Tower Semiconductor

2026 Non-Union 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 2026 Benefits Administration and Annual Enrollment activity, the Tower Semiconductor Benefits Center can be contacted online or by phone. Contact details are on page 40 of this booklet. The Tower Semiconductor Benefits Service Center is provided by PlanSource.

BENEFIT PLANS FOR 2026

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 2026.

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. This year, you will have access to IMA Rx that assists with pharmacy savings for specialty medications.

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 continue to 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 , Hospital Indemnity, and Accident will be offered through Reliance Standard. A MetLife legal plan provides 4 hours of non-covered Legal services. Pet Benefit Solutions will continue to be the pet discount plan for 2026, and a new pet insurance option will now be available through Pet Partners.

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 2026 and will require re-election.

Table of Contents

Welcome to the 2026 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 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, vision, Health Savings Account (HSA) and Flexible Spending Account (FSA) to create a single point of contact for you. 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 PlanSource, 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 2026. Employees will have until January 31, 2026 to submit proof of registered domestic partnership to PlanSource, or they will be terminated from the plans retroactive to January 1, 2026.

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, 2026 through December 31, 2026. Benefits for eligible new hires will commence as follows:

ELIGIBILITY DATE

Your coverage is effective on your **date of hire** and must be actively at work to enroll. You must enroll within 30 days from your hire date.

BENEFIT PLANS

- **Anthem Medical EPO, PPO, and HDHP**
- **Guardian Dental DHMO and PPO**
- **EyeMed Vision**
- **HealthEquity Flexible Spending Account (FSA) and Health Savings Account (HSA)**
- **Reliance Standard Basic Life/AD&D, Long-Term Disability, Voluntary Long-Term Disability (Buy-Up), and Voluntary Life/ AD&D**
- **Reliance Standard Voluntary Accident, Hospital Indemnity, & Critical Illness**
- **MetLife Business Travel Accident**
- **MetLife Voluntary Legal Plans**
- **Pet Benefits Solutions Pet Care Plan**
- **Pet Partners Pet Insurance 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 $50 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 Plansource, 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 annual 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 Plansource Tower Semiconductor Benefits Center website or paper enrollment forms, whichever you use.

Please note that if you waive coverage, the next opportunity to enroll in your benefits will be next year's annual open enrollment 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 in this benefit guide. 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?

PLANSOURCE - 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.

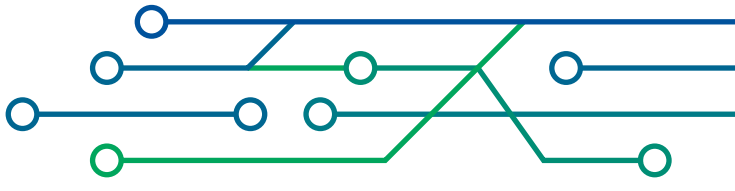
Do I Have to Enroll?

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.

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.



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	**Yes**	**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 + RxBenefits®

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®.

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®

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.

PHARMACY
ADVOCATES PROGRAM

IMA Rx is a *FREE* program to you and your family members, available through your employer.

Get enrolled today and start receiving eligible medications delivered to your home at a $0.00 copay through this program benefit.

Eligible medications include specialty and high-cost brand named medications that are covered through your employers' primary prescription insurance plan.

PHARMACY PROGRAM THAT SAVES YOU TIME AND MONEY

Once enrolled, IMA Pharmacy Advocates Program provides the following services free:

+ Specialty Medication Assistance
+ High-cost Brand Name Medication Assistance
+ Pharmacy Related Questions
+ Managing Medication Adherence
+ Provider Office/Patient Liaison

Participation Matters

By participating in this new pharmacy benefit, this saves you and the health plan time & money - which translates into more stable premiums over time.

Protecting private health information

IMA Rx is separate from your employer and will not share any of your personal health information.

CALL TODAY!

IMA Rx (IMA Pharmacy Advocate Program) is here to answer questions and provide further assistance with enrollment completion.

Feel free to reach out to your trusted pharmacy advocate representative.

By phone: 866.530.9989 | or email: *imarx@imacorp.com*

This material is for general information only and should not be considered as a substitute for legal, medical, tax and/or actuarial advice. Contact the appropriate professional counsel for such matters. These materials are not exhaustive and are subject to possible changes in applicable laws, rules, and regulations and their interpretations.
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IMACORP.COM

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)*	$1,700 / $4,500	$3,400 / $10,200
Annual Out-of-pocket Maximum		
Individual / Family	$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	$10 / 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	$500 / $1,500
Annual Out-of-pocket Maximum	
Individual / Family	$3,500 / $10,500
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	$20 / $40 / $60
Specialty	CVS Specialty: 30%
PrudentRx Specialty	30%
Mail Order Prescription Drugs (90-day Supply)	
Preventive	$0
Generic / Formulary Brand / Non-Formulary Brand	$40 / $80 / $120

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

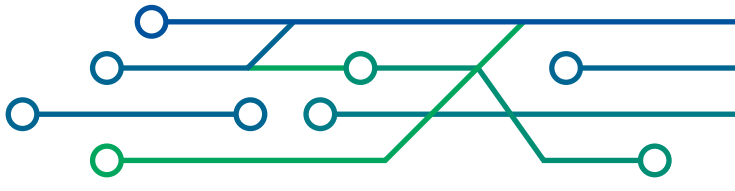
Anthem	In-Network	Out-of Network
Annual Deductible		
Individual / Family	$1,500 / $4,500	$3,000 / $9,000
Annual Out-of-pocket Maximum		
Individual / Family	$5,000 / $15,000	$15,000 / $45,000 *
Lifetime Maximum	Unlimited	Unlimited
Professional Services		
Primary Care Physician *(PCP)*	$30 / visit **	30% 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	30%	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 2026, 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. You must elect into the HSA in PlanSource with a minimum $0 employee contribution to receive the employer contribution.

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 2026, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,400 if you are enrolled in the High Deductible Health Plan for employee-only coverage, and $8,750 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.
- 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).

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.

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
- $10 – HDHP

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 on the Dental HMO plan 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	$2,000	$2,000
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 $1,500 (Child Only)	50% covered up to $1,500 (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

Plan Highlights — Vision PPO Plan

EyeMed	In-Network	Out-of Network
Eye Exam - every 12 months	100% after $20 copay	Up to $35 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.

How to find a provider:

1. Go to ***Eyemed.com/en-us*** and select Find an Eye doctor
2. Select "Insight Network" in the Network menu and enter your location

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 1x 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

Elimination Period	
Newport Beach, CA	180 days

If your disability extends beyond the elimination period, Long-Term Disability coverage through Reliance Standard can replace 60% of your earnings, up to maximum of $10,000 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 ("Base Plan") is offered to you at no cost.

You have an option of buying-up to an increased benefit that pays 66 2/3% of your earnings, up to maximum of $20,000 per month.

You may be insured under either Plan I or Plan II but not both. You will automatically be insured under Plan I unless you elect Plan II. If you cease paying premium for Plan II, you will be automatically insured under Plan I.

TAX CONSIDERATIONS

Base Plan (Plan I) premium cost for Long Term Disability Insurance is paid 100% by Tower Semiconductor. Employees are given the option of buying-up to an increase benefit Buy-Up Plan (Plan II). Premiums for Plan II are paid by the employee on an after tax basis and calculated based on the employee's covered monthly earnings (CME).

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: By paying 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**

Contributory Long Term Disability

Contributory Long Term Disability Insurance

COVERAGE
Disability income protection insurance provides a benefit for "long term" disability resulting from a covered injury or sickness. Benefits begin at the end of the elimination period and continue while you are disabled up to the maximum benefit duration.

ELIGIBILITY
Active full-time Employee working 20 hours or more per week in the State of Texas.

BENEFIT AMOUNT
Core: 60% of covered earnings to a maximum benefit of $10,000 per month
Buy-Up: 66.67 % of covered earnings to a maximum benefit of $20,000 per month

CONTRIBUTION REQUIREMENTS
Core: Coverage is 100% employer paid.
Buy-Up: Coverage is 100% employee paid.

RATES
See attached Rate Sheet.

FEATURES
- Extended Disability Benefit
- FMLA Continuation
- Minimum Benefit Payable - $100
- Own Occupation Coverage - 24 months
- Residual and Partial Disability
- Specific Indemnity Benefit
- Survivor Benefit - 3 months
- Work Incentive & Child Care provisions

LIMITATIONS
- Mental/Nervous Illness Limitation - 24 month out -patient
- Offsets (such as, but not limited to, Social Security, Workers Compensation, State Disability Plans)
- Pre-Existing Condition Limitation - 3/12
- Substance Abuse Limitation - 24 months Please note- pre-ex limitations also apply to benefit increases

VALUE ADDED SERVICES
- Travel Assistance Service
- Employee Assistance Program

ELIMINATION PERIOD
90 consecutive days of total disability

MAXIMUM BENEFIT DURATION
Benefits will not extend beyond the longer of: Social Security Normal Retirement Age or Duration of Benefits below:

Age at Disablement	Duration of Benefits
61 or less	to age 65
62	3 ½ years
63	3 years
64	2 ½ years
65	2 years
66	1 ¾ years
67	1 ½ years
68	1 ¼ years
69 or more	1 year

EXCLUSIONS
Benefits will not be payable for any disability caused by: an intentionally self-inflicted injury; an act of war (declared or undeclared); commission of a felony; injury or sickness occurring while confined in any penal or correctional institution. For a comprehensive list of exclusions, limitations, and any applicable benefit offsets, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits. This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6564, et al.

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 for Max is $3,400
- 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 for Max is $3,400

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 2026 is $7,500

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 2026 HEALTHCARE OR LIMITED PURPOSE FSA TO 2027

Tower Semiconductor will offer employees the ability to carryover up to $680 from your 2026 Healthcare or Limited Purpose Flexible Spending Account to the 2027 plan year. We have outlined what this means to FSA participants below:

- While the Plan Year runs from January 1 to December 31, 2026, Tower Semiconductor allows employees to carryover up to $680 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, 2026 through March 31, 2027, allowing you to seek reimbursement for expenses 3 months after the plan year ends for expenses incurred through December 31, 2026.
- The amount of your carryover from 2026 will not affect your annual maximum allowed contribution to your 2027 FSA.
- Remember, any remaining amounts above $680 that are not submitted for expenses incurred between January 1, 2026 and December 31, 2026 to Health Equity by the end of the "run-out period" March 31, 2027 will be forfeited.
- To receive a rollover amount for Health Care and Limited Purpose FSA, you must actively re-enroll for 2027 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.'**

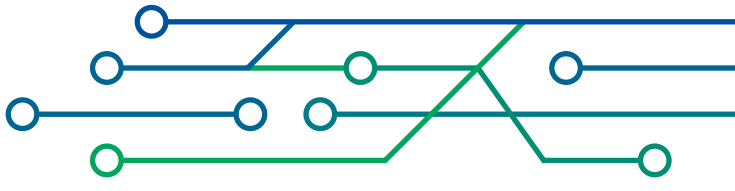
Please keep in mind that all FSA payments require an itemized receipt or an insurance explanation of benefits to substantiate the claim. You may be required to provide this documentation to HealthEquity.

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, 2027 to submit a reimbursement request for claims incurred between January 1 and December 31, 2026. 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, telephonic, or video counseling 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 Reliance Standard 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).

RELIANCE STANDARD A MEMBER OF THE TOKIO MARINE GROUP	Low Plan	High Plan
Injuries	**Plan pays you**	**Plan pays you**
Fractures	$50 - $5,000	$100 - $10,000
Dislocations	$100 - $3,200	$200 - $6,400
Second & Third Degree Burns	$100 - $6,400	$175 - $11,200
Concussions	$200	$400
Cuts/Lacerations	$12.50 - $200	$25 - $400
Eye Injuries	$100 - $200	$150 - $300
Medical Services & Treatments	**Plan pays you**	**Plan pays you**
Ambulance	$200 - $1,000	$300 - $1,500
Emergency Care	$75	$112.50
Non-Emergency Care	$75	$75
Physician Follow-up (6 maximum)	$50	$75
Therapy Services (including Physical Therapy)	$25	$25
Medical Testing Benefit	$50	$75
Medical Appliances	$500	$1,000
Inpatient Surgery	$300 - $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 30 days	$200 / day up to 30 days
Accidental Death	**Plan pays you**	**Plan pays you**
Employee receives 100% of amount shown,	$25,000	$50,000
Spouse receives 50% of amount shown, and	$12,500	$25,000
Child(ren) receive 20% of amount shown	$5,000	$10,000

Voluntary Critical Illness Plan

Offered by Reliance Standard, 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 $50 benefit.

* Visit PlanSource for the full Benefit Summary.

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Eligible Individual	Initial Benefit	Requirements
Employee	Increments of $15,000 up to $30,000	Coverage is guaranteed provided you are actively at work
Spouse / Domestic Partner	Increments of $5,000 up to $30,000, not to exceed 100% of employee amount	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

Voluntary Hospital Indemnity Plan

Offered by Reliance Standard, Hospital indemnity coverage supplements your existing health insurance coverage by helping pay expenses for hospital stays. This coverage gives you cash payments to help pay for the added expenses that may come while you recover.

Eligible employees can enroll for themselves, their spouses, and child dependents (birth to age 26). Children beyond 26 who are incapable of self support may also be enrolled in this coverage. Please note: Employee must be insured under the policy for dependent spouse and/or children to be insured. A person may not have coverage as both an employee and a dependent.

Payout examples:

- Hospital Confinement - First Day Benefit (maximum once per year): $1,000
- Hospital Confinement - Daily Benefit (maximum 30 days per year): $100
- Intensive Care Unit (ICU) Confinement - First Day Benefit (maximum once per year) - $1,500

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

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 Discount Plan

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!**

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.

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**

Pet Insurance - NEW PLAN

Policy Term: 1/1/2026-1/1/2027

OnePack Plan™ by petpartners

PetPartners Group Pet Insurance

Help take the stress out of unexpected vet bills. Pet insurance reimburses you for the eligible costs of accidents and illnesses. Coverage Includes: emergency treatments, surgeries, medications, laboratory services, and more. Plus, you can visit any licensed veterinarian or specialist. **Available only during Open Enrollment or Qualifying Life Events.**

Base Plan	
Annual Deductible	$250
Coinsurance	80%
Annual Limit	$10,000
Age (Min/Max)*	8 Weeks min - No Max age
Benefit Waiting Periods:	
Injuries	Waived
Illnesses	Waived
Orthopedics	6 Months
Pre-Existing Conditions	Covered after 12 months
Prior Coverage Credits+	Included

Optional Wellness	Annual Reimbursement
Rabies Vaccine	$30
Flea & Tick Prevention	$50
Heartworm Prevention	$50
Blood, Fecal, Parasite Test	$30
Preventative Vaccines	$45
Urinalysis or ERD	$30
Heartworm or Feline Leukemia Test (FeLV)	$30
Spay/Neuter	$50
Microchip	$50
Office Visit/Exam	$35

Additional benefits		
Rehabilitation and Physical Therapy	Covers physical therapy, hydrotherapy, thermotherapy and therapeutic massage	Subject to Deductible and Coinsurance
Inherited and Congenital Care	Covers diabetes, IVDD, luxating patella, osteoarthritis, spondylosis, hip dysplasia and birth defects	Subject to Deductible and Coinsurance and 30-day Benefit Waiting Period
Alternative and Behavioral Care	Covers acupuncture, chiropractic, homeopathy, herbal therapy, naturopathy, and vitamins/ supplements	Subject to Deductible and Coinsurance Behavioral Care subject to $1,000 Annual Limit and 14-day Benefit Waiting Period
Final Respects	Covers cremation and burial expenses	$300 Limit Paid in excess of Annual Limit (Not subject to Deductible and Coinsurance)

Accident and Illness (per covered pet)

Per Pay Rate	Cat:	20.18	Dog:	$36.55

Accident and Illness Plan With Wellness (per covered pet)

Per Pay Rate	Cat:	$25.45	Dog:	$43.06

Contact PetPartners Customer Care:
800-956-2495
mypolicy@petpartners.com

*Does not apply to the Accident Only plan. Pets enrolled before the age of 11 years old can remain on the Accident & Illness plan. Mention the age they are at the time of enrollment.
+If you currently have coverage with another pet insurance carrier, we may be able to apply that coverage towards our benefit waiting periods. Call our Customer Care team for more details.
All pet insurance plans have limitations and exclusions. Specific products, features, rates, and discounts may vary by state, eligibility, and are subject to change. For all terms and conditions visit: https://www.petpartners.com/sample-policies.
Insurance products are underwritten by Independence American Insurance Company (NAIC #26581), 11333 N. Scottsdale Rd. Suite 160, Scottsdale, AZ 85254, and produced by PetPartners Inc. (NPN #7612549; CA license #0F27261 PPI Pet Insurance Agency, Inc.), 8051 Arco Corporate Drive, Suite 350, Raleigh, NC 27617.

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 100% of the first 3% of your Compensation that you contribute to the Plan and 50% of the next 2% of your Compensation that you contribute to the Plan.

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: 48456

Contributions

Contributions will occur on the first 2 paychecks each month. Spousal Surcharge may apply if covering spouse who is employed by another employer (other than Tower Semiconductor)

Medical Contributions - 2026

	Premium Rate	Monthly Employee Cost	Employee Cost Per Pay Period	Employer Monthly Cost
Anthem EPO				
Employee Only	$857.52	$257.26	$128.63	$600.26
Employee + Spouse	$1,800.79	$540.24	$270.12	$1,260.55
Employee + Child(ren)	$1,543.61	$463.08	$231.54	$1,080.53
Employee + Family	$2,658.39	$797.52	$398.76	$1,860.87
Anthem PPO				
Employee Only	$1,140.04	$399.01	$199.51	$741.03
Employee + Spouse	$2,394.06	$837.92	$418.96	$1,556.14
Employee + Child(ren)	$2,052.16	$718.25	$359.13	$1,333.91
Employee + Family	$3,534.15	$1,236.96	$618.48	$2,297.19
Anthem HDHP				
Employee Only	$824.46	$206.12	$103.06	$618.34
Employee + Spouse	$1,731.32	$432.84	$216.42	$1,298.48
Employee + Child(ren)	$1,484.08	$371.02	$185.51	$1,113.06
Employee + Family	$2,555.82	$638.96	$319.48	$1,916.86
Kaiser HMO				
Employee Only	$715.91	$214.77	$107.39	$501.14
Employee + Spouse	$1,503.41	$451.02	$225.51	$1,052.39
Employee + Child(ren)	$1,288.64	$386.59	$193.30	$902.05
Employee + Family	$2,219.32	$665.80	$332.90	$1,553.52

This is a closed plan with no new enrollments.

Contributions

Dental Contributions - 2026

	Premium Rate	Monthly Employee Cost	Employee Cost Per Pay Period	Employer Monthly Cost
Guardian DHMO				
Employee Only	$9.01	$2.25	$1.13	$6.76
Employee + Spouse	$18.02	$4.50	$2.25	$13.52
Employee + Child(ren)	$20.13	$5.03	$2.52	$15.10
Employee + Family	$30.74	$7.68	$3.84	$23.06
Guardian DPPO				
Employee Only	$38.17	$11.45	$5.73	$26.72
Employee + Spouse	$83.03	$24.91	$12.46	$58.12
Employee + Child(ren)	$94.88	$28.47	$14.24	$66.41
Employee + Family	$155.04	$46.52	$23.26	$108.52

Vision Contributions - 2026

	Premium Rate	Monthly Employee Cost	Employee Cost Per Pay Period	Employer Monthly Cost
EyeMed				
Employee Only	$5.52	$1.66	$0.83	$3.86
Employee + Spouse	$10.51	$3.15	$1.58	$7.36
Employee + Child(ren)	$11.06	$3.32	$1.66	$7.74
Employee + Family	$16.25	$4.87	$2.44	$11.38

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	towersemi.mydrugcosts.com my.collectivehealth.com	
Pharmacy Plan	Prudent Rx	888-203-1768		
Pharmacy Plan	Tria Health	888-799-8742		
Pharmacy Plan	IMA Rx Specialty	866-530-9989		
Guardian Dental Plans *DHMO & DPPO*	Collective Health	833-440-1639	my.collectivehealth.com	
Eyemed Vision Plan *PPO*	EyeMed	866-723-0596	eyemed.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 & Hospital Indemnity Critical Illness Plans	Reliance Standard	877-202-0055	reliancematrix.com	Accident VAI2000044285 Critical Illness VCI2000044284 Hospital Indemnity VHI2000044283
Legal Plans	MetLife	800-821-6400	legalplans.com	Password: LEGAL
Employee Assistance Plan	ACI Specialty Benefits	855-775-4357	rsli.acieap.com	
Pet Discount Plans	Pet Benefit Solutions	800-891-2565	petbenefits.com/land/towersemiconductor	
Pet Insurance Plans	Pet Partners	866-774-1113	onepackplan.com	

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.

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Annual Notices

Tower Semiconductor Health and Welfare Benefits Annual Notice Packet

January 1, 2026

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
- Medicare Part D Non-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 ***US.Benefits@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:
Benefits Team

Email: *US.Benefits@towersemi.com*

Notice: CMS Part D Notice of Creditable or Non-Creditable Coverage

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1 % of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
PPO Core Plan **PPO Buy-up Plan**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at ***https://www.shiphelp.org***.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 1/1/26

Name of Entity/Sender: Tower Semiconductor

Contact—Position/Office: Benefits Team

Address: 4321 Jamboree Rd, Newport Beach, CA 92660

Email: US.Benefits@towersemi.com

Notice: Special Enrollment Rights

If you are declining enrollment 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 stopped contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you 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. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights	You have the right to: – Get a copy of your health and claims records – Correct your health and claims records – Request confidential communication – Ask us to limit the information we share – Get a list of those with whom we've shared your information – Choose someone to act for you – File a complaint if you believe your privacy rights have been violated
Your Choices	You have some choices in the way that we use and share information as we: – Answer coverage questions from your family and friends – Provide disaster relief – Market our services and sell your information
Our Uses and Disclosures	We may use and share your information as we: – Help manage the health care treatment you receive – Run our organization – Pay for your health services – Help with public health and safety issues – Do research – Comply with the law – Respond to organ and tissue donation requests and work with a medical examiner or funeral director – Address workers' compensation, law enforcement and other government requests – Respond to lawsuits and legal action
Your Rights	When it comes to your health information, you have certain rights. – This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records	– You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. – We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. – We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	– You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. – We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	– You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. – We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	– You can ask us not to use or share certain health information for treatment, payment or our operations. – We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	– You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. – We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	– You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	– If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. – We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	– You can complain if you feel we have violated your rights by contacting us using the information on page 9. – 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 (877) 696-6775, or visiting hhs.gov/ocr/privacy/hipaa/complaints/. – We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what to share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	– Share information with your family, close friends, or others involved in payment for your care – Share information in a disaster relief situation – If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases we never share your information unless you give us written permission:	– Marketing purposes – Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information.

We typically use or share your health information in the following ways.

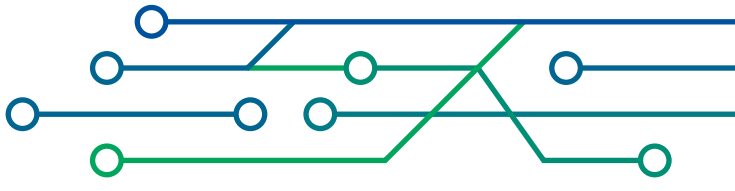
Help manage the health care treatment you receive	– We can use your health information and share it with professionals who are treating you.	**Example:** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	– We can use and disclose your information to run our organization and contact you when necessary. – We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.	**Example:** *We use health information about you to develop better services for you.*
Pay for your health services	– We can use and disclose your health information as we pay for your health services.	**Example:** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your Plan	– We may disclose your health information to your health plan sponsor for plan administration.	**Example:** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: ***Your Rights Under HIPAA I HHS.gov***.

Help with public health and safety issues	We can share health information about you for certain situations such as: – Preventing disease – Helping with product recalls – Reporting adverse reactions to medications – Reporting suspected abuse, neglect or domestic partner violence – Preventing or reducing a serious threat to anyone's health or safety
Do research	– We can use or share your information for health research
Comply with the law	– We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	– We can share health information about you with organ procurement organizations. – We can share health information with a coroner, medical examiner or funeral director when an individual dies.



Address workers' compensation, law enforcement and other government requests	– For workers' compensation claims – For law enforcement purposes or with a law enforcement official – With health oversight agencies for activities authorized by law – For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	– We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: ***Your Rights Under HIPAA I HHS.gov***.

Notice: Consolidated Omnibus Budget Reconciliation Act (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:

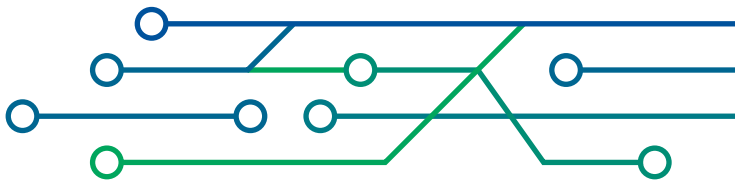
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally 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; or
- 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 the contact person shown at the end of these notices.

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 (for fully insured plans issued in California, coverage generally last for 36 months). 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, 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 **www.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 8-month special enrollment period 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.

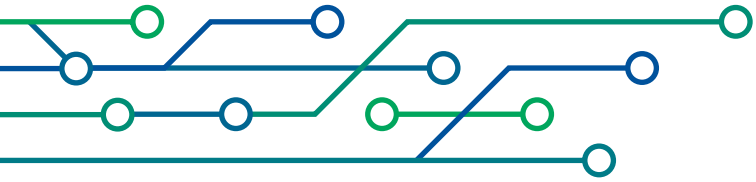
If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA 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 ***https://www.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 information at the end of these notices. 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 **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.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.

Notice: Women's Health and Cancer Rights Act (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

Notice: (APPLICABLE TO HMO GROUP HEALTH PLANS AND ALL FULLY-INSURED GROUP HEALTH PLANS IN OREGON): Patient Protection – Primary Care Designation

Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

Notice: (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection – Obstetrics & Gynecological Care (HMO)

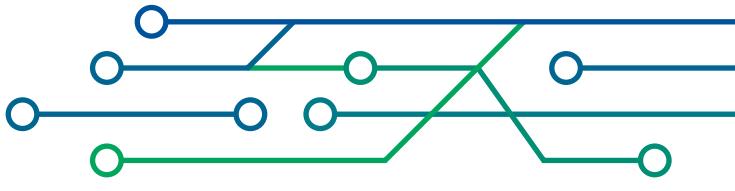
You do not need prior authorization from your group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, see the contact information at the end of these notices.

Notice: Grandfathered Plans

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or ***www.dol.gov/ebsa/healthreform***. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice: (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): Patient Protection – Obstetrics & Gynecological Care (HMO)

You do not need prior authorization from your group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, see the contact information at the end of these notices.



Notice: 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, **www.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.

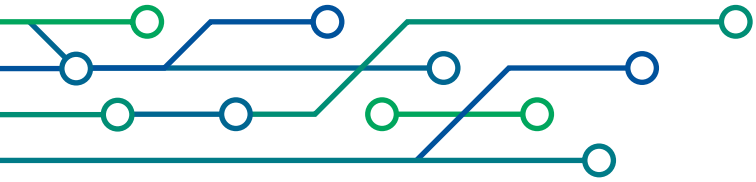
If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial (877) KIDS NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, 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 **www.askebsa.dol.gov** or call (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, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://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+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay: 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991 / State Relay: 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid|Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki-Healthy and Well Kids in Iowa| Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP)| Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.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	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.asp Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS(5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311(Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059



TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program |Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://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, 2025, or for more information on Special Enrollment Rights, contact either:

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

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

OMB Control Number 1210-0137 (Expires: 1/31/2026)

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

For more information, contact:
Name: Benefits Team
Address: 4321 Jamboree Rd, Newport Beach, CA 92660
Email: US.Benefits@towersemi.com

Effective date of this Notice: January 1, 2025


Tower
Semiconductor