Tower Semiconductor

2022 Union

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 Summary provide quality choices that are comprehensive, 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 2022 Benefits Administration and 2022 Annual Enrollment activity, the Tower Semiconductor Benefits Center can be reached on line or by phone. Contact details are on page 43 of this booklet. The Tower Semiconductor Benefits Service Center is provided by *PlanSource*.

BENEFIT PLANS FOR 2022

Medical Insurance: *Self-Insured plans using Anthem Blue Cross network for CA. This plan will be administered by Collective Health.*

The Kaiser plan is a closed plan and is only available for employees in CA who enrolled in the plan prior to 2021. There will be no new enrollments allowed on the Kaiser plan in 2022.

Dental Insurance: *the MetLife plans will continue; there are No Plan Design Changes.*

Vision Insurance: the *EyeMed plan will continue; there are No Plan Design Changes*

Life and AD&D Insurance: *all company provided and voluntary life and accident insurance coverage will be offered through Reliance Standard.*

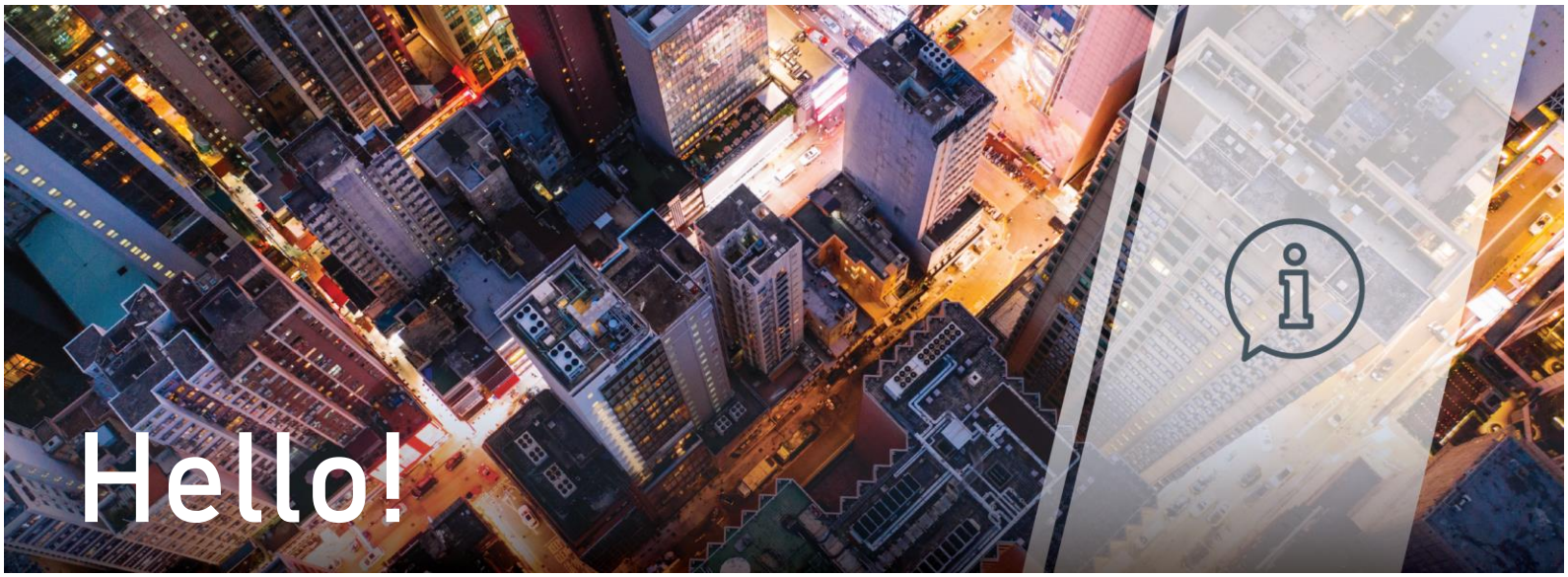
Disability Insurance: *Long Term Disability insurance will be provided through Reliance Standard.*

Voluntary Benefits: *Voluntary Critical Illness, Accident and Legal will continue to be offered through MetLife. Pet Benefit Solutions will continue to be the pet care plan for 2022.*

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

Health Savings Account and Flexible Spending Account: *HealthEquity will be the carrier for all Health Savings Account and Flexible Spending Accounts for 2022 and will require re-election.*

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



Welcome to your 2022 Benefits Plan Year. Tower Semiconductor is proud to offer a range of employee benefit plans to help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool designed to familiarize you with the plans and programs you and your family can enroll in for the plan year. If you have any questions regarding your benefits, please contact Human Resources.

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What is Collective Health?

Collective Health is a one-stop shop platform that brings together your medical, your Health Savings Account and Flexible Spending Account, and creates a single point of contact for you to get questions answered. When you're trying to understand and use your benefits, we are here for you.

From choosing your Anthem Blue Cross plan to using it, Collective Health is your first point of contact on your care journey.

1

Select a plan

Our Open Enrollment website 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 our app, and more.

3

Sign in

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

4

Find a doctor

Our "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 our Member Advocate team for compassionate, knowledgeable help.

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.

Enrollment

Who can Enroll?

Regular full-time employees working a minimum of 30 hours per week are eligible to participate in the benefits program. Eligible employees may also choose to enroll eligible family members, including a legal spouse / registered domestic partner. Employees are required to provide documentation to validate a dependent's eligibility for coverage. Please contact Tower Semiconductor's Benefits Service Center at 877.284.5077 for additional information.

Children are considered eligible if they are:

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

Please Note: Staring 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 2022 Employees will have until January 31, 2022 to submit proof of registered domestic partnership to PlanSource, or they will be terminated from the plans retroactive to January 1st 2022.

When Does Coverage Begin?

Your enrollment choices remain in effect for the benefits plan year, January 1, 2022 through December 31, 2022. Benefits for eligible **new hires** will commence as outlined below:

Eligibility Date	Benefit Plan
Your coverage is effective after 30 days from your **date of hire** and must be actively at work to enroll. You must enroll within 30 days of your hire date.	Kaiser Medical HMO - CA Only **(Closed Plan – Not Eligible for New Enrollments)**
PPO eligibility for Union employees requires 2 years of service. Service requirement must be met before January 1, 2022.	Anthem Medical EPO
	Anthem Medical PPO
	Anthem Medical HDHP
	MetLife Dental DHMO and PPO
	EyeMed Vision
	Reliance Standard Basic Life / AD&D
	Reliance Standard Long Term Disability
	Reliance Standard Voluntary Long Term Disability (Buy-Up)
	Reliance Standard Voluntary Life / AD&D
	MetLife Business Travel Accident
	HealthEquity Flexible Spending Account (FSA)
	HealthEquity Health Savings Account (HSA)
	MetLife Voluntary Accident & Critical Illness
	MetLife Voluntary Legal Plans
	Pet Benefits Solutions Pet Care Plan
	ACI Specialty Benefits Employee Assistance Plan (EAP)
	Fidelity Investments 401(k)

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

This is a **passive** enrollment, meaning you are not required to take action and enroll in your benefits in order to continue coverage. However, you **must** re-elect your contribution amounts each year to participate in the Flexible Spending Account (FSA) Plans and Health Savings Account (HSA) Plans.

Spousal and Domestic Partner Surcharge

Employees must pay an additional cost to cover a spouse / registered domestic partner who has the option to elect health care coverage through their employer. The additional cost, or surcharge, to the employee will be $35 per month. If the situation below applies to you, you will want to consider how the additional cost may impact your coverage choice. Please contact Tower Semiconductor Benefits Service Center at 877.284.5077 for additional information.

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

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the open enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

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

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

Waive-Out Provision?

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

Please note that if you waive coverage, the next opportunity to enroll in your benefits will be January 1, 2023 or when a Qualifying Status Change occurs.

Paying for Coverage

Tower Semiconductor strives to provide you with a valuable benefits package at a reasonable cost. Based on your benefit selections and coverage level, you may be required to pay for a portion of the cost. Employee cost or cost sharing amounts for benefits can be found on the separate document titled Benefit Rates & Deductions that was included in the materials that were emailed to your work email account.

How Do I Enroll?

Tower Semiconductor Benefits Service Center

To enroll, simply follow these steps: Log on at https://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
    - Click the "Log In" button
    - Example: DOB May 22, 1982; 19820522
- 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 www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical/dental/and/or vision coverage if you have access to coverage through another plan. To waive coverage, you must do so by calling or going to the Tower Semiconductor Benefits Service Center website. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1st, 2023 or if a qualifying status change occurs.

What are my Options?

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

	HMO	EPO	PPO/HDHP
	Kaiser- CA Only (Closed Plan)	**Anthem Blue Cross**	**Anthem Blue Cross**
Required to select and use a Primary Care Physician (PCP)	**Yes**	**No**	**No**
Seeing a Specialist	PCP referral required in most cases	No referral required	No referral required
Deductible Required	No	No	Yes
Finding a Provider	Kaiser 1. Visit www.kp.org 2. Select Find a Doctor 3. Select an Area 4. Search by City or by Zip Code and a Specific Doctor (if interested)	Anthem Blue Cross 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	• Usually handled by providers	• EPO/PPO/HDHP providers will submit claims • You submit claims for other services	
Other Important Tips	• This plan requires that you see a doctor in a specific network to receive coverage • Out-of-Network services without proper PCP referral will not be covered • Emergencies covered worldwide	• 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

TIP

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.

MyDrugCosts

What is myDrugCosts?

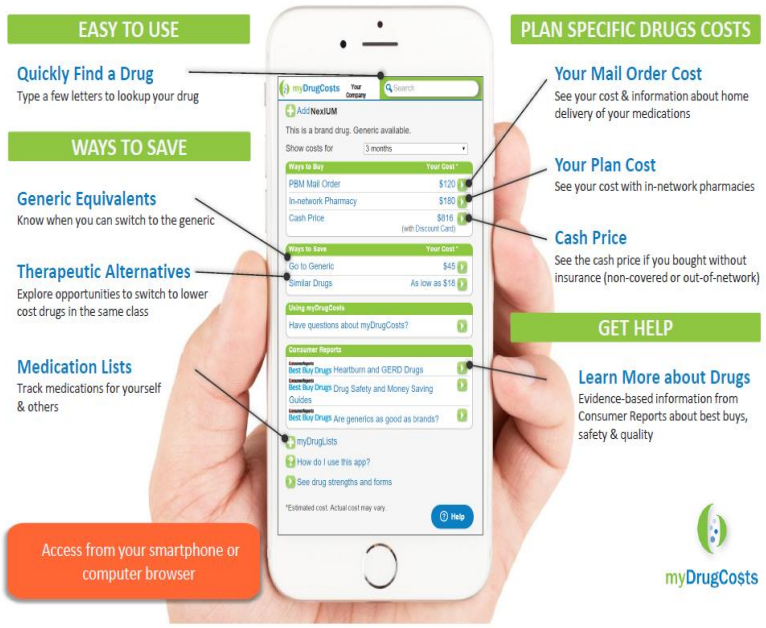
myDrugCosts empowers companies and their employees with insights to lower their costs for prescription drugs. It is an award-winning, cloud-based solution that uses analytics based on your specific healthcare plan to present choices you can take to reduce costs without minimizing your options.

Expenses are reduced through enhanced cost transparency, employee-physician engagement, incentives, and use of preferred pharmacies.

With instant mobile access to prescription drug costs, you can readily consider costs and make informed purchase decisions. Self-funded employers and health plans can customize myDrugCosts with plan specific information to lower plan spending and enhance member communication.

Go to https://towersemi.mydrugcosts.com

Note: The services above are only available to members enrolled in an Anthem medical plan.



Prudent RX

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

How it works

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

PrudentRx + RxBenefits®

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.

Plan Highlights	Kaiser CA HMO (Not Eligible for New Enrollments)
	In-network Only
Annual Deductible	
Individual	None
Family	None
Annual Out-of-pocket Maximum	
Individual	$1,500
Family	$3,000
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP) / Specialist	$25/visit
Preventive Care Exam	No charge
Well-baby Care	No charge
Diagnostic X-ray and Lab	$10/encounter
Diagnostic X-ray and Lab (Outpatient Facility)	$10/encounter
Diagnostic X-ray (Complex Imaging)	$50/procedure
Therapy, including Physical, Occupational and Speech	$25/visit
Hospital Services	
Inpatient	$500/admit
Outpatient Surgery	$100/procedure
Emergency Room	$100/visit (waived if admitted)
Urgent Care	$25/visit
CVS Minute Clinic Urgent Care*	$25/visit *(outside CA in states where there is no Kaiser facility)*
Maternity Care	
Physician Services (prenatal)	No charge
Hospital Services	$500/admit
Mental Health & Substance Abuse	
Inpatient	$500/admit
Outpatient	
Mental / Behavioral Health	$25/visit
Substance Abuse	$5/visit
Retail Prescription Drugs (30-day supply)	
Tier 1 – Generic	$10
Tier 2 – Formulary Brand	$30
Tier 3 – Non-Formulary Brand	$30
Mail Order Prescription Drugs (100-day supply)	
Tier 1 – Generic	$20
Tier 2 – Formulary Brand	$60
Tier 3 – Non-Formulary Brand	$60

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

* If 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.

Plan Highlights	Anthem Blue Cross EPO
	In-network Only
Annual Deductible	
Individual	None
Family	None
Annual Out-of-pocket Maximum	
Individual	$2,500
Family	$7,500
Lifetime Maximum	
Individual	Unlimited
Professional Services	
Primary Care Physician (PCP)	$30/visit
Specialist (Referral not required)	$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	$40/visit (maximum 35 visits per year)
Hospital Services	
Inpatient	$500/admit
Outpatient Surgery	$300/procedure
Emergency Room	$150/visit (waived if admitted)
Urgent Care	$50/visit
CVS Minute Clinic Urgent Care	$30/visit
Maternity Care	
Physician Services (prenatal)	$40/visit
Hospital Services	$500/admit
Mental Health & Substance Abuse	
Inpatient	$500/admit
Outpatient Office Visit	$40/visit
Retail Prescription Drugs (30-day supply)	
Preventive	$0
Tier 1 – Generic	$10
Tier 2 – Formulary Brand	$30
Tier 3 – Non-Formulary Brand	$50
PrudentRx Specialty Medications	$0 Copay; Enrollment Required 30% - If not enrolled in PrudentRx
Mail Order Prescription Drugs (90-day supply)	
Preventive	$0
Tier 1 – Generic	$20
Tier 2 – Formulary Brand	$60
Tier 3 – Non-Formulary Brand	$100

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

Plan Highlights	Anthem Blue Cross PPO	
	In-network	**Out-of-network**
Annual Deductible		
Individual	$500	$1,000
Family	$1,500	$3,000
Annual Out-of-pocket Maximum		
Individual	$3,000	$10,000
Family	$9,000	$30,000***
Lifetime Maximum		
Individual	Unlimited	
Professional Services		
Primary Care Physician (PCP)	$20 (deductible waived)	30%
Specialist	$40 (deductible waived)	30%
LiveHealth Online	$10 (deductible waived)	Not Covered
Preventive Care Exam	No charge (deductible waived)	30%
Well-baby Care	No charge (deductible waived)	30%
Diagnostic X-ray and Lab	10%	30%
Complex Diagnostics (MRI/CT Scan)	10%	30%
Therapy, including Physical, Occupational and Speech (maximum 35 visits per year)	$40 (deductible waived)	30%
Hospital Services		
Inpatient	10%	30%
Outpatient Surgery	10%	30%
Emergency Room (copay waived if admitted)	$150 copay + 10%	$150 copay + 10%
Urgent Care	$50 (deductible waived)	30%
CVS Minute Clinic Urgent Care	$20 (deductible waived)	Not Covered
Maternity Care		
Physician Services (prenatal)	$40 (deductible waived)	30%
Hospital Services	10%	30%
Mental Health & Substance Abuse		
Inpatient	10%	30%
Outpatient Office Visit	$40 (deductible waived)	30%
Retail Prescription Drugs (30-day supply)		
Preventive	$0	30% (up to $250)
Tier 1 – Generic	$20	30% (up to $250)
Tier 2 – Formulary Brand	$40	30% (up to $250)
Tier 3 – Non-Formulary Brand	$70	30% (up to $250)
PrudentRx Specialty Medications	$0 Copay; Enrollment Required 30% - If not enrolled in PrudentRx	Not covered
Mail Order Prescription Drugs (90-day supply)		
Preventive	$0	30% (up to $250)
Tier 1 – Generic	$40	Not covered
Tier 2 – Formulary Brand	$80	Not covered
Tier 3 – Non-Formulary Brand	$140	Not covered

***** Maximum Out of Pocket 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

Anthem Blue Cross HDHP

	In-network	Out-of-network
Annual Deductible		
Individual	$1,500	$3,000
Family (Aggregate)	$4,500	$9,000
Annual Out-of-pocket Maximum		
Individual	$2,000	$4,000
Family (Aggregate)	$6,000	$12,000***
Lifetime Maximum		
Individual	Unlimited	
Professional Services		
Primary Care Physician (PCP)	20%	50%
Specialist	20%	50%
LiveHealth Online	$59/visit	Not Covered
Preventive Care Exam	No charge (deductible waived)	50%
Well-baby Care	No charge (deductible waived)	50%
Diagnostic X-ray and Lab	20%	50%
Complex Diagnostics (MRI/CT Scan)	20%	50%
Therapy, including Physical, Occupational and Speech	20%	50%
Hospital Services		
Inpatient	20%	50%
Outpatient Surgery	20%	50%
Emergency Room	20%	20%
Urgent Care	20%	50%
CVS MinuteClinic	20%	Not Covered
Maternity Care		
Physician Services (prenatal)	20%	50%
Hospital Services	20%	50%
Mental Health & Substance Abuse		
Inpatient	20%	50%
Outpatient	20%	50%
Retail Prescription Drugs (30-day supply)		
Preventive – HDHP ACA List Generic & Brand	$0 (deductible waived)	Copay+50%
Tier 1 – Generic & Specialty	$10 after deductible	Copay+50%
Tier 2 – Formulary Brand & Specialty	$25 after deductible	Copay+50%
Tier 3 – Non-Formulary Brand & Specialty	$40 after deductible	Copay+50%
Mail Order Prescription Drugs (90-day supply)		
Preventive	$0 (deductible waived)	Copay+50%
Tier 1 – Generic	$20 after deductible	Not covered
Tier 2 – Formulary Brand	$50 after deductible	Not covered
Tier 3 – Non-Formulary Brand	$80 after deductible	Not covered

***** Maximum Out of Pocket 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.

Health Savings Account (HSA)

What is it?

By enrolling in the Anthem Blue Cross high-deductible health plan, 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?

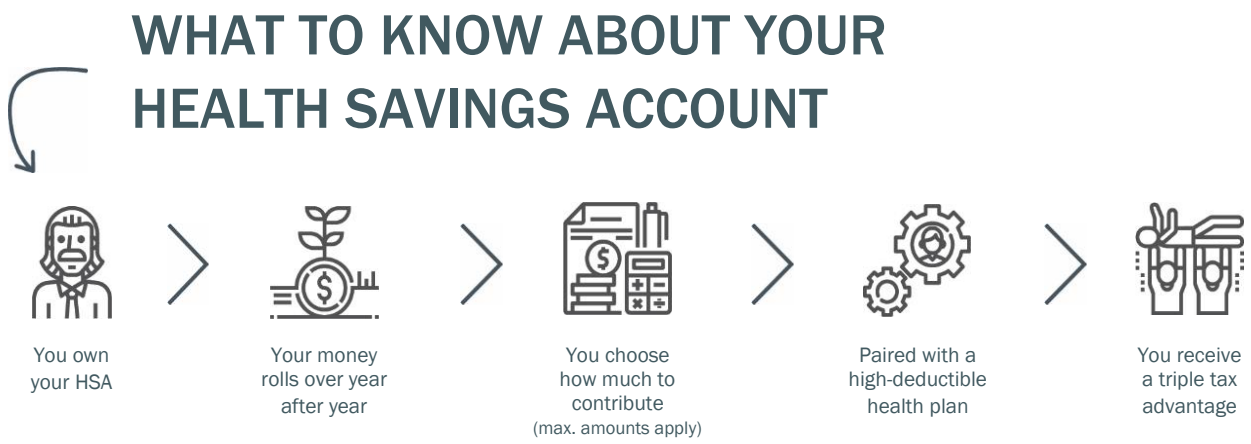
Administered by HealthEquity, an HSA accumulates funds that can be used to pay current and future health care costs.

- 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.[1]
- 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 a qualified medical plan.
- 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) or general Health Reimbursement Arrangement (HRA).



A few rules you need to know:

- For 2022, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,650 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,300 for employees with dependent coverage.
- 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 www.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 FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care 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 1 of the first year and continues to be eligible to contribute to an HSA until December 31 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 www.healthequity.com.**

Anthem LiveHealth Online

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

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

Getting started is easy

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

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

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

Set up an account

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

1. Go to www.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 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 you 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

1. 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.

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.

Care Navigation

We are here to help manage your care!

When it comes to managing your medical care, sometimes a little extra help can make all the difference. Collective Health's Care Management team is composed of pharmacists, social workers, dieticians, nurses and care coordinators who are here to help members navigate through their care. Care Navigation is available at no additional cost to you.

How do I get started?

To get started, members can send a secure message through their Collective Health account, or call the Care Management team to begin the process. You may contact the Care Management Team at 833.834.1170 and they are available, Monday through Friday 9 a.m. – 6 p.m. PST.

What can Care Navigation help with?

The Care Navigation team is trained to help members handle just about anything, below are some ideas of how they can help – but if it's not on the list, call anyway!

- Mental health conditions
- Managing infusions, injectables, or multiple medications (such as multiple sclerosis and rheumatoid arthritis)
- Pregnancy, newborn or birth-related complications
- Gender affirmation surgery and services
- Genetic and rare conditions
- Transplant surgery
- Traumatic injury
- Developmental conditions such as autism
- Neurological, cardiac, or gastrointestinal conditions
- Cancer
- Stroke
- Diabetes
- Asthma

Please Note: Care Managers cannot provide clinical services such as diagnoses, treatments or prescriptions.

How can Care Navigation help?

The Care Managers are trained experts and are available to go over the details of your condition(s) with you to help develop a personalized care plan to fit your needs. They can also help you connect with resources who specialize in your specific condition(s). Whether you have complicated medical needs, emotional health needs, financial needs, or any other needs, they will help you get connected to the right resources.

How do I contact Care Navigation?

You may contact the Care Management Team at 833.834.1170; Monday through Friday 9 a.m. – 6 p.m. PST.

Anthem Tools & 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, Heart Failure
- **Future Moms** – Support from nurse coaches trained in maternity care dedicated to helping expectant parents have a healthy pregnancy and delivery

360° Health

360° Health, offered by Anthem, is a collection of support and wellness programs that surrounds you with the tools you need to live healthier, feel better and save money.

Personalized information, 24/7 access to a nurse, and trained health management professionals are all available to help you navigate the health care system and use your benefits wisely. Plus, it's part of your plan at no extra cost. Start by taking a MyHealth Assessment at www.anthem.com/ca, which can analyze the choices you make and the steps you can take and include:

- **Tobacco Cessation:** Educational program and a personalized "quit" plan
- **Weight Management:** From dietary education to personal coaching, this program coaches members on how to reach and maintain a healthy weight
- **Stress Management:** Learn how to identify stress triggers and apply proven coping techniques every day

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 a 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.

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.

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!

KP Preventive Care App!

As a Kaiser Permanente member, important personalized health reminders and information are available for you and your family members on the go. With this app, you are able to:

- Get alerts when you or your family members are due for routine health screenings, tests and immunizations
- Receive appointment reminders for scheduled visits
- See details of your upcoming appointments
- Contact your doctor
- Store medical record numbers in one convenient place
- Visit the App Store or Google Play to download the KP Preventive Care app today!

PlanSource Mobile

With the PlanSource Mobile App, you can:

- Begin enrollment on mobile and finish later on desktop or vice versa.
- Compare plan options and costs and get personalized recommendations
- Access detailed plan documents to understand what's covered by the plan
- Chat with benefits experts to get real-time answers (for Employee Contact Center customers)

New! iNGAGED

Available for iOS and Android mobile devices, the iNGAGED app makes checking your health and benefits information easier than ever!

- With iNGAGED, you can:
- View our company's benefit plans and resources, 24/7.
- Access policy information and group numbers.
- Quickly contact a benefits carrier.
- Keep up with important benefit plan announcements.
- Store images of your ID cards directly in the app.

Download the "iNGAGED Benefits" app from the App Store or Google Play and use our Company Code **TOWER** to login to the app.

Dental Plan

Your Dental HMO Plan

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

Using the 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 MetLife dental network. If you receive services from a provider outside of the approved network, you would be responsible for paying the entire dental bill yourself. **Please Note**: You are required to select a Primary Dentist to access coverage.

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

Plan Highlights	MetLife Dental HMO	MetLife Dental PPO	
	In-Network Only CA	**In-Network**	**Out-of-Network 80th UCR**
Annual Deductible	n/a	$50/$150	$50/$150
Annual Maximum	Unlimited	$1,200	$1,200
Preventive	No Charge	100%	100%
Basic Services	Copays vary	80%	80%
Major Services	Copays vary	50%	50%
Orthodontia Services	$1,850 copay (Adult & Child)	50% up to $1,200 lifetime max (Child Only)	50% up to $1,200 lifetime max (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.

TIP

Find your Favorite Dentist

In order to receive dental coverage when using an HMO, it is essential to use an in-network dental office that is an HMO provider. To find an in-network dentist, go to www.metlife.com/mybenefits and type **TOWER SEMICONDUCTOR** and click NEXT to find your employer's MyBenefits page. Search the Provider Network online or call 800.880.1800 (DHMO) or 800.942.0854 (DPPO). For CA DHMO members, please search by the plan name, **MET245**.

Vision Plan

Your Vision 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 EyeMed by calling 866.723.0596 or visiting their website, www.eyemed.com.

Freedom Pass

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

Plan Highlights	Eyemed Vision PPO	
	In-Network (Insight)	**Out-of-Network**
Exam – Every 12 months	100% after $10 copay	Up to $42 reimbursement
Lenses – Every 12 months		
Single	100% after $20 copay	Up to $35 reimbursement
Bifocal	100% after $20 copay	Up to $49 reimbursement
Trifocal	100% after $20 copay	Up to $74 reimbursement
Frames – Every 24 months	$130 allowance + 20% amount over allowance	Up to $60 reimbursement
Contacts – Every 12 months, in lieu of lenses & frames		
Exam	Up to $40 (standard)	N/A
Elective	$120 allowance 15% off balance	Up to $96 reimbursement

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

TIP

Five Tips for Superior Vision

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

- **Eat lots of leafy greens and dark berries**
- **Get regular eye exams**
- **Give your eyes a rest from staring into the computer screen**
- **Wear sunglasses to protect your eyes from bright light**
- **Wear safety eyewear whenever necessary**

Basic Life and AD&D

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.

Your coverage

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, *minimum* $40,000
- AD&D of 2x annual earnings up to $1,250,000, *minimum* $40,000

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%

TIP

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 https://benefits.plansource.com or call 877.284.5077**

Voluntary Life and AD&D

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.

- **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):** $5,000 to $25,000 (Increments of $5,000)
- **Optional AD&D:** No requirements for a medical questionnaire and coverage is available for purchase in the same amounts as optional life insurance amounts above. This plan is unbundled and can be elected separately from Voluntary Life without submitting Evidence of Insurability (EOI).

  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)

If you do not elect optional life insurance when you are first eligible, you will be required to submit a health questionnaire to Reliance Standard, also known as Evidence of Insurability (EOI). 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 date otherwise your application for excess coverage will be closed.

Please note: Benefits coverage is reduced when you reach age 65 to 65%, age 70 to 45%, age 75 to 30% and age 80 to 20%.

Cost of Voluntary Coverage

Employee 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
Dependent Child(ren) to age 26	**$0.200**

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

Voluntary AD&D

Single $0.025 per $1,000 of coverage

Family $0.036 per $1,000 of coverage

Long Term Disability

Added protection

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.

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

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: http://www.affordableinsuranceprotection.com/disability_facts

Tax considerations

The premium cost for Long Term Disability Insurance is paid 100% by Tower Semiconductor.

When employer paid LTD coverage is provided on a pre-tax basis, there is no income tax paid on the premium. Any benefit received under the plan will be subject to federal income tax.

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

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:

FSA Type	Detail
 Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2022 is $2,750. *(2022 IRS Maximums have not been released yet)* • You cannot enroll on this plan if you are enrolled in the HDHP plan. • Visit http://www.irs.gov/pub/irs-pdf/p502.pdf for a complete list of Health Care FSA eligible expenses
 Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan. • Use this FSA to reimburse for eligible preventive care, dental and vision expenses. • Maximum contribution for 2022 is $2,750. *(2022 IRS Maximums have not been released yet)* • Visit http://www.irs.gov/pub/irs-pdf/p502.pdf for a complete list of Health Care FSA eligible expenses
 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 2022 is $5,000. *(2022 IRS Maximums have not been released yet)* • Visit http://www.irs.gov/pub/irs-pdf/p502.pdf for a complete list of Health Care 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 www.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.'
7. You will receive a call or text with a temporary password. Enter the password and click 'Next.'
    - After entering the passcode correctly, you can set up your account username and password
8. If you cannot verify your phone number, clock '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 2022 Healthcare FSA to 2023

Tower Semiconductor will offer employees the ability to carryover up to $550 from your 2022 Healthcare Flexible Spending Account to the 2023 plan year. We have outlined what this means to Healthcare FSA participants below:

- Although the Plan Year runs from January 1, 2022 through December 31, 2022 you will have the opportunity to carryover up to $550 of any unused FSA funds from January 1, 2022 through December 31, 2022 to January 1, 2023 through December 31, 2023 and get reimbursed for expenses incurred during that time.
- 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, 2023 through March 31, 2023, allowing you to seek reimbursement for expenses 3 months after the plan year ends on December 31, 2022.
- The amount of your carryover from 2022 will not affect your annual maximum allowed contribution to your 2023 FSA.
- Remember, any remaining amounts above $550 that are not submitted for expenses incurred between January 1, 2022 and December 31, 2022 to Health Equity by the end of the "run-out period" March 31, 2023 will be forfeited.
- **To receive a rollover amount, you must actively re-enroll in the Limited Purpose FSA in 2022 with a contribution of at least $100.**

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 www.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 www.myhealthequity.com. You may also contact Collective Health at 833.440.1639.

Receiving Reimbursements

You will have until March 31, 2023 to submit a reimbursement request for claims incurred between January 1 and December 31, 2022. 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 (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.

Program Component	Coverage Details
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare • Eldercare • Legal services • Identity theft • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse and recovery • Financial support • Consumer information
Number of Sessions	3 face-to-face sessions per year per member per incident

TIP

How to Access:

- **By Phone: 855.775.4357**
- **Online: http://rsli.acieap.com**

Supplemental Insurance

Voluntary Accident Plan

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! The MetLife policy may pay cash to help families offset the expenses associated with accidents or injuries. Employees will have a choice of selecting coverage between two options: High Plan or Low Plan. Benefits are based on a flat schedule amount (not reimbursement) that varies depending on the plan.

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, contact Tower Semiconductor Benefit Center (provided by Plan Source).

Benefit Type[1]	Low Plan MetLife Accident Insurance Pays YOU	High Plan MetLife Accident Insurance Pays YOU
Injuries		
Fractures[2]	$50 – $3,000	$100 – $6,000
Dislocations[2]	$50 – $3,000	$100 – $6,000
Second and Third Degree Burns	$50 – $5,000	$100 – $10,000
Concussions	$200	$400
Cuts/Lacerations	$25 – $200	$50 – $400
Eye Injuries	$200	$300
Medical Services & Treatment		
Ambulance	$200 – $750	$300 – $1,000
Emergency Care	$25 – $50	$50 – $100
Non-Emergency Care	$25	$50
Physician Follow-Up	$50	$75
Therapy Services (including physical therapy)	$15	$25
Medical Testing Benefit	$100	$200
Medical Appliances	$50 – $500	$100 – $1,000
Inpatient Surgery	$100 – $1,000	$200 – $2,000
Hospital[3] Coverage (Accident)		
Admission	$500 – $1,000 per accident	$1,000 – $2,000 per accident
Confinement (non-ICU confinement paid for up to 365 days. ICU confinement paid for 30 days)	$100 (non-ICU) – $200 (ICU) a day	$200 (non-ICU) – $400 (ICU) a day
Inpatient Rehab (paid per accident)	$100 a day, up to 15 days	$200 a day, up to 15 days
Benefit Type[1]	**Low Plan MetLife Accident Insurance Pays YOU**	**High Plan MetLife Accident Insurance Pays YOU**
Accidental Death		
Employee receives 100% of amount shown, spouse receives 50% and children receive 20% of amount shown.	$25,000 $75,000 for common carrier[4]	$50,000 $150,000 for common carrier[4]

Voluntary Critical Illness Plan

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

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

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

* Visit PlanSource for the full Benefit Summary.

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	**$15,000 or $30,000**	Coverage is guaranteed provided you are actively at work.[3]
Spouse/Domestic Partner[1]*	**100% of the employee's Initial Benefit**	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth on the enrollment form and in the Certificate.[3]
Dependent Child(ren)[2]*	**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.[3]

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).

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

Members can easily locate attorneys and schedule appointments by calling the Client Service Center toll-free (800.821.6400) and speaking to a knowledgeable and experienced representative, or by visiting MetLife's new redesigned website, www.legalplans.com.

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 and pharmacy 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 https://petbenefits.com/land/towersemiconductor to search for veterinarians in your area

3. Pet Benefit Solutions contact information:

    Phone: 800.891.2656

    Website: www.petbenefits.com

Even More Coverage Options

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 http://www.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

Business Travel Accident Insurance

MetLife

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

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.

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.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

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.

Medicare Part D notice

Is this plan considered creditable or noncreditable for purposes of CMS reporting?

Important Notice about Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, 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 15 to December 7. 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 prescription drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Prescription Drug Plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area.

If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human Resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

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 your employer and don't join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 www.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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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).**

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Model Individual NON-CREDITABLE Coverage Disclosure

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Tower Semiconductor has determined that the prescription drug coverage offered is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the [Insert Name of Plan]. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

When can you join a Medicare drug plan?

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

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 coverage as an active employee, please note that if your coverage is subject to the Medicare Secondary Payer rules, the plan 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 will be significantly reduced if your coverage is subject to the Medicare Secondary Payer rules, which applies to all employers with 20 or more employees. Medicare will usually pay primary for your prescription drug benefits if you participate in coverage as an individual who loses eligibility under the plan (e.g., termination, reduction in hours).

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

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

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

For More Information about this Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. 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 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 www.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 the Social Security Administration (SSA) online at www.socialsecurity.gov or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Tower Semiconductor

Attention: Craig Rowe, HR Director

4321 Jamboree Rd

Newport Beach, CA 92660

949.435.8327

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

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, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage [1]
- Acquisition of a new spouse or dependent through marriage [1], adoption [1], placement for adoption [1] or birth [1]
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families) (60-day notice) [1]
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

"Change in Status" Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved "change in status" as defined by the IRS.
- Examples of permitted "change in status" events include:
- Change in legal marital status (e.g., marriage [2], divorce or legal separation)
- Change in number of dependents (e.g., birth [2], adoption [2] or death)
- Change in eligibility of a child
- Change in your / your spouse's / your registered domestic partner's employment status (e.g., reduction in hours affecting eligibility or change in employment)
- A substantial change in your / your spouse's / your registered domestic partner's benefits coverage
- A relocation that impacts network access
- Enrollment in state-based insurance Exchange
- Medicare Part A or B enrollment
- Qualified Medical Child Support Order or other judicial decree
- A dependent's eligibility ceases resulting in a loss of coverage [3]
- Loss of other coverage [2]
- Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
- You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

- You do not need prior authorization from your insurance provider 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, contact your Human Resources office.

Grandfathered Plans

If your group health plan is grandfathered then the following will apply. 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.

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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.

[1] Indicates that this event is also a qualified "Change in Status"
[2] Indicates this event is also a HIPAA Special Enrollment Right
[3] Indicates that this event is also a COBRA Qualifying Event

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: [Enter name of appropriate party].

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

How is COBRA continuation coverage provided? (Continued)

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, 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 an 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 or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit 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.

Plan contact information

[Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.]

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness [1]; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. [2]

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months [3], and if at least 50 employees are employed by the employer within 75 miles.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.
[2] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"
[3] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627
www.wagehour.dol.gov

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment

Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions

For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE: January 1, 2022.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

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; and contact you for fundraising efforts.

If you are not able to tell us your preference, for example if you are unconscious, the Plan may go ahead and share your information if it believes it is in your best interest. The Plan may also share your information when needed to lessen a serious and imminent threat to health or safety.

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also 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.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. 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.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- 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.
- Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.
- Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.
- Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.
- Assign someone as your medical power of attorney or your legal guardian, who 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.

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- Maintain the privacy and security of your health information.
- Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, 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.
- Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction, amendment or other request.
- Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint

If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

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.

Contact Person

If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Tower Semiconductor
Attention: Craig Rowe, HR Director
4321 Jamboree Rd
Newport Beach, CA 92660
949.435.8327

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **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 **1-877-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 **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	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 January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

Notes

Notes

Directory & Resources

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

Information Regarding	Group / Policy #	Contact Information	
Medical Coverage – Anthem			
• Medical coverage or benefit questions • Verify coverage • Provider Search • Request an ID card	Collective Health Member Advocate Team *4am – 6pm PST Mon-Fri* *7am – 11am PST Sat*	833.440.1639	join.collectivehealth.com/TowerSemiconductor my.collectivehealth.com
Pharmacy Plan – Anthem Members			
• Prescription drug coverage • Mail service pharmacy	Collective Health Member Advocate Team	833.440.1639	join.collectivehealth.com/TowerSemiconductor my.collectivehealth.com
Pharmacy Plan – PrudentRx			
• Prescription drug coverage		888.203.1768	
Medical Coverage - Kaiser			
Kaiser HMO – CA Only	231139	800.464.4000	www.kp.org
Online & Phone Enrollment & Dependent Audit Verification			
PlanSource		877.284.5077	https://benefits.plansource.com/
Dental Coverage			
MetLife • DHMO & DPPO	96860	800.942.0854	www.metlife.com/mybenefits
Vision Coverage			
EyeMed Insight Network • PPO	9937038	866.723.0596	www.eyemed.com
Life / AD&D			
Reliance Standard • Basic Life/Voluntary Life • Basic AD&D/Voluntary AD&D	GL153147 VAR206340	800.351.7500	www.reliancestandard.com
Disability			
Reliance Standard • LTD, Voluntary Buy-up LTD	LTD125957	800.351.7500	www.reliancestandard.com
Health Savings Account (HSA) & Flexible Spending Account (FSA)			
HealthEquity through Collective Health		833.440.1639	join.collectivehealth.com/TowerSemiconductor my.collectivehealth.com
Voluntary Benefits			
• MetLife Accident & Critical Illness • MetLife Legal Plans	0096860 Password: LEGAL	800.438.6388 800.821.6400	www.metlife.com/mybenefits www.legalplans.com
Retirement Savings			
Fidelity Investments	Plan #48456	800.835.5097	www.401k.com
Employee Assistance Plan			
ACI Specialty Benefits		855.775.4357	http://rsli.acieap.com
Pet Discount Savings Plan			
Pet Benefit Solutions		800.891.2565	https://petbenefits.com/land/towersemiconductor
Benefits Broker			
Marsh & McLennan Insurance Agency 1 Polaris Way, Ste. 300 Aliso Viejo, CA 92656	Marc Pannier Cecile Endrinal Jackie Johnson Trang Nguyen	Contact HR department	www.MarshMMA.com

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