (FSA) and Health Savings Account (HSA)
- MetLife Voluntary Accident & Critical Illness and Voluntary Legal Plans
- Pet Benefits Solutions Pet Care Plan
- ACI Specialty Benefits Employee Assistance Plan (EAP)
- Fidelity Investments 401(k)

This is an **active enrollment**, meaning you are required to take action and enroll in your benefits in order to continue coverage. You are required to re-elect your contribution amounts each year to participate in the Flexible Spending Account (FSA) Plans and Health Savings Account (HSA) plans.



Spousal & Domestic Partner Surcharge

Employees must pay an additional cost to cover a spouse/registered domestic partner who has the option to elect health care coverage through their employer. The additional cost, or surcharge, to the employee will be $35 per month. If the situation below applies to you, you will want to consider how the additional cost may impact your coverage choice. Please contact Tower Semiconductor Benefits Service Center at 877-284-5077 for additional information.

To help you determine if the surcharge applies to your situation, consider the following scenarios:

YES SURCHARGE:

- If your spouse/registered domestic partner is working at an employer who offers group health insurance, but has declined that coverage and wants to remain or enroll on the Tower Semiconductor health plan.

NO SURCHARGE:

- If you and your spouse/registered domestic partner are BOTH employed at Tower Semiconductor. In addition, you are both covered on the Tower Semiconductor health plan under either you or your spouse's or registered domestic partner's coverage.
- If your spouse/registered domestic partner is not actively working or is retired.
- If your spouse/registered domestic partner is self-employed.
- If your spouse/registered domestic partner is a part-time employee and has NO access to health coverage.
- If your spouse/registered domestic partner has insurance available through their own employer, but the employer makes NO contribution toward the cost of the insurance

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit and provide supporting documentation within 30 days of the qualified life event.

Change in status examples include:

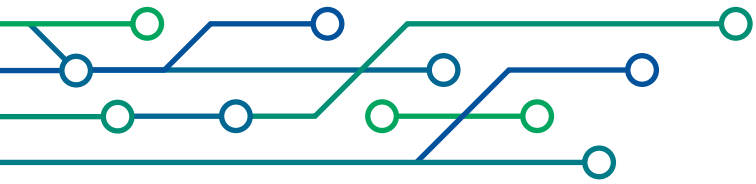
- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's/registered domestic partner's loss or gain of coverage through our organization or another employer.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents.

Waive-Out Provision

Employees may elect to "Waive" medical, dental and vision coverage if you have access to coverage through a spouse/registered domestic partner or through another plan. To waive coverage, select the no coverage option on the Tower Semiconductor Benefits Center website or paper enrollment forms, whichever you use. Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

Please note that if you waive coverage, the next opportunity to enroll in your benefits will be January 1, 2026 or when a qualifying status change occurs.



Paying for Coverage

Tower Semiconductor strives to provide you with a valuable benefits package at a reasonable cost. Based on your benefit selections and coverage level, you may be required to pay for a portion of the cost. Employee cost or cost sharing amounts for benefits can be found on a separate document titled Benefit Rates & Deductions. Human Resources will determine and approve whether retroactive benefit premiums are due dependent upon: 1) when your benefit changes are received and 2) the timing of when payroll processes. Retro benefit premiums will be communicated to the employee and submitted to payroll accordingly.

How do I Enroll?

TOWER SEMICONDUCTOR
BENEFITS SERVICE CENTER

To enroll, simply follow these steps: Log on at ***benefits.plansource.com***. Your password will reset before Open Enrollment.

Enter your user name

- First time User:
  - Your first name initial
  - Up to six characters of your last name
  - Last four digits of your SSN
  - **Example:** Sally Smith 111-11-1234; SSmith1234

Enter your password

- First time user:
  - Your date of birth, YYYYMMDD
  - **Example:** DOB May 22, 1982; 19820522
  - Click the **"Log In"** button
- Click **"Enroll in Benefits – Open"** and follow the series of steps, clicking "Continue" after each step, being sure you add or remove any dependents during the process
- After clicking **"Continue"**, you will be presented with your enrollment screen where you can make elections for each benefit and the system will automatically cover eligible dependents based on the coverage level you select
- Once you have completed your enrollment in all benefits, click **"Confirm"** at the bottom of the main enrollment page; a confirmation message and email will be sent to you if you have an email address on file
- If you have questions regarding the on-line enrollment or if you want to enroll by phone, please call 877-284-5077. Benefit Service Center is provided by PlanSource.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates. To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit ***cciio.cms.gov***. You can also visit ***coveredca.com*** to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical, dental, and/or vision coverage if you have access to coverage through another plan. To waive coverage, you must do so by calling or going to the Tower Semiconductor Benefits Service Center website. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2026 or if a qualifying status change occurs.

Medical ID Cards

Once you enroll, Collective Health will send ID cards for you and your enrolled dependents within 2-3 weeks. If you need immediate services before you receive your card, please contact Collective Health, for Anthem members, at 833-440-1639 or the Benefits Service Center through PlanSource at 877-284-5077.

Medical Coverage

What are my Options?

Use the chart below to help compare medical plan options and determine which plan is best for you and your family. Kaiser HMO is not open for new enrollment unless you and/or your dependents are currently enrolled in the plan.

	EPO	PPO/HDHP
	Anthem	Anthem
Required to select and use a Primary Care Physician (PCP)	**No**	**No**
Seeing a Specialist	No referral required	No referral required
Deductible Required	**No**	**Yes**
Finding a Provider	To find an in-network provider, go to the Collective Health website join.collectivehealth.com/TowerSemiconductor and click on the "Get Care" link, or contact the Member Advocate team at 833-440-1639 or by signing into Collective Health to send a Message.	
Claims Process	– EPO/PPO/HDHP in-network providers will submit claims – You submit claims for other services	
Other Important Tips	– EPO requires that you see an in-network doctor – PPO/HDHP allows you to choose in or out of network care, however in-network care provides you a higher level of benefit – Emergencies covered in or out of network and worldwide – The HDHP account provides a tax-favored vehicle to help you manage your out-of-pocket expenses in and out of network – Although the PPO/HDHP plan has a higher deductible than most plans, it requires lower payroll deductions	

Please note: the above examples are used for general illustrative purposes only. Please consult with Collective Health for more specific information as it relates to your specific plan.

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Regardless of the plan you have, you may save money by filling prescription requests at participating pharmacies. Additional important information regarding your prescription drug coverage is outlined below:

- **Tiered prescription drug plans** require varying levels of payment depending on the drug's tier. Your copayment or coinsurance will be higher with a higher tier number
- **The Kaiser plan** has 2 tiers with Tier 1 covering generic formulary medications and Tier 2 covering brand-name formulary drugs
- **The Anthem plans** have 3 tiers with Tier 1 covering generic formulary medications, Tier 2 covering brand-name formulary drugs, Tier 3 covering non-formulary medications
- **Mail Order:** save time and money by utilizing a mail order service for maintenance medications. A 100-day supply of your medication will be shipped to you, instead of a typical 30-day supply at a walk-in pharmacy

Prudent RX

PrudentRx has collaborated with CVS Caremark® to offer a third-party (manufacturer) copay assistance program that may help save you money when you fill your prescription through CVS Specialty®.

PrudentRx + RxBenefits®

HOW IT WORKS

If you are enrolled in the Anthem plans, we will work with you to obtain third-party copay assistance for your medication, if available.* Once you are enrolled, you will pay nothing out-of-pocket – that's right, $0! – for medications on your plan's specialty drug list dispensed by CVS Specialty.

PrudentRx can answer any questions you may have from 5 a.m. to 5 p.m. PST, Monday through Friday. You may contact PrudentRx at 888-203-1768.

*Some manufacturers require you to sign up to take advantage of the copay assistance that they provide for their medications – in that case, you must call PrudentRx to participate in the copay assistance for that medication. PrudentRx will also contact you if you are required to enroll in the copay assistance for any medication that you take. If you do not return their call, choose to opt-out of the program, or if you do not affirmatively enroll in any copay assistance as required by a manufacturer, you will be responsible for 30 percent of the cost of your specialty medications.

Tria Health

Tria Health is available for Anthem medical plan members who take multiple medications or have a chronic condition. Many times, chronic conditions are managed with medications. Tria Health offers the ability to have confidential consultations with pharmacists to ensure your medications are working the way they are supposed to work; in order to keep you healthy and active.

WHO PARTICIPATES?

Individuals who take multiple or specialty medications and have one or more chronic conditions, such as:

- Diabetes
- Heart disease
- High cholesterol
- Respiratory illness
- Pain
- Osteoporosis
- High blood pressure

WHAT'S IN IT FOR ME?

It is FREE and no risk! Tria Health is part of your Anthem benefit plan. If you qualify, you will receive an enrollment packet in the mail and will qualify for **FREE GENERICS AND HALF OFF BRAND** medications.

HOW DO I GET STARTED?

Members can complete the online enrollment form at any time at ***triahealth.com/enroll***. In addition, you may call Tria Health at 888-799-8742 for assistance in completing your enrollment form.

WHAT CAN I EXPECT?

After enrolling, you will schedule your first one-on-one telephonic consultation. During your appointment, you and your Tria pharmacist will review your medications, evaluate how well they work to treat the current condition(s) and make recommendations. After your appointment, you will receive a summary of the care plan discussed. The same information will be shared with your physician.

Medical services covered in full

The federal Health Care Reform law now requires insurance companies to cover preventive care services in full; saving you money and helping you maintain your health. Preventive services may include annual check-ups, well-baby and child visits and certain immunizations and screenings.

To confirm that your preventive care services are covered, refer to your plan documents.

Plan Highlights

High Deductible Health Plan

Anthem	In-Network	Out-of Network
Annual Deductible		
Individual / Family *(Aggregate)*	$1,650 / $4,500	$3,300 / $9,900
Annual Out-of-pocket Maximum		
Individual / Family *(Aggregate)*	$3,000 / $9,000	$6,000 / $18,000 *
Lifetime Maximum	Unlimited	Unlimited
Professional Services		
Primary Care Physician *(PCP)*	20% AD	50% AD
Specialist Care *(SPC)*	20% AD	50% AD
LiveHealth Online	$55 / visit **	Not covered
Preventive Care Exam	No charge **	50% AD
Well-baby Care	No charge **	50% AD
Diagnostic Lab and X-Ray	20% AD	50% AD
Complex Diagnostics *(MRI/CT Scan)*	20% AD	50% AD
Therapy, including Physical, Occupational, and Speech *(up to 35 visits per year)*	20% AD	50% AD
Hospital Services		
Inpatient	20% AD	50% AD
Outpatient Surgery	20% AD	50% AD
CVS Minute Clinic Urgent Care	20% AD	Not covered
Urgent Care	20% AD	50% AD
Emergency Room	20% AD	20% AD
Maternity Care		
Physician Services *(Prenatal)*	20% AD	50% AD
Hospital Services	20% AD	50% AD
Mental Health and Substance Abuse		
Inpatient	20% AD	50% AD
Outpatient	20% AD	50% AD
Retail Prescription Drugs (30-day Supply)		
Preventive	$0 **	Copay + 50% AD
Generic / Formulary Brand / Non-Formulary Brand	$10 / $25 / $40 AD	Copay + 50% AD
PrudentRx Specialty	$10 / $25 / $40 AD	Not covered
Mail Order Prescription Drugs (90-day Supply)		
Preventive	$0 **	Copay + 50% AD
Generic / Formulary Brand / Non-Formulary Brand	$20 / $50 / $80 AD	Not covered

AD: After Deductible

** Deductible Waived

* Out-of-pocket maximum based on the maximum allowable charge Anthem allows; this does not include any balance billing that may occur when using an Out of Network Provider.

The above information is a summary only. Please refer to your Summary Plan Description for complete details of Plan benefits, limitations and exclusions.

Plan Highlights

EPO Plan

Anthem	In-Network Only
Annual Deductible	
Individual / Family	None
Annual Out-of-pocket Maximum	
Individual / Family	$2,500 / $7,500
Lifetime Maximum	Unlimited
Professional Services	
Primary Care Physician *(PCP)*	$30 / visit
Specialist Care *(SPC)*	$40 / visit
LiveHealth Online	$10 / visit
Preventive Care Exam	No charge
Well-baby Care	No charge
Diagnostic Lab	No charge
Diagnostic X-Ray	$25 copay
Diagnostic X-Ray *(Complex Imaging)*	$75 copay
Therapy, including Physical, Occupational, and Speech *(up to 35 visits per year)*	$40 / visit
Hospital Services	
Inpatient	$750 / admission
Outpatient Surgery	$300 / procedure
CVS Minute Clinic Urgent Care	$30 / visit
Urgent Care	$50 / visit
Emergency Room *(waived if admitted)*	$250 / visit
Maternity Care	
Physician Services *(Prenatal)*	$40 / visit
Hospital Services	$500 / admission
Mental Health and Substance Abuse	
Inpatient	$750 / admission
Outpatient	$40 / visit
Retail Prescription Drugs (30-day Supply)	
Preventive	$0
Generic / Formulary Brand / Non-Formulary Brand	$10 / $30 / $50
Specialty	CVS Specialty: 30%
PrudentRx Specialty	$0
Mail Order Prescription Drugs (90-day Supply)	
Preventive	$0
Generic / Formulary Brand / Non-Formulary Brand	$20 / $60 / $100

The above information is a summary only. Please refer to your Summary Plan Description for complete details of Plan benefits, limitations and exclusions.

Plan Highlights

PPO Plan

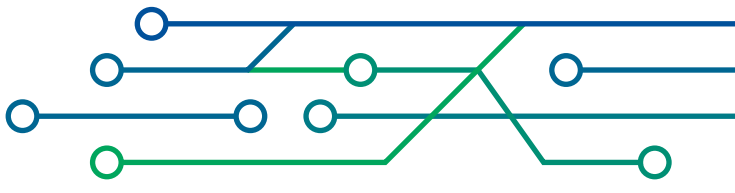
Anthem	In-Network	Out-of Network
Annual Deductible		
Individual / Family	$1,000 / $3,000	$2,000 / $6,000
Annual Out-of-pocket Maximum		
Individual / Family	$3,500 / $10,500	$10,500 / $31,500 *
Lifetime Maximum	Unlimited	Unlimited
Professional Services		
Primary Care Physician *(PCP)*	$30 / visit **	30% AD
Specialist Care *(SPC)*	$60 / visit **	30% AD
LiveHealth Online	$10 / visit **	Not covered
Preventive Care Exam	No charge **	30% AD
Well-baby Care	No charge **	30% AD
Diagnostic Lab and X-Ray	10% AD	30% AD
Complex Diagnostics *(MRI/CT Scan)*	10% AD	30% AD
Therapy, including Physical, Occupational, and Speech *(up to 35 visits per year)*	$60 / visit **	30% AD
Hospital Services		
Inpatient	10% AD	30% AD
Outpatient Surgery	10% AD	30% AD
CVS Minute Clinic Urgent Care	$20 / visit **	Not covered
Urgent Care	$50 / visit **	30% AD
Emergency Room *(copay waived if admitted)*	$150 / visit + 10% AD	$150 / visit + 10% AD
Maternity Care		
Physician Services *(Prenatal)*	$60 / visit **	30% AD
Hospital Services	10% AD	30% AD
Mental Health and Substance Abuse		
Inpatient	10% AD	30% AD
Outpatient	$60 / visit **	30% AD
Retail Prescription Drugs (30-day Supply)		
Preventive	$0 **	30% *(up to $250)*
Generic / Formulary Brand / Non-Formulary Brand	$20 / $40 / $70	30% *(up to $250)*
Specialty	CVS Specialty: 30%	Not covered
PrudentRx Specialty	$0	Not covered
Mail Order Prescription Drugs (90-day Supply)		
Preventive	$0 **	30% AD *(up to $250)*
Generic / Formulary Brand / Non-Formulary Brand	$40 / $80 / $140	Not covered

AD: After Deductible

* Out-of-pocket maximum based on the maximum allowable charge Anthem allows; this does not include any balance billing that may occur when using an Out of Network Provider.

** Deductible Waived

The above information is a summary only. Please refer to your Summary Plan Description for complete details of Plan benefits, limitations and exclusions.



Health Savings Account (HSA)

What is a Health Savings Account?

By enrolling in the Anthem Blue Cross High Deductible Health Plan (HDHP), you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

WHAT ARE THE BENEFITS?

Administered by HealthEquity, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no "Use it or Lose it" provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.

HOW DO I QUALIFY FOR AN HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under Tower Semiconductor's HDHP.
- You are not enrolled in non-qualified health insurance outside of Tower Semiconductor's HDHP.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA).

For those who enroll in the High Deductible Health Plan

For 2025, Tower Semiconductor will contribute $500 to your Health Savings Account (HSA), designed to support your healthcare expenses. This contribution is prorated based on hire date and distributed evenly every paycheck, ensuring consistent financial support throughout the year.

What to know about your HSA

1. YOU OWN YOUR HSA
2. YOUR MONEY ROLLS OVER YEAR AFTER YEAR
3. YOU CHOOSE HOW MUCH TO CONTRIBUTE
4. PAIRED WITH A HIGH DEDUCTIBLE HEALTH PLAN
5. YOU RECEIVE A TRIPLE TAX ADVANTAGE

A FEW RULES YOU NEED TO KNOW:

- For 2025, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,300 if you are enrolled in the HSA-PPO for employee-only coverage, and $8,550 for employees with dependent coverage.
- If you are enrolled in a high deductible health plan (HDHP) that is HSA-eligible, and you are at least 55 years old — or will turn 55 any time in the calendar year — you can make an additional $1,000 contribution to an HSA.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit ***healthequity.com***.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.

How do I manage my HSA?

- The most convenient way to pay for qualified expenses is to utilize the debit card.
- You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account.
- It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS.
- View the status of your claims and check your HSA balance at ***healthequity.com***.

- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care, or Medicare). However, you may be covered by a Limited Purpose FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a pro-rata portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1st of the first year and continues to be eligible to contribute to an HSA until December 31st of the following year (i.e., for the entire subsequent year).

Anthem Live Health Online

The convenience of an old-fashioned house call with the speed of modern technology

LiveHealth Online offers a great new way to see a doctor without having to go to the doctor. You can simply use a computer and visit a doctor via two-way video or secure instant messaging. Here's a quick guide to show you how it works.

GETTING STARTED IS EASY

Your health plan allows you to see a doctor online anytime for the following copays:

- $10 – EPO
- $10 – PPO
- 20% coinsurance – HDHP ($55 if you have not met your deductible)

Just enroll for free at ***livehealthonline.com***, set up a personal account and choose a doctor.

SET UP AN ACCOUNT

When you first set up an account, you will fill out a health summary that the doctor can review each time you request a visit. This health summary is confidentially stored in your account and is available for future visits. **All you have to do is:**

1. Go to ***livehealthonline.com*** and click the **"Enroll First"** link. Only enrolled users will have the option to select from a list of insurance plans to cover the cost of an online visit. Or, call LiveHealth Online at 1-844-784-8409 from 7 a.m. to 11 p.m., 24/7.
2. Answer a brief set up questions to create your profile. Choose a secure password so you can get to LiveHealth Online from any computer at any time.
3. Log in by clicking the **"Sign In"** link at the top right corner of the main page. From there, your home page will show all of your options.

USE IT RIGHT NOW

If you are ready to use LiveHealth Online right now:

1. Click the green **"Talk Now"** button and connect to a doctor.
2. Answer a few questions before you see the doctor.
3. You'll have an opportunity to enroll and save this information for future use once your conversation is complete.

PRESCRIBING MEDICINE

If your doctor is eligible to prescribe in your state and you've chosen a preferred pharmacy, LiveHealth Online may allow the doctor to prescribe medications during your session. If so, you'll see a notice in the chat window, and the prescription will appear in the **"Provider Entries"** tab.

DURING YOUR APPOINTMENT, YOU CAN SEE THE NOTES YOUR DOCTOR IS MAKING

Click on the **"Provider Entries"** tab while you're in your session and you'll see what your doctor is noting, including diagnoses, instructions and follow-up items.

WRAPPING UP YOUR SESSION

After your visit ends, all of this will be captured in a conversation summary report so you can look at it whenever you need to. If you've enrolled, this will be available in **"My History"** under the **"My Health"** menu. If you haven't enrolled, you may choose to email a conversation summary to yourself.

TIP

You can print or email copies of your conversation report – so even your doctors who aren't on LiveHealth Online can have a record. Also, if you see another doctor on LiveHealth Online, these reports can give them a better understanding of your history.

Anthem Case Management

We are here to help manage your care!

Managing illness can sometimes be a difficult thing to do. Knowing who to contact, what test results mean, or how to get needed resources can be a bigger piece of a healthcare puzzle that for some, are frightening and complex issues to handle.

Anthem Blue Cross is available to offer assistance in these difficult moments with our Case Management Program. Our Case Managers are part of an interdisciplinary team of clinicians and other resource professionals that are there to support members, families, primary care physicians and caregivers. The case management process utilizes experience and expertise of the care coordination team whose goal is to educate and empower our members to increase self-management skills, understand their illness, and learn about care choices in order to access quality, efficient health care.

Members or caregivers can refer themselves or family members by calling the number located below. They will be transferred to a team member based on the immediate need. Physicians can also refer by contacting us telephonically or through electronic means. No issue is too big or too small. We can help with transitions across level of care so that patients and caregivers are better prepared and informed about healthcare decisions and goals.

Case managers will stay in contact, with regular follow-ups and automated phone messages. There are even times when they'll send a health professional to the home, to coordinate care, community resources, the member's home environment — or to help transition home from a hospital stay.

HERE'S HOW IT WORKS

Registered nurse case managers reach out to you directly to assess your needs and help you:

1. Find out more about your health issue and treatment options.
2. Make sure your doctors and care team are talking and working together effectively.
3. Understand your health plan better, so you can get the most value from it.
4. Connect with resources in your area, like home care services and community health programs.
5. Make healthy lifestyle changes.

How do I get in contact with the Anthem Case Management Program?

By Phone: 833-440-1639

Anthem Tools and Programs

Anthem Resources

24/7 NURSELINE

Anytime, toll-free access to highly experienced nurse coaches for answers to general health questions and guidance with critical health concerns.

CONDITIONCARE

Nurse coaches help members with chronic conditions to better manage and improve their health. Conditions include; Asthma, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease, and Heart Failure.

BUILDING HEALTHY FAMILIES (BHF)

An intuitive digital experience providing members access to pre-pregnancy, maternity, and post-partum care as well as parenting support.

CVS Vaccination Program

Anthem members can receive a flu shot for a $0 copay at any of the 63,000+ pharmacies in CVS' national network. Members will need to present their medical ID card and a valid photo ID to the pharmacist in order to receive the flu shot. Members who are not enrolled on the Anthem plans will not receive the pharmacy benefit.

To locate a participating CVS pharmacy:

1. Sign into your Collective Health member portal.
2. Select **"Get Care"** from the top tabs.
3. Input Pharmacy and Zip Code.

CVS MinuteClinic Program

Kaiser members are eligible to receive in-person urgent care services at a CVS MinuteClinic locations while traveling outside of states where Kaiser Permanente operates. Members will only have to pay their normal copay. After the visit, they will be charged for any additional part of the cost they may owe. Anthem members are eligible to receive in-person urgent care services at any CVS MinuteClinic, regardless of location.

If Kaiser members receive urgent care services at a CVS MinuteClinic location within a state where Kaiser Permanente operates (even if the CVS MinuteClinic is outside of a Kaiser Permanente service area) or within their home region, they will be asked to pay upfront for services. Then, they can submit a request for reimbursement as outlined by their plan rules.

The clinics are staffed by non-Kaiser Permanente nurse practitioners and physician assistants who can treat a range of simple urgent care services for conditions and symptoms such as the flu, ear infections, sinus infections, indigestion, and minor wounds and abrasions.

Kaiser members can call 951-268-3900 from anywhere in the world to find out how to get care while traveling.

Anthem members can call Collective Health Member Advocates at 833-440-1639 to find out how to get care while traveling.

Lyra Behavioral Health Services

Who is Eligible?

Lyra is available to all Anthem members and their dependents, including children ages 2 and older. **Members will have access to 12 sessions at no cost to you.**

What Lyra Provides

Lyra offers support for feeling overwhelmed, stuck, having relationship issues, and other complex concerns like stress, anxiety, and depression. Members will receive care through various methods including:

- Access to personalized recommendations for top coaches and therapists
- Meeting with a coach via live video or live messaging or meet with a therapist via live video, phone, or in-person
- 12 coaching or therapy sessions for employees, dependents, and spouses at no cost to you
- Access to continued care and medication management support after free therapy sessions end (subject to in-network cost sharing) for Health Plan members, dependents, and spouses
- Scheduling appointments online at ***towersemi.lyrahealth.com*** or call 877-255-4941 to get started.

How can I continue to work with my current provider?

If you are currently seeing a provider, and are interested in learning if your sessions could be covered under the Lyra benefit, you can invite your provider to apply to join Lyra at ***lyrahealth.com/apply-now***. If your provider chooses to apply, Lyra will evaluate their approach to short-term, evidence-based therapy and see if they meet other criteria to become a Lyra provider.

No matter what you're dealing with, Lyra can help

Confidential care from the best quality providers, so you can feel better faster. **How Lyra works:**

1

GETTING STARTED IS EASY

Share what you're dealing with, get care recommendations, and book an appointment. Lyra members waste less time looking for care and spend more time feeling better.

2

THE BEST COACHES AND THERAPISTS NATIONWIDE

Lyra providers are ready to meet you where you are — via live video, live messaging, or even in-person. Many use digital lessons and exercises to enhance your care experience between sessions.

3

HIGH-QUALITY CARE THAT WORKS

Lyra is dedicated to offering the best care possible and supporting only treatments that are the most effective at relieving symptoms, typically within a short period of time.

4

TAP INTO ADDITIONAL WORK-LIFE SERVICES

Receive expert advice to help you stay on top of your busy life, including legal, financial, identity theft, and dependent care services.

Benefits Information On the Go

Collective Health

With the Collective Health app, you can:

- Check your plan details
- Find claims
- Find doctors in your network
- Get questions answered
- Have your cards on you, always

DOWNLOAD FROM THE APP STORE

DOWNLOAD FROM GOOGLE PLAY

Anthem LiveHealth Online!

With Anthem LiveHealth Online, you can:

- Access an online doctor visit using two-way video and secure instant messaging
- Receive care for colds, the flu, allergies, and minor infections
- Avoid scheduling an appointment or sitting in waiting rooms
- Save yourself time and money
- Access registered physicians 24 / 7 / 365

Get started now at ***livehealthonline.com***!

DOWNLOAD FROM THE APP STORE

DOWNLOAD FROM GOOGLE PLAY

Reimbursement Preferences

How to set up your reimbursement preferences

When using out-of-network services, you can choose to receive reimbursement via direct deposit or check. Follow this guide to set up your preferences in My Collective™. Please note that you will need to register to receive reimbursement, regardless of your payment preference.

Get started by accessing your account at *my.collectivehealth.com.*

1. Click the person icon in the upper right corner of the Home page
2. Select **"Payment Method"** from the menu. Note that payment settings are only available in the desktop or browser version of My Collective.
3. Edit your street address if needed, then click **Next**
4. Select the **Direct Deposit / ACH** payment method, enter your banking information, then click **Next**, or select the **Check** payment method, review the payment information, then click **Next**.
5. Click the **X** in the upper right corner of the pop-up.

WHAT HAPPENS TO MY FINANCIAL INFORMATION?

The banking information you provide while setting up direct deposit is stored by a third party payment platform called Tipalti. This information is not stored with Collective Health. Tipalti's Privacy Policy can be found on the second page of the registration process.

WHEN DO THESE CHANGES GO INTO EFFECT?

If you just set up your payment preference for the first time, you are all set! The changes go into effect immediately for all of your claims. Note that if you updated your preference and had a claim in **Payment Approved**, **Payment Processing**, or **Paid** status before you made the change, the reimbursement for that claim may come to you based on your previous setting.

Collective Health

Not seeing the Payment Method option?

Only plan subscribers can change payment settings and set up direct deposit because reimbursement funds are sent to the plan subscriber only.

MORE QUESTIONS?
Contact the Collective Health Member Advocate team by phone, chat, or secure message.

LEARN ABOUT YOUR REIMBURSEMENT OPTIONS FOR OUT-OF-NETWORK CLAIMS

Dental Coverage

The Dental HMO Plan and the Dental PPO Plan

You and your eligible dependents will have the option to enroll in a Dental Health Maintenance Organization (HMO) plan or a Dental Preferred Provider Organization (PPO) plan offered by Guardian through Collective Health. We encourage you to review the coverage details and select the option that best suits your needs.

Using your Plan

In order to receive benefits while enrolled in the Dental HMO plan, you and your enrolled eligible dependents must obtain services from a primary care dentist who participates in the Guardian dental network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself.

Please Note: You are required to select a Primary Dentist to access coverage.

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind; you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

Plan Highlights	HMO Plan	PPO Plan	
Guardian	In-Network Only	In-Network	Out-of Network
Annual Deductible	None	$50 Individual / $150 Family	$50 Individual / $150 Family
Annual Maximum	Unlimited	$1,200	$1,200
Preventive Services	No charge	100% covered	100% covered
Basic Services	Copays vary	80% covered	50% covered
Major Services	Copays vary	50% covered	50% covered
Orthodontic Services Lifetime Maximum	$1,850 copay (Adult & Child)	50% covered up to $1,200 (Child Only)	50% covered up to $1,200 (Child Only)

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Find your favorite dentist

To find an in-network dentist, use the "Get Care" link on Collective Health website, or contact the Member Advocate team at 844-803-0211 or by signing into Collective Health to send a Message.

Vision Coverage

The Vision PPO Plan

Vision coverage is offered by EyeMed as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. Any questions pertaining to your vision coverage can be directed to Collective Health by calling 833-440-1639 or visiting ***join.collectivehealth.com/towersemiconductor***.

Five tips for superior vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

1. Eat lots of leafy greens and dark berries
2. Get regular eye exams
3. Give your eyes a rest from the computer screen
4. Wear sunglasses to protect your eyes from bright light
5. Wear safety eyewear whenever necessary

Freedom Pass

Your EyeMed vision plan includes the Freedom Pass! With this benefit, members may purchase any frame, any brand at any price at Target Optical for no out-of-pocket cost.

Plan Highlights — Vision PPO Plan

eyemed	In-Network	Out-of Network
Eye Exam - every 12 months	100% after $10 copay	Up to $42 reimbursement
Lenses - every 12 months		
Single	100% after $20 copay	Up to $35 reimbursement
Bifocal	100% after $20 copay	Up to $49 reimbursement
Trifocal	100% after $20 copay	Up to $74 reimbursement
Frames - every 24 months	$130 allowance + 20% off balance	Up to $60 reimbursement
Contacts - every 12 months*		
Exam	Up to $40 (standard)	N/A
Elective	$120 allowance + 15% off balance	Up to $96 reimbursement

* In lieu of Lenses & Frames

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Life Insurance

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Basic Life and AD&D Insurance

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Paid for in full by Tower Semiconductor, the benefits outlined below are provided by Reliance Standard:

- Basic Life Insurance of 2x annual earnings up to $1,250,000
- AD&D of 2x annual earnings up to $1,250,000
- Guaranteed Issue Limit is $750,000

You will be required to submit Evidence of Insurability (EOI) for any amounts over $750,000; a Health questionnaire or additional information may be required by Reliance Standard and excess coverage amount is subject to underwriting review and approval.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Age Reduction Schedule: At age 65, reduces by 35%; at age 70 by 55%; at age 75 by 70%; at age 80 by 80%

Required! Are your Beneficiaries up to date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated
- To select or change your beneficiary, visit ***benefits.plansource.com*** or call 877-284-5077

Voluntary Life and AD&D Insurance

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase through Reliance Standard. Employee coverage is required for spouse and dependent coverage.

- **For employees:** Increments of $10,000 up to 5x annual earnings up to a $1,250,000 maximum
- **For your spouse:** $10,000 increments, up to 100% of the employee elections
- **For your child(ren) to age 26:** $5,000 to $25,000 (increments of $5,000)
- **Age Reduction Schedule:** At age 65, reduces by 35%; at age 70 by 55%; at age 75 by 70%; at age 80 by 80%
- **Optional AD&D:** No requirements for a medical questionnaire and coverage is available for purchase in the same amounts as voluntary life insurance amounts above. This plan is unbundled and can be elected separately from Voluntary Life without submitting Evidence of Insurability.
- **Spouse AD&D coverage:** 40% of employee coverage amount OR 50% of employee coverage amount (if no children are enrolled).
- **Child/ren AD&D coverage:** 10% of employee coverage amount OR 15% of employee coverage amount (if no spouse is enrolled).

Cost of Voluntary Life

Age	Monthly Rate per $1,000
Under 25	$0.053
25-29	$0.063
30-34	$0.084
35-39	$0.095
40-44	$0.160
45-49	$0.239
50-54	$0.372
55-59	$0.554
60-64	$0.752
65-69	$1.347
70+	$2.421
Child(ren)	$0.200

Spouse's rate is based on employee's age.

Cost of Voluntary AD&D

	Monthly Rate per $1,000
Single	$0.025
Family	$0.036

If you do not elect optional life insurance when you are first eligible, you will be required to submit an EOI to Reliance Standard. An EOI will also be required if you wish to become insured for an amount greater than $500,000 or if you wish to insure a dependent spouse for an amount greater than $50,000.

The EOI must be submitted to Reliance Standard within 60 days of the plan election; otherwise, your application for excess coverage will be closed.

Disability Insurance

Long-Term Disability

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

COVERAGE DETAILS

If your disability extends beyond 180 days, the LTD coverage through Reliance Standard can replace 60% of your earnings, up to maximum of $5,000 per month. Your benefits may continue to be paid until you reach 65 as long as you meet the definition of disability. If disability occurs at or after age 62, benefits will be paid according to the benefit schedule. This benefit is offered to you at no cost.

TAX CONSIDERATIONS

The premium cost for Long-Term Disability Insurance is paid 100% by Tower Semiconductor.
When employer paid LTD coverage is provided on a pre-tax basis, there is no income tax paid on the premium. Any benefit received under the plan will be subject to federal income tax.

Post and Pre-Tax Terms

Pre-tax: By paying for your disability coverage on a pre-tax basis, you will pay income taxes on any LTD benefits you receive. In effect, you are reducing your taxable income and will not have income taxes withheld on the portion of your income used to pay your disability insurance.

After-tax: If you pay your disability coverage on an after-tax basis, you will not have to pay income taxes on any LTD benefits you receive.

Please note: Consult your tax advisor for additional taxation information or advice.

Disability facts and figures

- One in every 7 people will become disabled for five years or more in their lifetime
- 30% of people use disability coverage
- Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability

Source: ***affordableinsuranceprotection.com/disability_facts***

Flexible Spending Accounts

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care & dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

HEALTH CARE FSA

- Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance
- Maximum contribution is $3,200 (2025 maximums have not been released)
- You cannot enroll on this plan if you are enrolled in the HDHP plan

LIMITED PURPOSE FSA

- Option for employees enrolled in a Health Savings Account (HSA) eligible plan
- Use this FSA to reimburse for eligible dental and vision expenses
- Maximum contribution is $3,200 (2025 maximums have not been released)

DEPENDENT CARE FSA

- Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves
- Maximum contribution for 2025 is $5,000

Visit *irs.gov/pub/irs-pdf/p502.pdf* for a complete list of FSA eligible expenses.

WHAT ARE THE BENEFITS?

Your taxable income is reduced and your spendable income increases! Save money while keeping you and your family healthy.

HOW TO ACCESS YOUR FLEXIBLE SPENDING ACCOUNT ONLINE

You must enroll in the FSA program through the Benefit Center within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, to view your account balance, report a lost or stolen card as well as submit a claim, first you must access your account using the HealthEquity portal.

1. Navigate to the member portal at ***myhealthequity.com***.
2. **Click 'Create user name and password'** located under the message **'Are you a member logging in for the first time?'**
3. Enter the **verification code** that appears on the screen.
4. Enter your personal information (first name, last name, zip code and birth date) and **click 'Next.'**
5. Enter the **last four digits of your social security number** and the **last four digits of your debit card number**.
   - » After entering the card number correctly, you can set up your account username and password.
   - » Otherwise, leave that field blank and click **'Next.'**
6. **Enter a phone number** for verification, select **'Text Me'** or **'Call Me'** and then click **'Next.'**
   - » You will **receive a call or text with a temporary password**. Enter the password and click **'Next.'**
7. After entering the passcode correctly, you can set up your account username and password
8. **If you cannot verify your phone number**, click 'I don't have a phone.' A popup message will appear stating that additional questions are required. Click 'Answer questions.'
9. **You will be asked a few questions** (usually three or four) on subjects such as: Vehicle ownership history, Education history, or Job History

Upon the creation of your FSA, you will receive a member welcome kit that includes a HealthEquity FSA debit card. Card activation instructions are included with the card.

CARRYOVER FUNDS FROM YOUR 2025 HEALTHCARE OR LIMITED PURPOSE FSA TO 2026

Tower Semiconductor will offer employees the ability to carryover up to $640 from your 2025 Healthcare or Limited Purpose Flexible Spending Account to the 2026 plan year. We have outlined what this means to FSA participants below:

- While the Plan Year runs from January 1 to December 31, 2025, Tower Semiconductor allows employees to carryover up to $640 of any unused funds to pay for eligible expense in the following year.
- If you have not had the opportunity to incur expenses during the plan year, this provision allows you additional time to incur expenses, up to the amount of your carryover.
- The plan will allow a "run-out period" from January 1, 2025 through March 31, 2026, allowing you to seek reimbursement for expenses 3 months after the plan year ends for expenses incurred through December 31, 2025.
- The amount of your carryover from 2025 will not affect your annual maximum allowed contribution to your 2026 FSA.
- Remember, any remaining amounts above $640 that are not submitted for expenses incurred between January 1, 2025 and December 31, 2025 to Health Equity by the end of the "run-out period" March 31, 2026 will be forfeited.
- To receive a rollover amount for Health Care and Limited Purpose FSA, you must actively re-enroll for 2026 with a contribution of at least $100.
- IRS does not allow rollover for Dependent Care FSA.

Any questions?

Be sure to contact Collective Health at 833-440-1639 or ***my.collectivehealth.com***.

HOW TO SUBMIT A CLAIM ONLINE

1. Navigate to the member portal at ***myhealthequity.com***.
2. Select **'Request Reimbursement'** from the **'Claims & Payments'** tab.
3. Indicate that you would like to **'Enter claim record and send payment'** and click **'Next.'**
4. Select **'Reimburse Me'** and click **'Next.'**
5. Choose whether you will be paying a **new expense or an existing claim**.
   - » Clicking **'New'** will allow you to enter specific claim details such as patient and date(s) of service.
6. The following screen will allow you to specify the amount you would like to be reimbursed and how you would like to be reimbursed.
   - » To set up recurring reimbursements, in the **'Reimbursement Amount'** section, select **'Scheduled Payments.'** You can specify the number of reimbursements, the amount of each reimbursement and the dates you would like them to be sent.
7. Click **'Next'** and review payment details.
8. Check the box to authorize payment before clicking **'Finish.'**

Please keep in mind that all FSA payments require an itemized receipt or an insurance explanation of benefits to substantiate the claim. You may be required to provide this documentation to HealthEquity.

For assistance submitting claims online, to access your account, or for assistance in adding your EFT, please contact HealthEquity member services at 877-472-8632, or login to ***myhealthequity.com***. You may also contact Collective Health at 833-440-1639.

RECEIVING REIMBURSEMENTS

You will have until March 31, 2026 to submit a reimbursement request for claims incurred between January 1 and December 31, 2025. If you do not receive automatic reimbursement by using your debit card, you can submit a manual reimbursement request by:

- **Fax:** 801-999-7829
- **Mail:** HealthEquity, Attn: Reimbursement Accounts 15 W Scenic Pointe Dr, Suite 100 Draper, UT 84020

Employee Assistance Program

Employee Assistance Program (EAP)

Tower Semiconductor understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

WHO CAN USE THE PROGRAM

All employees, dependents of employees, and members of your household.

TOPICS MAY INCLUDE

- Childcare
- Eldercare
- Legal services
- Identity theft
- Marital, relationship or family problems
- Bereavement or grief counseling
- Substance abuse and recovery
- Financial support
- Consumer information

NUMBER OF SESSIONS

3 face-to-face sessions per year per member per incident

How to access the EAP

By Phone: 855-775-4357
Online: *rsli.acieap.com*

Supplemental Insurance

Voluntary Accident Plan

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! The MetLife policy may pay cash to help families offset the expenses associated with accidents or injuries. Employees will have a choice of selecting coverage between two options: High Plan or Low Plan. Benefits are based on a flat schedule amount (not reimbursement) that varies depending on the plan. If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, contact Tower Semiconductor Benefit Center (provided by Plan Source).

MetLife	Low Plan	High Plan
Injuries	**Plan pays you**	**Plan pays you**
Fractures	$50 - $3,000	$100 - $6,000
Dislocations	$50 - $3,000	$100 - $6,000
Second & Third Degree Burns	$50 - $5,000	$100 - $10,000
Concussions	$200	$400
Cuts/Lacerations	$25 - $200	$50 - $400
Eye Injuries	$200	$300
Medical Services & Treatments	**Plan pays you**	**Plan pays you**
Ambulance	$200 - $750	$300 - $1,000
Emergency Care	$25 - $50	$50 - $100
Non-Emergency Care	$25	$50
Physician Follow-up	$50	$75
Therapy Services (including Physical Therapy)	$15	$25
Medical Testing Benefit	$100	$200
Medical Appliances	$50 - $500	$100 - $1,000
Inpatient Surgery	$100 - $1,000	$200 - $2,000
Hospital Coverage (Accident)	**Plan pays you**	**Plan pays you**
Admission	$500 - $1,000	$1,000 - $2,000
Confinement		
Non-ICU (up to 365 days)	$100 / day	$200 / day
ICU (up to 30 days)	$200 / day	$400 / day
Inpatient Rehab (paid per Accident)	$100 / day up to 15 days	$200 / day up to 15 days
Accidental Death	**Plan pays you**	**Plan pays you**
Employee receives 100% of amount shown, **Spouse** receives 50% of amount shown, and **Child(ren)** receive 20% of amount shown	$25,000 $75,000 for common carrier	$50,000 $150,000 for common carrier

Voluntary Critical Illness Plan

Offered by MetLife, critical illness coverage is generally paid in the form of a one-time, lump sum payment, dependent on the illness. This will help reduce expenses associated with life-threating diseases.

Guaranteed Issue will be available in the amounts of $15,000 or $30,000 for employees. Spouses/registered domestic partners and/or children will be offered 100% of the employee benefit amount. You will be permitted to enroll and provided either/or of this coverage amount regardless of health status, age, gender or other factors.

Receive a $50 or $100 Wellness Credit per calendar year per individual if a health screening test is performed, depending on the benefit amount elected. In addition, if a covered person undergoes a covered mammogram, the plan would pay a $200 benefit.

* Visit PlanSource for the full Benefit Summary.

MetLife

Eligible Individual	Initial Benefit	Requirements
Employee	$15,000 or $30,000	Coverage is guaranteed provided you are actively at work
Spouse / Domestic Partner	100% of the Employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate
Dependent Child(ren)	100% of the Employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth on the enrollment form and in the Certificate

MetLife Legal Plans

Offered by MetLife, MetLife Legal Plans provide convenient access to legal services at an affordable cost through a nationwide network of more than 14,000 attorneys, or from an out-of-network attorney. MetLife Legal Plans provide easy, direct access to a national network of attorneys who provide telephone advice and office consultations on an unlimited number of personal legal matters and fully covered services for the most frequently needed personal legal matters (excluding employment issues).

Please note the MetLife Legal Plan now includes up to 4 hours of non-covered Legal services including contested Divorce or DUI.

Examples of covered legal services include:

- Preparation of wills and trusts
- Real estate matters
- Debt matters, including identity theft defense
- Consumer Protection
- Document preparation and review
- Traffic and juvenile matters
- Family law, including adoptions

MetLife

1

EASY TO FIND AN ATTORNEY

Visit ***members.legalplans.com*** to learn more about your plan. Search for an attorney based on your ZIP code and filters such as attorney experience, specialty, or minority, veteran, or LGBTQ-owned. Or call the Client Service Center to speak with an experienced representative that can match you with the right attorney.

2

EASY TO MAKE AN APPOINTMENT

Call the attorney directly after searching on the MetLife website. Meet with an attorney in person or over the phone. Or call the Client Service Center at 800-821-6400 and MetLife will schedule your appointment directly with the attorney.

3

EASY FROM START TO FINISH

That's it! There are no limits on the number of times you can use the benefit. And no copays, deductibles, or claim forms when you use a network attorney for a covered matter.

Pet Insurance

Pet Benefit Solutions Discount Plan

For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too! Our Pet Discount Benefit, offered by Pet Benefit Solutions, covers dogs, cats, birds and some other exotic animals.

PET ASSURE VETERINARY DISCOUNT PLAN

Pet Assure Veterinary Discount Plan will save you hundreds on your pets' healthcare care every year by giving you access to quality veterinary care at a discounted rate. Pet Assure Members receive an instant 25% discount on all in-house medical services at participating veterinarians, including savings on wellness, sick and emergency care.

Members save on:

- Vaccinations
- Spay & Neuter
- Dental Procedures
- Emergency Visits
- Surgeries
- And More!

How to enroll

1. Enrollments should be completed through ***benefits.plansource.com***
2. Once you enroll in PlanSource, go to ***petbenefits.com/land/towersemiconductor*** to search for veterinarians in your area
3. Pet Benefit Solutions contact information:

   Phone: 800-891-2656

   Website: ***petbenefits.com***

There are no exclusions based on type, breed, age or health of your pets. All pets are eligible for Pet Assure, and even pre-existing and hereditary conditions are covered. Pet Assure can be used as an alternative or complement to pet insurance. Pet Assure also includes a 24/7 Lost Pet Recovery Service. **$8.00/month** for one pet or **$11.00/month** for an unlimited number of pets.

PETPLUS PRESCRIPTION DISCOUNT PLAN

PetPlus Prescription Savings Plan will save you money on the products your pets are already using. You will receive wholesale prices on brand name prescriptions, preventatives and more. Enroll any dog or cat. There are no exclusions. Shipping is always free, and most prescriptions are available over 60,000 Caremark pharmacies nationwide, like CVS, Walgreen, Walmart or Target. **With PetPlus you will save on:**

- Prescriptions
- Preventatives
- Dietary Foods
- Supplements
- And More!

There are no exclusions. You can enroll any dog or cat. PetPlus guarantees savings on the products that your pets are already using. Members should download the PetPlus app which makes reordering prescriptions even faster and easier. PetPlus also includes a 24/7 Pet Help Line powered by whiskerDocs which gives members access to US-based veterinarians any time, day or night. **$3.75/month** for one dog or cat or **$7.50/month** for all of the dogs and cats in your home.

Travel Insurance

Travel Assistance

Through your group coverage with Reliance Standard, you automatically receive travel assistance services provided by **On Call International (On Call)**. On Call is a 24-hour, 365 days a year, toll-free service that provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. **On Call** also offers pre-trip assistance including passport/visa requirements, foreign currency and weather information. The following is an outline of the **On Call** emergency travel assistance service program.

COVERED SERVICES

When traveling more than 100 miles from home or in a foreign country, **On Call** offers you and your dependents the following services:

PRE-TRIP ASSISTANCE

- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

EMERGENCY PERSONAL SERVICES

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/ personal possessions
- Legal assistance and/or bail bond

EMERGENCY MEDICAL TRANSPORTATION

- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

MEDICAL SERVICES INCLUDE

- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglasses replacement
- Convalescence arrangements

HOW IT WORKS

At any time before or during the trip, you may contact **On Call** for emergency assistance services. It is recommended that you keep a copy of this summary with your travel documents.

To reach On Call via international calling: Go to ***att.com/esupport/traveler.jsp?group=tips*** for complete dialing instructions.

It is recommended that you do this prior to departing the US, find the access code from the country you will be visiting.

Within the US: 800-456-3893
Outside the US, call collect: 603-328-1966

MetLife Business Travel Accident Insurance

All employees traveling on company business are automatically provided 24/7 coverage, in the event of death or disability due to an accident or injury. Coverage is provided through **MetLife**. Each employee is insured for $100,000. There is no paperwork or online enrollment required to enroll in this plan. This policy pays, in addition to any other group individual life or disability insurance the employee may have.

General Information: 800.638.5433
Claim Information: 800.638.6420
Plan #146044 | ***metlife.com***

401(k) Program

Tower Semiconductor offers a 401(k) Savings Program that allows you to put aside a bit of your paycheck to save for retirement. Employees will be able to contribute 1%-60% of regular hours worked, up to the IRS limits. Tower offers an employer match to your contribution in the amount equal to 50% of your deferral subject to a maximum of $850. Employees will achieve full vestment of the match after 3 years of service.

Fidelity Investments is the recordkeeper of your Plan. To enroll, make changes to investments, or perform transactions, please use the contact information below:

- Phone number: 1-800-835-5097
- Website: ***401k.com***
- Plan Number: 48455

Directory & Resources

Below, please find important contact information and resources for Tower Semiconductor.

Benefit	Contact	Phone	Website	More Info
Enroll in Plan Administration *Medical, Dental, HSA, & FSA*	Collective Health Member Advocate Team	833-440-1639	join.collectivehealth.com/ TowerSemiconductor	M-F: 4am – 6pm PST SAT: 7am – 11am PST
Online & Phone Enrollment **Dependent Audit Verification**	Plan Source	877-284-5077	benefits.plansource.com	
Anthem Medical Plans *EPO, PPO & HDHP*	Collective Health	833-440-1639	my.collectivehealth.com	
Kaiser Permanente *HMO - CA Only*	Collective Health	833-440-1639	my.collectivehealth.com kp.org	Group #231139
Pharmacy Plan *Anthem Plan Members Only*	Collective Health	833-440-1639	my.collectivehealth.com	
Pharmacy Plan	Prudent Rx	888-203-1768	my.collectivehealth.com	
Pharmacy Plan	Tria Health	888-799-8742		
Guardian Dental Plans *DHMO & DPPO*	Collective Health	833-440-1639	my.collectivehealth.com	
Eyemed Vision Plan *PPO*	Collective Health	833-440-1639	my.collectivehealth.com	
HealthEquity **Health Savings Account** (HSA)	Collective Health	833-440-1639	my.collectivehealth.com	
HealthEquity **Flexible Spending Account** (FSA)				

Benefit	Contact	Phone	Website	More Info
Basic & Voluntary Life Plans	Reliance Standard	800-351-7500	reliancestandard.com	Policy # GL153147
Basic & Voluntary AD&D Plans				Policy # VAR206340
Long-Term Disability Plan				Policy # LTD125957
Lyra Behavioral Health	Lyra	877-255-4914	towersemi.lyrahealth.com	
Accident & Critical Illness Plans	MetLife	800-438-6388	metlife.com/mybenefits	Policy # 0096860
Legal Plans		800-821-6400	legalplans.com	Password: LEGAL
Employee Assistance Plan	ACI Specialty Benefits	855-775-4357	rsli.acieap.com	
Pet Insurance Plans	Pet Benefit Solutions	800-891-2565	petbenefits.com/land/towersemiconductor	

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

This guide describes the benefit plans and policies available to you as an employee of Tower Semiconductor. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant only to cover the major points of each plan or policy. It does not contain all the details that are included in your Summary Plan Descriptions (as required by ERISA) found in your other employee benefit materials. If there is ever a question about one of these plans and policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.

Note: The benefits highlighted and described in this guide may be changed at any time and do not represent a contractual obligation – either implied or expressed – on the part of Tower Semiconductor.

Annual Notices

Tower Semiconductor Health and Welfare Benefits Annual Notice Packet

January 1, 2025

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- Medicare Part D Creditable Coverage Notice
- HIPAA Special Enrollment Rights Notice
- HIPAA Notice of Privacy Practices
- Children's Health Insurance Program (CHIP) Notice
- Women's Health and Cancer Rights Act (WHCRA) Notice
- Newborns' Mothers Health Protection Act (NMHPA) Notice
- General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us at ***benefits.us@towersemi.com***.

Medicare Part D Creditable Coverage Notice

Important Notice from Tower Semiconductor About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tower Semiconductor and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Tower Semiconductor has determined that the prescription drug coverage offered by Tower Semiconductor is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Tower Semiconductor coverage as an active employee, please note that your Tower Semiconductor coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Tower Semiconductor coverage as a former employee.

You may also choose to drop your Tower Semiconductor coverage. If you do decide to join a Medicare drug plan and drop your current Tower Semiconductor coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Tower Semiconductor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Tower Semiconductor changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit ***medicare.gov***
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at ***socialsecurity.gov***, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

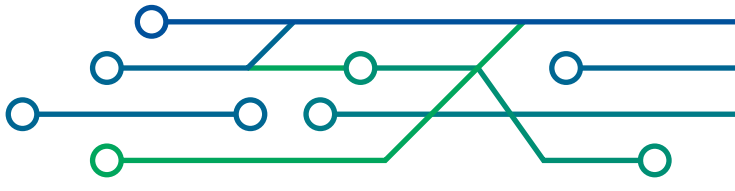
Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Name of Entity/Sender: Tower Semiconductor

Contact—Position/Office:
Isis Diaz Linares / Alyssa Yan

Phone Number: 210-522-7777

Email: ***benefits.us@towersemi.com***



Medicare Part D Non-Creditable Coverage Notice

Important Notice from Tower Semiconductor About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Tower Semiconductor and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Tower Semiconductor has determined that the prescription drug coverage offered by the Anthem Blue Cross is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Anthem Blue Cross. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Anthem's HDHP plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Tower Semiconductor since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under Anthem HDHP Plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Tower Semiconductor's coverage as an active employee, please note that your coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Tower Semiconductor's coverage as a former employee.

You may also choose to drop your Tower Semiconductor coverage. If you do decide to join a Medicare drug plan and drop your current Tower Semiconductor coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under Anthem HDHP plan is not creditable, you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information or contact ***benefits.us@towersemi.com***. NOTE: You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Tower Semiconductor's changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit ***medicare.gov***
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at ***socialsecurity.gov***, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Name of Entity/Sender: Tower Semiconductor

Contact—Position/Office:
Isis Diaz Linares / Alyssa Yan

Address: 4321 Jamboree Rd,
Newport Beach, CA 92660

Phone Number: 210-522-7777

Email: ***benefits.us@towersemi.com***

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Tower Semiconductor group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Tower Semiconductor sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Tower Semiconductor, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. Your past, present or future physical or mental health or condition;
2. The provision of health care to you; or
3. The past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Tower Semiconductor, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact Tower Semiconductor:

Name of Entity/Sender: Tower Semiconductor

Contact—Position/Office:
Isis Diaz Linares / Alyssa Yan

Address: 4321 Jamboree Rd,
Newport Beach, CA 92660

Phone Number: 210-522-7777

Email: ***benefits.us@towersemi.com***

Effective Date
This Notice as revised is effective January 1, 2025.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

– ***Organ and Tissue Donation***

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

– ***Military and Veterans***

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

– ***Workers' Compensation***

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

– ***Public Health Risks***

We may disclose your protected health information for public health actions. These actions generally include the following:

» to prevent or control disease, injury, or disability;

» to report births and deaths;

» to report child abuse or neglect;

» to report reactions to medications or problems with products;

» to notify people of recalls of products they may be using;

» to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

» to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

– ***Health Oversight Activities***

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

– ***Lawsuits and Disputes***

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

– ***Law Enforcement***

We may disclose your protected health information if asked to do so by a law enforcement official:

» in response to a court order, subpoena, warrant, summons or similar process;

» to identify or locate a suspect, fugitive, material witness, or missing person;

» about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;

» about a death that we believe may be the result of criminal conduct;

» about criminal conduct; and

» in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

– ***Coroners, Medical Examiners and Funeral Directors***

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

– ***National Security and Intelligence Activities***

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

– ***Inmates***

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

– ***Research***

We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

– ***Government Audits***

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

– ***Disclosures to You***

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

– ***Notification of a Breach***

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

OTHER DISCLOSURES

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

- ***Right to Inspect and Copy***

  You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

- ***Right to Amend***

  If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - » is not part of the medical information kept by or for the Plan;
  - » was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - » is not part of the information that you would be permitted to inspect and copy; or
  - » is already accurate and complete.

  If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

– ***Right to an Accounting of Disclosures***

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

– ***Right to Request Restrictions***

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

– ***Right to Request Confidential Communications***

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

– ***Right to a Paper Copy of This Notice***

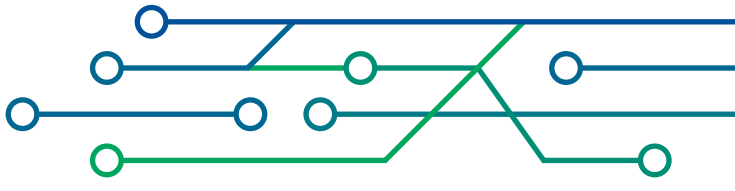
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see *Your Rights Under HIPAA*.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting ***hhs.gov/ocr/privacy/hipaa/complaints/***.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.



Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit ***healthcare.gov***.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or ***insurekidsnow.gov*** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled.

This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at ***askebsa.dol.gov*** or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums.

The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility:

ALABAMA – Medicaid

Website: *myalhipp.com*

Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program

Website: *myakhipp.com/*

Phone: 1-866-251-4861

Email: *CustomerService@MyAKHIPP.com*

Medicaid Eligibility: *health.alaska.gov/dpa/Pages/default.aspx*

ARIZONA – Medicaid

Website: *AZAHCCCS.gov/*

Phone: 602-417-4000

Toll Free: 1-800-654-8713

ARKANSAS – Medicaid

Website: *myarhipp.com*

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: *dhcs.ca.gov/hipp*

Phone: 916-445-8322

Fax: 916-440-5676

Email: *hipp@dhcs.ca.gov*

COLORADO – Health First Colorado (Colorado's Medicaid Program) **& Child Health Plan Plus** (CHP+)

Health First Colorado Website: *healthfirstcolorado.com*

Health First Colorado Member Contact Center: 1-800-221-3943 / **State Relay** 711

CHP+: *hcpf.colorado.gov/child-health-plan-plus*

CHP+ Customer Service: 1-800-359-1991 / **State Relay:** 711

Health Insurance Buy-In Program (HIBI): *mycohibi.com*

HIBI Customer Service: 1-855-692-6442

CONNECTICUT – Medicaid

Website: *portal.ct.gov/oha/health-care-plans/other-plans/medicaid*

Department of Social Services: 1-800-842-2159

HUSKY Website: *portal.ct.gov/husky*

HUSKY/Children's Health InfoLine: 1-800-434-7869

DELAWARE – Medicaid

Website: *dhss.delaware.gov/dmma*

Email: *MedicaidInfo@delaware.gov*

Customer Relations: 866-843-7212

Health Benefits Manager: 1-800-996-9969

FLORIDA – Medicaid

Website: *flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html*

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: *medicaid.georgia.gov/health-insurance-premium-payment-program-hipp*

Phone: 678-564-1162, *Press 1*

GA CHIPRA Website: *medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra*

Phone: 678-564-1162, *Press 2*

HAWAII – Medicaid

Website: *medquest.hawaii.gov*

Phone: 1-800-316-8005

IDAHO – Medicaid

Website: *healthandwelfare.idaho.gov/services-programs/medicaid-health*

Phone: 888-528-5861

ILLINOIS – Medicaid

Website: *abe.illinois.gov/abe/access*

Phone: 1-800-843-6154

INDIANA – Medicaid

Health Insurance Premium Payment Program: *in.gov/fssa/dfr*

Medicaid Website: *in.gov/medicaid*

Family and Social Services Administration
Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Iowa Medicaid: *hhs.iowa.gov/programs/welcome-iowa-medicaid*

Iowa Medicaid Phone: 1-800-338-8366

Health and Well Kids in Iowa (HAWKI)
Website: *hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki*

HAWKI Phone: 1-800-257-8563

Health Insurance Premium Payment (HIPP)
Website: *hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp*

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: *kancare.ks.gov*

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: *chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx*

Phone: 1-855-459-6328

Email: *KIHIPP.PROGRAM@ky.gov*

KCHIP Website: *kynect.ky.gov*

Phone: 1-877-524-4718

Kentucky Medicaid Website: *chfs.ky.gov/agencies/dms*

LOUISIANA – Medicaid

Website: *medicaid.la.gov* or *ldh.la.gov/lahipp*

Phone: 1-888-342-6207 *(Medicaid hotline)*
or 1-855-618-5488 *(LaHIPP)*

MAINE – Medicaid

Enrollment Website:
mymaineconnection.gov/benefits

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:
maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740

TTY: Maine relay 711

MARYLAND – Medicaid

Website: *marylandhealthconnection.gov/how-to-enroll/medicaid*

Website: *health.maryland.gov/mmcp/Pages/home.aspx*

Phone: 1-855-642-8572

MASSACHUSETTS – Medicaid and CHIP

Website: *mass.gov/masshealth/pa*

Phone: 1-800-862-4840

TTY: 711

Email: *masspremassistance@accenture.com*

MICHIGAN – Medicaid

Website: *michigan.gov/medicaid*

Phone: 1-800-803-7174

MINNESOTA – Medicaid

Website: *mn.gov/dhs/health-care-coverage*

Phone: 1-800-657-3672

MISSISSIPPI – Medicaid

Website: *medicaid.ms.gov*

Toll-free: 800-421-2408

Phone: 601-359-6050

MISSOURI – Medicaid

Website: *dss.mo.gov/mhd/participants/pages/hipp.htm*

Phone: 573-751-2005

MONTANA – Medicaid

Website: *dphhs.mt.gov/MontanaHealthcarePrograms/HIPP*

Phone: 1-800-694-3084

Email: *HHSHIPPProgram@mt.gov*

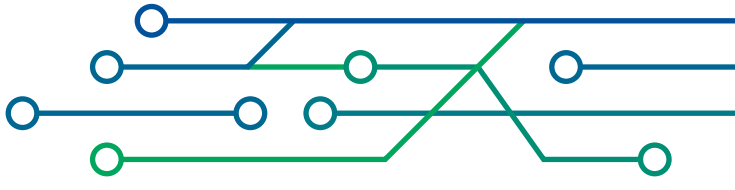
NEBRASKA – Medicaid

Website: *ACCESSNebraska.ne.gov*

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178



NEVADA – Medicaid

Medicaid Website: *dhcfp.nv.gov*

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: *dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program*

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: *DHHS.ThirdPartyLiabi@dhhs.nh.gov*

NEW JERSEY – Medicaid and CHIP

Medicaid Website: *state.nj.us/humanservices/dmahs/clients/medicaid/*

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: *njfamilycare.org/index.html*

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW MEXICO – Medicaid

Website: *yes.state.nm.us*

Phone: 1-800-283-4465

NEW YORK – Medicaid

Website: *health.ny.gov/health_care/medicaid*

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: *medicaid.ncdhhs.gov*

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: *hhs.nd.gov/healthcare*

Phone: 1-844-854-4825

OHIO – Medicaid

Website: *medicaid.ohio.gov*

Phone: 1-800-324-8680

OKLAHOMA – Medicaid and CHIP

Website: *insureoklahoma.org*

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: *healthcare.oregon.gov/Pages/index.aspx*

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: *pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html*

Phone: 1-800-692-7462

Children's Health Insurance Program (CHIP) Website: *dhs.pa.gov/CHIP/Pages/CHIP.aspx*

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: *eohhs.ri.gov/*

Phone: 1-855-697-4347, or 401-462-0311 *(Direct RIte Share Line)*

SOUTH CAROLINA – Medicaid

Website: *scdhhs.gov*

Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: *dss.sd.gov*

Phone: 1-888-828-0059

TENNESSEE – Medicaid

Website: *tenncareconnect.tn.gov*

Phone: 1-855-259-0701

TEXAS – Medicaid

Website: *hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program*

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: *medicaid.utah.gov/upp*

Email: *upp@utah.gov*

Phone: 1-888-222-2542

Adult Expansion Website: *medicaid.utah.gov/expansion*

Utah Medicaid Buyout Program Website: *medicaid.utah.gov/buyout-program*

CHIP Website: *chip.utah.gov*

VERMONT– Medicaid

Health Insurance Premium Payment Program Website: *dvha.vermont.gov/members/medicaid/hipp-program*

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: *dmas.virginia.gov*

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: *hca.wa.gov*

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: *dhhr.wv.gov/bms*

Website: *mywvhipp.com*

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: *dhs.wisconsin.gov/badgercareplus/p-10095.htm*

Phone: 1-800-362-3002

WYOMING – Medicaid

Website: *health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility*

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
1-877-267-2323, *Menu Option 4, Ext. 61565*

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your plan administrator at benefits.us@towersemi.com.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: *benefits.us@towersemi.com*.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of COBRA continuation coverage***

  If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

– ***Second qualifying event extension of 18-month period of continuation coverage***

  If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at ***healthcare.gov***.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

– The month after your employment ends; or
– The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage.

However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit ***medicare.gov/medicare-and-you***.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit ***dol.gov/agencies/ebsa***. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit ***healthcare.gov***.

Keep your Plan informed of address changes

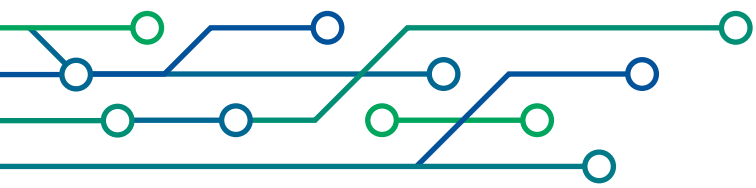
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity/Sender: Tower Semiconductor
Contact—Position/Office:
Isis Diaz Linares / Alyssa Yan
Address: 4321 Jamboree Rd,
Newport Beach, CA 92660
Phone Number: (210) 522-7777
Email: ***benefits.us@towersemi.com***

[1] ***https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start***. These rules are different for people with End Stage Renal Disease (ESRD).

Notes



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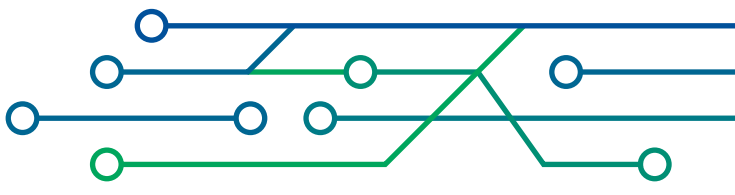


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