# 2023 Benefits Guide

Your guide to health and wellbeing, financial security and lifestyle benefits at Teva

Effective: January 1, 2023
Revised: October 2022

# We care

We provide valuable medications that improve the everyday lives of our patients, and we provide meaningful benefits that improve the everyday lives of our employees and families.

No matter where you are in your personal wellbeing journey, Teva is with you every step of the way, for every important moment. Our benefits program is designed to help you achieve your goals and make life more fulfilling.

We ensure that you and your family have access to the care you need. And, you have the opportunity to reflect on your current situation, explore your benefits options and choose wisely.

This shared commitment to take care for our benefits program is what makes our people—and Teva—stronger. And, our shared desire to take care of others is what makes our patients healthier. Together, when we care, our passion and dedication can make a difference to all.

**Validate Your Dependents and Social Security Numbers**

If you are enrolling dependents for the first time, you will need to validate those dependents. A few weeks after you enroll, you will receive an email and a packet of information at your home address on file that highlights the required validation process.

Confirm all Social Security numbers (SSNs) in the enrollment system are accurate. If your SSN is incorrect, contact AskHR via ServiceNow; you can correct any dependent SSN errors in the enrollment system.

*This Benefits Guide (and any additional items or documents referred to in this guide) is a summary of material modifications (SMM) for the Teva Medical Plan #15803. This SMM amends the most recent Summary Plan Description (SPD) and should be read together with the SPD. The SMM describes changes and provides clarifications to the SPD regarding the rules applicable to and benefits provided by the plans. You should keep this SMM together with the SPD.*

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## Questions?

For online enrollment support, visit **mytevabenefits.com** or call the Teva Benefits Service Center at **(800) 979-1733** (8:30 a.m.-8 p.m., ET, Monday-Friday). For benefits-related questions, visit **mytevahealth.com** or contact your Teva Care Coordinator at **(877) 922-6778**.

# Before You Begin

Teva partners with world-class vendors to help ease your health care experience throughout the year. But, before you start choosing your benefits from Teva, these three resources can help make enrolling easier for you and your family:

## 1. Benefits Guide Site

The Benefits Guide Site is a user-friendly website that you can use to quickly access information about specific benefits from your smartphone, tablet or computer.

Visit the Benefits Guide Site at **mytevabenefitsguide.com**.

## 2. Teva Care Coordinators

Teva Care Coordinators are an expert team of dedicated nurses, patient service representatives and specialists trained in Teva's benefits who are ready to help you. They act as your personal health care team—when you reach out, a patient service representative will help address your needs. If you're on a health care journey, you will be connected to a person who will be your single point of content every time you call.

Contact your Teva Care Coordinator at **(877) 922-6778** or visit **mytevahealth.com** for help with:

- Claims, billing and benefits questions
- Finding in-network providers
- Pre-certification for medical services
- Prescription drug-related questions
- Nurse support
- Anything that will make the health care process easier for you!

## 3. ALEX

ALEX is an interactive, entertaining and simple online tool designed to help you figure out what Teva benefits to choose based on your responses.

Visit **https://www.myalex.com/teva/2023**.

Respond to ALEX's questions about you and your family (everything you provide is confidential).

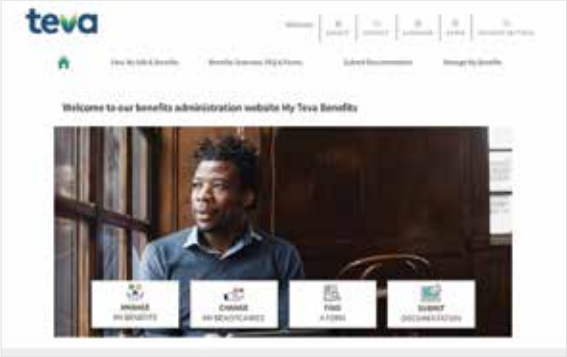
Print out the recommendation summary from ALEX to keep handy when you enroll through **mytevabenefits.com**.

### Get to Know: **My Teva Rewards**

My Teva Rewards is your one-stop-shop for personal information about your health and wellness and financial security benefits at Teva. You can use this online total rewards portal to view your current benefit elections, keep track of how you're using your benefits throughout the year and find programs, tools and resources you might not be taking advantage of today. To register or log in, visit **mytevarewards.com** any time, from any device.

# How To Enroll

**1** **Log on** to **mytevabenefits.com**




**2** **Click "Enroll Now"** at the top to:

- View your personal details and Social Security number (SSN)
- Add/Edit dependents/beneficiaries and their SSNs
  - If your SSN is incorrect, contact AskHR via ServiceNow; you can correct any dependent SSN errors in the enrollment system.
- Compare plan offerings
- Select your benefits
  - If you used ALEX to compare plans, have a printout of the recommendations nearby while choosing your benefits.

**3** **Complete** your enrollment

- Once you've made your elections, you must confirm your choices to complete the enrollment process.
- Check to make sure your benefit elections and contributions are accurate.
- Enter the last four digits of your Social Security number.
- Click **"Confirm Enrollment."**
- If you change your elections after completing enrollment, you must reconfirm your choices; if you don't, your previously confirmed elections will remain valid.

**4** **Print** your Confirmation Statement for your records

- Review your Confirmation Statement for errors.
- If incorrect, go back into the enrollment system and make updates and resubmit before the enrollment period ends.

## Don't Forget!

Changes to your benefits during the year can only occur as a result of of a life event.

- Life Events
  - If you experience a life event (e.g., marriage, birth/adoption, death of a dependent, etc.), go to **mytevabenefits.com** to make changes to your benefits.
  - You have 30 days from the date of the event to make updates and provide supporting documentation.
  - To get started, click the "Life Events" link on the homepage, and then select the type of life event from the drop-down menus.
  - Questions? Call the Teva Benefits Service Center at **(800) 979-1733** (8:30 a.m.-8 p.m., ET, Monday-Friday).
- Designating Your Beneficiaries
  - Ensure that your beneficiaries are designated and up-to-date in the event of your death.
  - The beneficiary on file will receive the Teva benefits you're entitled to if you die.
  - To designate and manage your beneficiaries, visit **mytevabenefits.com** or call **(800) 979-1733**.

# Health & Wellness

Health is more than just taking care of your physical wellbeing. Health is about using the programs, tools and resources at Teva to make informed decisions and improve the quality of your life.

## Are You Eligible?

Teva offers medical, dental, vision and select voluntary benefits (Accident, Critical Illness and Hospital Indemnity Insurance) to all employees who are regularly scheduled to work 20 hours or more each week. Your benefits are effective on your date of hire.

You, your spouse/domestic partner (if applicable) and/or your eligible dependents (if applicable) can be enrolled in one of our four medical plans to receive both medical and prescription drug coverage. A valid Social Security number and proof of dependent status (e.g., a birth/adoption certificate, tax form or marriage license) is needed for each dependent. Newborn children can be enrolled without a Social Security number, but you'll need to provide the Social Security number within 90 days of birth.

Take a moment to review some **key definitions**.

### Eligibility Rules

You are a full-time employee for purposes of benefits eligibility if you are credited with at least 130 hours of service per month or an average of 30 hours of service per week. If we cannot determine beforehand whether you will be a full-time employee, we will determine the average number of hours of service per week or per month that you earn during a 12-month "measurement" period. If you work on average at least 130 hours per month or 30 hours per week during the measurement period, you will be a full-time employee for purposes of our benefits during the next 12-month "stability" period.

| Dependent* | Definition |
|---|---|
| **Spouse (same- or opposite-sex)** | An individual who is legally married to you. |
| **Domestic Partner (same- or opposite-sex)** | An individual who has been in a relationship of mutual caring for at least six months, resides with you and shares mutual obligation for basic living expenses.<br><br>You must submit documentation to verify your partner meets these requirements by completing the Affidavit of Domestic Partnership Enrollment Form and providing the form to the Teva Benefits Service Center. The form is available on mytevabenefits.com. If your covered beneficiaries are not defined as tax dependents by the Internal Revenue Service (IRS), Teva must calculate the estimated fair market value of your health benefits and charge the value to you as imputed income. |
| **Child** | Your or your spouse's or domestic partner's adult children up to age 26, or disabled** dependent children of any age. |

** Proof of dependent status is required at enrollment and may be required for re-verification periodically to ensure the accuracy of our records and coverage. Please take the time to review the eligibility criteria to ensure your covered dependents qualify for coverage. Any dependents found to be ineligible for coverage will be removed from the plan retroactive to your effective date in the plan.*

*** You must provide documentation of the disability and dependency of an adult child age 26 or older within 31 days of the child's 26th birthday.*

## ID Cards

If you enroll in medical/prescription drug or vision coverage, you will receive an ID card sent to your home address on file. You will not receive an ID card for dental coverage.

Be sure to show your ID cards to your doctors and pharmacists so they have the information for their billing records.

For ID card questions, call your Teva Care Coordinator at **(877) 922-6778**, or visit mytevahealth.com.

## Pre-Certification for Certain Medical Services

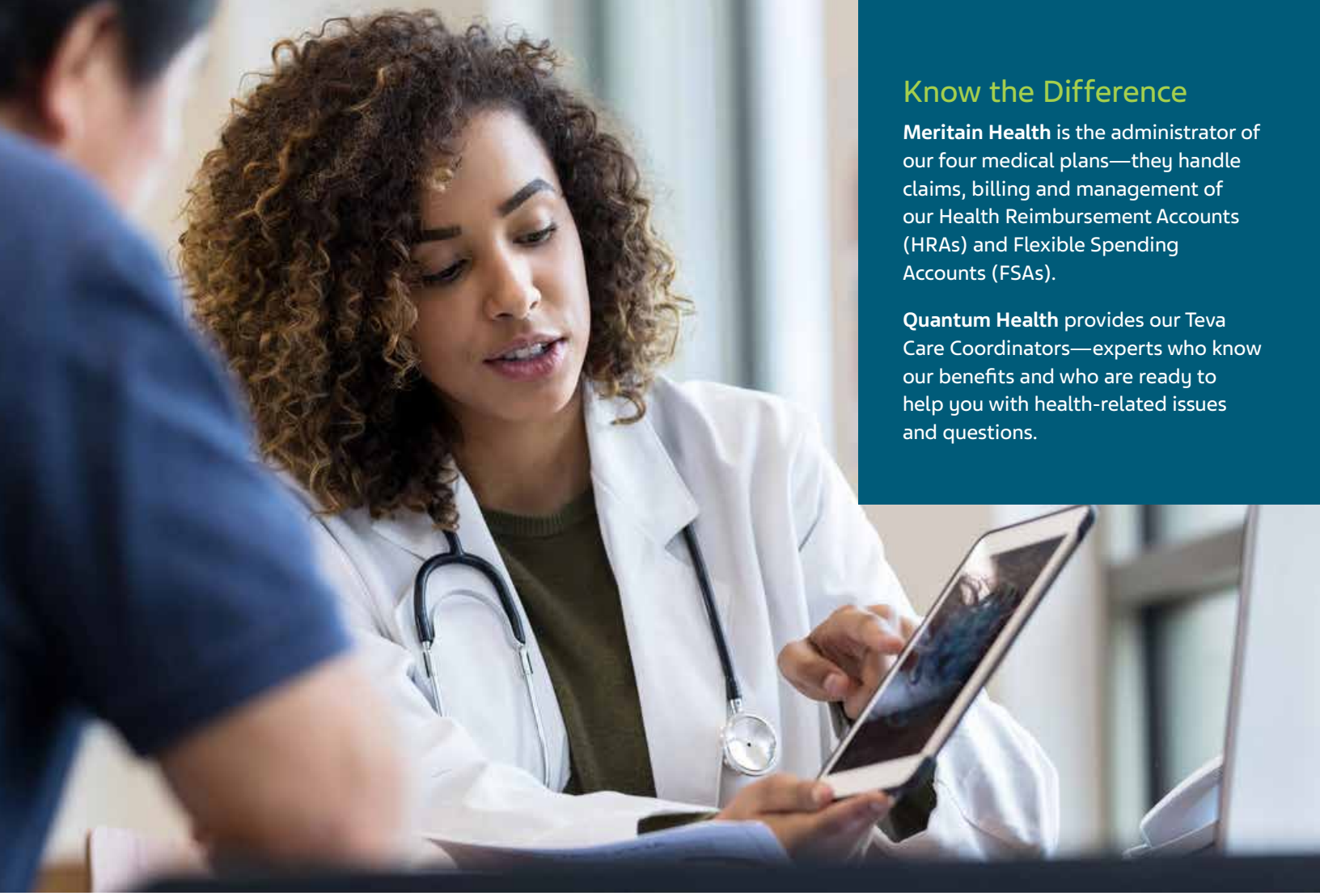
Before you receive certain medical services your health plan requires a doctor to obtain pre-certification to confirm the medical reason for that service or procedure.

The pre-certification process helps you and your doctor learn ahead of time whether or not a service will be covered—before you receive a bill. Also, this process ensures your Teva Care Coordinator is better informed so he/she can help coordinate your care.

Failure to obtain pre-certification could result in reduction of payment or denial of coverage for services. If you or your provider has any questions, please contact a Teva Care Coordinator at (877) 922-6778.

You must call your Teva Care Coordinator prior to getting any of the following services:

- Inpatient Admissions
- Durable Medical Equipment over $1,500
- Surgery (Inpatient or Outpatient)
- Transplants
- Home Health & Hospice
- Skilled Nursing Admissions
- MRI, MRA & PET Scans
- Oncology Therapy
- Therapy Services
- Dialysis
- Partial Hospitalization and Intensive Outpatient Care for Mental Health/Substance Abuse
- Applied Behavior Analysis (ABA) Therapy



## Know the Difference

**Meritain Health** is the administrator of our four medical plans—they handle claims, billing and management of our Health Reimbursement Accounts (HRAs) and Flexible Spending Accounts (FSAs).

**Quantum Health** provides our Teva Care Coordinators—experts who know our benefits and who are ready to help you with health-related issues and questions.

# Medical: An Overview

Teva offers four medical plan options. When you elect medical coverage through Teva, you automatically receive prescription drug benefits. Meritain Health (an Aetna company) is the administrator of all four medical plans. Those plans are:

- **Option 1 with Health Reimbursement Account (HRA)**
- **Option 2 with Health Savings Account (HSA)**
- **Option 3**
- **Option 4**

## In-Network Care

Although all four plans offer coverage for in- and out-of-network care, you can maximize your benefits and reduce your health care costs by using in-network providers. Call your Teva Care Coordinator at **(877) 922-6778** or visit mytevahealth.com to see if your doctors, specialists and hospitals are within the **Aetna POS II** network. If you plan to go out-of-network, consider using pre-tax Health Care FSA or HSA funds to offset your medical expenses.

## US Imaging Network

If enrolled in a Teva medical plan, US Imaging Network can help you and your family save money by scheduling your advanced radiology procedures, including MRI, CT and PET scans, at high-quality, in-network facilities that provide services at a reduced rate negotiated by Teva.

Call **(877) 874-6385** to schedule an in-network radiology appointment. You can also visit **usimagingnetwork.com** to learn more.

*Note: US Imaging Network, LLC and/or INA, LLC are not affiliated with US Imaging, Inc.*

# Medical Plan Comparison Chart

| | Option 1 with HRA | | Option 2 with HSA | | Option 3 | | Option 4 | |
|---|---|---|---|---|---|---|---|---|
| **Employee Premiums (Per Pay Period)** | | | | | | | | |
| **Employee Only** | $42.27 | | $28.62 | | $94.19 | | $16.71 | |
| **Employee + Spouse** | $121.05 | | $86.93 | | $251.37 | | $56.40 | |
| **Employee + Child(ren)** | $90.19 | | $64.03 | | $189.91 | | $40.79 | |
| **Employee + Family** | $166.21 | | $120.54 | | $340.82 | | $79.45 | |
| **Medical Services** | | | | | | | | |
| | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** | **In-Network** | **Out-of-Network** |
| **Preventive Care** | 100% covered; no deductible | 80% of R&C covered; no deductible | 100% covered; no deductible | 80% of R&C covered; no deductible | 100% covered; no deductible | 80% of R&C covered; no deductible | 100% covered; no deductible | 80% of R&C covered; no deductible |
| **Annual Deductible** | $1,500 Employee Only<br>$3,000 Employee + Family | $3,000 Employee Only<br>$6,000 Employee + Family | $1,500 Employee Only<br>$3,000 Employee + Family | $3,000 Employee Only<br>$6,000 Employee + Family | $500 Employee Only<br>$1,000 Employee + Family | $1,000 Employee Only<br>$2,000 Employee + Family | $1,800 Employee Only<br>$3,600 Employee + Family | $3,600 Employee Only<br>$7,200 Employee + Family |
| **Automatic Account Funding from Teva*** | $600 Employee Only<br>$1,200 Employee + Family | | $400 Employee Only<br>$800 Employee + Family | | No Teva funding | | No Teva funding | |
| **Coinsurance** | 80% after deductible | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 80% after deductible | 60% of R&C after deductible |
| **Annual Out-of-Pocket Maximum**** | $3,500 Employee Only<br>$7,000 Employee + Family | $7,000 Employee Only<br>$14,000 Employee + Family | $4,000 Employee Only<br>$8,000 Employee + Family | | $2,000 Employee Only<br>$4,000 Employee + Family | $4,000 Employee Only<br>$8,000 Employee + Family | $4,800 Employee Only<br>$9,600 Employee + Family | $9,600 Employee Only<br>$19,200 Employee + Family |
| **Annual Lifetime Maximum** | Unlimited | | | | | | | |
| **Primary Care Office Visit** | 80%; deductible waived | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 85%; deductible waived | 70% of R&C after deductible | 80%; deductible waived | 60% of R&C after deductible |
| **Specialty Care** | 80%; deductible waived | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 85%; deductible waived | 70% of R&C after deductible | 80%; deductible waived | 60% of R&C after deductible |
| **Physical Therapy (Outpatient)***** | 80% after deductible | 60% of R&C after deductible | 85% of R&C after deductible | 70% of R&C after deductible | 85% of R&C after deductible | 70% of R&C after deductible | 80% of R&C after deductible | 60% of R&C after deductible |
| **Behavioral Therapy** | $0 copay; deductible waived | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | $0 copay; deductible waived | 70% of R&C after deductible | $0 copay; deductible waived | 60% of R&C after deductible |
| **Emergency Room** | 80% after deductible; 50% after deductible for non-emergency | | 85% after deductible; 50% after deductible for non-emergency | | 85% after deductible; 50% after deductible for non-emergency | | 80% after deductible; 50% after deductible for non-emergency | |
| **Inpatient Hospital** | 80% after deductible | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 80% after deductible | 60% of R&C after deductible |
| **Outpatient Surgery** | 80% after deductible | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 80% after deductible | 60% of R&C after deductible |
| **Diagnostic Labs/ X-rays** | 80% after deductible | 60% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 85% after deductible | 70% of R&C after deductible | 80% after deductible | 60% of R&C after deductible |
| **Hearing** | | | | | | | | |
| **Evaluation** | 100% covered; no deductible | 60% of R&C after deductible; max. of one routine hearing exam per year | 85% after deductible | 70% of R&C after deductible; max. of one routine hearing exam per year | 100% covered; no deductible | 70% of R&C after deductible; max. of one routine hearing exam per year | 100% covered; no deductible | 60% of R&C after deductible; max. of one routine hearing exam per year |
| **Hearing Aids** | 80% after deductible for bilateral aids every five years; max. of $5,000 | | | | | | | |

** Automatic funding is pro-rated based on enrollment date.*

*** Out-of-pocket maximum includes deductible and coinsurance in all medical plan options.*

**** Calendar-year maximum benefit of 60 visits (includes telemedicine); once the maximum is exhausted, additional benefits may be allowed if determined to be medically necessary.*

*Note: Reasonable and customary (R&C) is the amount paid for a medical service in a geographic area based on what providers in the area charge for the same or similar medical service. R&C is used to determine the allowed amount paid by the Teva Medical Plan.*

## Option 1 with Health Reimbursement Account (HRA)

**Meritain Health is the administrator of all Teva medical plans, including Option 1 with HRA**. For a detailed comparison of Option 1 with HRA against our other plans, please see page 7.

| Coverage Level | Cost Per Pay Period | Automatic HRA Funding from Teva |
|---|---|---|
| **Employee Only** | $42.27 | $600 |
| **Employee + Spouse** | $121.05 | $1,200 |
| **Employee + Child(ren)** | $90.19 | $1,200 |
| **Employee + Family** | $166.21 | $1,200 |

### HRA Rollover Limit

Unused HRA credits in **Option 1 with HRA** roll over each year up to the in-network deductible and chosen coverage level but are reduced by the automatic HRA contribution provided by Teva ($900 for Employee Only; $1,800 for Family).

## Meet Jeff and Jill

**Ages:** Mid-30s

**Medical Plan:** **Option 1 with HRA**

**Coverage:** Employee + Family

**Premiums:** $166.21 per pay period

**Automatic HRA Funding:** +$1,200 in HRA credits from Teva

**Deductible:** $3,000 (in-network)

**Out-of-Pocket Maximum:** $7,000 (in-network)

**Situation:** Jeff and Jill live an active lifestyle with two kids. Jill enrolls in **Option 1 with HRA**. It has premiums they can afford and a lower deductible. Knowing a hospital stay is a possibility for any family member, Jill also enrolls in Hospital Indemnity Insurance. If a covered family member is hospitalized, Jill will get cash to help cover their medical expenses. To find out if Jeff and Jill needed to use their Hospital Indemnity Insurance, please see page 19.

## Health Reimbursement Account (HRA)

When you enroll in **Option 1 with Health Reimbursement Account (HRA),** you have access to an HRA.

| What Is It? | How Does It Work? | What Can I Use It For? |
|---|---|---|
| An HRA is used to pay for eligible medical expenses, including deductibles and coinsurance. HRAs cannot be used for prescription drug, vision or dental expenses. | Teva provides funding credits to your HRA when you enroll in **Option 1 with HRA** ($600 for Employee Only; $1,200 for Family).*<br><br>HRA credits do not roll over into an HSA. | HRA credits will be automatically used to pay for eligible medical expenses.<br><br>Common uses for HRA credits include eligible:<br>• Deductible amounts<br>• Coinsurance amounts<br>• Out-of-pocket expenses<br><br>The credits in the HRA are pooled and will be applied to eligible expenses incurred by any member of your family currently covered under **Option 1 with HRA**. |

** Automatic funding is prorated based on enrollment date.*

### All About: The HRA

HRA credits will automatically apply to eligible medical expenses. HRA credits can help offset the cost of your deductible, coinsurance or out-of-pocket expenses. Questions? Call your Teva Care Coordinator at **(877) 922-6778**.

## Key HRA Details

Here are a few things to keep in mind when managing and using an HRA:

- **Eligibility**
  - **When you enroll in Option 1 with HRA, you have access to an HRA.**
- **Funding**
  - The funding depends on your level of coverage when you enroll in **Option 1 with HRA** ($600 for Employee Only coverage; $1,200 for Family coverage)—this is an automatic credit from Teva.
  - You cannot make contributions to your HRA through payroll deductions.
  - HRA credits from Teva are pro-rated based on the date you enroll in **Option 1 with HRA.**
- **Rules/Limits**
  - All HRA credits are made by Teva, excluded from your gross taxable income and are tax-free.
  - In **Option 1 with HRA**, unused HRA credits roll over each year (up to $900 for Employee Only; up to $1,800 for Family). The maximums are lower than the plan's in-network deductible to account for the automatic HRA contribution provided by Teva for enrolling the plan.
  - Rollover HRA credits will be available to you early in the second quarter of the following year.
  - HRA credits cannot be rolled over into an HSA.
- **Administration**
  - The HRA is administered by Meritain Health.
  - If you are enrolled in **Option 1 with HRA**, and also enrolled in a Health Care Flexible Spending Account (FSA), eligible claims will be paid from your HRA first and your Health Care FSA second. Any available Health Care FSA funds will be reimbursed secondarily to your available HRA credits.

### HRA Rollover Limit

Unused HRA credits in **Option 1 with HRA** roll over each year up to the in-network deductible and chosen coverage level but are reduced by the automatic HRA contribution provided by Teva ($900 for Employee Only; $1,800 for Family).

## Option 2 with Health Savings Account (HSA)

**Meritain Health is the administrator of all Teva medical plans, including Option 2 with HSA.** For a detailed comparison of **Option 2 with HSA** against our other plans, please see page 7.

| Coverage Level | Cost Per Pay Period | Automatic HSA Funding from Teva |
|---|---|---|
| **Employee Only** | $28.62 | $400 |
| **Employee + Spouse** | $86.93 | $800 |
| **Employee + Child(ren)** | $64.03 | $800 |
| **Employee + Family** | $120.54 | $800 |

### Individual v. Family Deductibles in Option 2 with HSA

There is no individual deductible in **Option 2 with HSA** when you cover one or more dependents. This means that one or all covered family members combined must reach the $3,000 deductible before the plan begins to pay medical or prescription drug benefits. To clarify, if one family member reaches $1,500 in health care expenses, the plan will not pay benefits for that individual until the $3,000 family deductible is reached. You may use your available HSA dollars to pay for eligible expenses related to your deductible.

## Meet Javier

**Age:** 45

**Medical Plan:** **Option 2 with HSA**

**Coverage:** Employee Only

**Premiums:** $28.62 per pay period

**Automatic HSA Funding:** +$400 in HSA contributions from Teva

**Deductible:** $1,500 (in-network)

**Out-of-Pocket Maximum:** $4,000 (in-network)

**Situation:** Javier likes to travel. He enrolls in **Option 2 with HSA** because the premiums and deductibles are affordable. Plus, he likes the tax advantages and long-term savings opportunities of the HSA. Javier also enrolls in Identity Theft Protection. Due to his extensive travel and complicated personal finances, he chooses to enroll in case he needs additional financial protection if his identity is compromised. To see if Javier needed to use his Identity Theft Protection, please see page 19.

## Health Savings Account (HSA)

When you enroll in **Option 2 with HSA**, you have access to a **Health Savings Account**.

| What Is It? | How Does It Work? | What Can I Use It For? |
|---|---|---|
| An HSA is a tax-free account for yourself, your spouse and your dependents.<br><br>The HSA allows you to save money for current and future medical expenses, helping you have funds available for qualified medical expenses when you'll likely need them most—in retirement.<br><br>Both you and Teva can contribute to your HSA up to the combined IRS maximum for 2023. If you are age 55 or older, you are eligible to make "catch-up" contributions that do not count toward the maximum. | Teva contributes dollars to your HSA when you enroll in **Option 2 with HSA** ($400 for Employee Only; $800 for Family).*<br><br>The money is "portable"—it's yours to keep when you leave or retire from Teva.<br><br>There is no "use it or lose it" feature; HSA funds roll over each year.<br><br>HSA funds do not roll over into an HRA. | You can use your HSA debit card to pay for eligible services; this card functions just like a bank debit card.<br><br>Common medical expenses you can use HSA funds for include:<br>• Deductible amounts<br>• Office visits and/or prescription drug costs<br>• Coinsurance amounts<br>• Dental treatment and orthodontia<br>• Eyeglasses, contact lenses and solution<br>• Certain over-the-counter health care products and medications (prescription required)<br><br>For questions about what is considered an eligible medical expense, visit irs.gov and search for Publication 969 and Publication 502. |

** Automatic funding is pro-rated based on enrollment date.*

## Key HSA Details

Here are a few things to keep in mind when managing and using an HSA:

- **Eligibility**
  - **When you enroll in Option 2 with HSA, you have access to an HSA.**
  - You do not have access to an HSA if you are covered under another non-high-deductible health plan, enrolled in Medicare and/or claimed as a dependent on someone else's tax return.
- **Funding**
  - Funding depends on your level of coverage when you enroll in **Option 2 with HSA** ($400 Employee Only; $800 Family)—this is an automatic contribution from Teva.
  - You can also contribute to your HSA through pre-tax payroll deductions.
- **Rules/Limits**
  - The combined maximum contributions for 2023 established by the IRS are $3,850 for Employee Only coverage; $7,750 for Family coverage.
  - If you are age 55 or older, you are eligible to make up to $1,000 in "catch-up" contributions that do not count toward the maximum.
  - HSA contributions from Teva are pro-rated based on the date you enroll in **Option 2 with HSA**.
  - Any change in coverage status during the year (e.g., Employee Only to Family) does not change the amount of HSA contributions from Teva.
  - There is no time limit of when you can submit for reimbursement for a qualified expense.
  - Keep your receipts in case the IRS asks you to prove how you're spending your HSA dollars.
  - A significant tax penalty will be levied against you for using HSA dollars for ineligible purchases.
  - HSA funds cannot be rolled over into an HRA.
- **Administration**
  - The HSA is administered by Fidelity.
  - You must activate your Fidelity HSA in order to receive funding from Teva.
  - For more information about the HSA, please visit netbenefits.com or call **(800) 544-3716.**

## 3 Things to Know: Option 2 with HSA

1. **Deductible:** When you enroll in **Option 2 with HSA**, you must meet your deductible before the medical plan begins to pay benefits. This includes all family members combined meeting the Family deductible (not an individual family member meeting the Employee Only deductible).
2. **Prescription Drugs:** Prescription drugs are subject to the deductible. This means you can expect to pay the full cost of non-preventive medications (including Teva generics) until you reach the deductible. You can use your HSA to pay for prescription drugs.
3. **Amwell:** Due to IRS regulations, if you enroll in **Option 2 with HSA**, you can use Amwell (our telehealth provider) for a nominal amount. What you pay to use Amwell will count toward your deductible.

## Option 3

**Meritain Health is the administrator of all Teva medical plans, including Option 3.**
For a detailed comparison of Option 3 against our other plans, please see page 7.

| Coverage Level | Cost Per Pay Period |
|---|---|
| **Employee Only** | $94.19 |
| **Employee + Spouse** | $251.37 |
| **Employee + Child(ren)** | $189.91 |
| **Employee + Family** | $340.82 |

## Meet Amanda and Kristen

**Ages:** Mid-40s

**Medical Plan:** **Option 3**

**Coverage:** Employee + Spouse

**Premiums:** $251.37 per pay period

**Automatic Account Funding:** None

**Deductible:** $1,000 (in-network)

**Out-of-Pocket Maximum:** $4,000 (in-network)

**Situation:** Amanda's wife, Kristen, has chronic health conditions. Amanda enrolls in **Option 3** even with its higher premiums because she knows she and Kristen will reach the deductible (and possibly the out-of-pocket maximum). For extra coverage, Amanda enrolls in Critical Illness Insurance. Should she or Kristen have a covered illness, they'll receive cash to help cover the medical expenses. To find out if Amanda needed to use her Critical Illness Insurance, please see page 19.

## Option 4

**Meritain Health is the administrator of all Teva medical plans, including Option 4.**
For a detailed comparison of Option 4 against our other plans, please see page 7.

| Coverage Level | Cost Per Pay Period |
|---|---|
| **Employee Only** | $16.71 |
| **Employee + Spouse** | $56.40 |
| **Employee + Child(ren)** | $40.79 |
| **Employee + Family** | $79.45 |

## Meet Carmen

**Age:** 35

**Medical Plan:** **Option 4**

**Coverage:** Employee + Child(ren)

**Premiums:** $40.79 per pay period

**Automatic Account Funding:** None

**Deductible:** $3,600 (in-network)

**Out-of-Pocket Maximum:** $9,600 (in-network)

**Situation:** Carmen is living paycheck-to-paycheck, so she likes the low premiums of **Option 4**—even if the deductible is higher than other plans. Carmen is healthy and mostly wants coverage for her daughter. She also enrolls in Accident Insurance. If something happens to her daughter, Carmen will get cash to help cover the accident costs. To see if Carmen needed to use her Accident Insurance, please see page 19.

# Voluntary Benefits

Voluntary benefits provide employees who are regularly scheduled to work at least 20 hours per week with additional financial protection in the event of an accident, critical illness, hospital stay, covered legal matter or disability.

Accident, Critical Illness and Hospital Indemnity Insurance are designed to give you and your family extra coverage beyond what's provided by the Teva Medical Plan. **Before you and your family pay for extra coverage, think about if these voluntary benefits are right for your physical and financial situation.**

## Accident Insurance

Accident Insurance through Aetna pays cash to help you with out-of-pocket expenses if you are accidentally injured—on- or off-the-job. The amount of the benefit depends on the type of injury and the service you receive. The plan pays benefits for inpatient and outpatient services for covered accidents and includes coverage for dislocations or fractures, doctor or urgent care services, physical therapy, emergency room treatment and ambulance rides.

Costs of coverage are based on your election and whom you choose to cover; please see the online enrollment system at **mytevabenefits.com** for details and premium amounts.

## Critical Illness Insurance

Critical Illness Insurance through Aetna can help with the treatment costs of covered critical illnesses, such as cancer, a heart attack, Alzheimer's disease, benign brain tumors or a stroke, plus additional secondary conditions ranging from diphtheria to tuberculosis. The coverage pays a lump-sum, cash benefit upon initial diagnosis of a covered critical illness.

For coverage for yourself, you can choose from $10,000 to $50,000 (in $5,000 increments).

For coverage for your spouse and children, the benefit will be 50% of the amount you choose for yourself.

Costs of coverage are based on your election, whom you choose to cover and your use of tobacco; please see the online enrollment system at **mytevabenefits.com** for details and premium amounts.

## Hospital Indemnity Insurance

Hospital Indemnity Insurance through Reliance Standard provides financial assistance to enhance your current medical coverage. If you are hospitalized as a resident bed patient due to a covered sickness or for injuries received in a covered accident, you are eligible for a cash benefit. You have two options:

- Standard Plan, which pays:
  - $500 for hospital admission (twice per calendar year)
  - $200 per day for hospital ongoing care (up to 31 days per calendar year)
  - $400 per day for Intensive Care Unit (ICU) confinement (twice per calendar year; up to 31 days)
- High Plan, which pays:
  - $1,000 for hospital admission (twice per calendar year)
  - $300 per day for hospital ongoing care (up to 31 days per calendar year)
  - $600 per day for Intensive Care Unit (ICU) confinement (twice per calendar year; up to 31 days)

Costs of coverage are based on your election and whom you choose to cover; please see the online enrollment system at **mytevabenefits.com** for details and premium amounts.

## Identify Theft Protection

Identity Theft Protection through NortonLifeLock protects your digital life in an always-connected world. You receive monitoring of personal information and records, proactive alerts by email, phone or text when an identity theft is in progress and help canceling and replacing the contents of a lost wallet or purse. You will also receive complete identity restoration and reimbursement of up to $1 million for stolen funds.

You can choose between the Benefit Essential and Benefit Premier Plans. Be sure to provide a primary personal or mobile phone number, personal email and Social Security numbers for all covered dependents. Cost of coverage is based on whom you choose to cover; please see the online enrollment system at **mytevabenefits.com** for details and premium amounts.

## Whole Life with Long-Term Care (LTC)

An additional life insurance coverage option for you and your family is Whole Life Insurance with Long-Term Care, or LTC, provided by Unum. Premiums for you and your spouse/domestic partner are based on age and tobacco use.

### Coverage for You

You can elect from $10,000 to $300,000. Coverage amounts are in $10,000 increments.

### Coverage for Your Family

You do not need to elect coverage for yourself to elect coverage for your spouse/domestic partner and child(ren).

You can elect from $10,000 to $70,000 in coverage for your spouse/domestic partner. Coverage amounts are in $10,000 increments.

You can elect from $5,000 to $25,000 in coverage for your child(ren). Coverage amounts are in $5,000 increments.

Costs of coverage are based on your election, whom you choose to cover and your use of tobacco; please see the online enrollment system at mytevabenefits.com for details and premium amounts.

## All about: Whole Life with LTC

The advantages of a Whole Life Insurance policy are:

- **Costs:** The costs stay the same over time. So, as you age, what you pay for coverage doesn't change.
- **Benefit:** The benefit amount and costs stay the same over time. So, as you age, your benefit amount doesn't change.
- **Long-Term Care Rider:** Allows you to use the policy's death benefit to pay for long-term needs.
- **"Living" benefit:** Allows you to request an early payout of the policy's death benefit following the diagnosis of a terminal illness.

## Excess Liability Insurance

Excess Liability Insurance* through Chubb helps cover high-cost damages when you or a dependent may be legally responsible. The coverage begins when the amount you are required to pay from a covered lawsuit judgment exceeds the limits of liability under your other insurance policies. Coverage is offered in wide ranges for property damage and bodily injury, personal injury, defense costs and underinsured or uninsured motorists. The premium for this plan is annualized and is due in full at the start of coverage. Cost of coverage is based on your election; please see the online enrollment system at mytevabenefits.com for details and premium amounts.

## Supplemental Individual Disability Insurance (IDI)

Supplemental Individual Disability Insurance (IDI)* through Unum can supplement your existing basic Long-Term Disability (LTD) coverage offered at no cost to you. If you qualify, the current LTD benefit begins when Short-Term Disability (STD) coverage ends. The LTD plan pays 60% of base salary, up to a reduced $15,000 per month. The IDI "buy-up" option is tax-favorable, includes bonus and commission dollars and provides coverage beyond the monthly maximum limit.

Cost of coverage is based on your salary; please see the online enrollment system at mytevabenefits.com for details and premium amounts. This benefit is only offered once a year during the Annual Benefits Enrollment period each fall.

** This benefit is only available to employees who are global grade 10 and above.*

# Voluntary Benefits Comparison Chart

Teva offers many voluntary benefits to help you complement your other coverage from the company. See below to learn more about these benefits, so you can decide if any of them are right for your physical and financial situation.

| | Accident | Critical Illness | Hospital Indemnity | Identity Theft Protection | Whole Life with LTC | Excess Liability Insurance | Supplemental Individual Disability Insurance (IDI) |
|---|---|---|---|---|---|---|---|
| **Eligibility** | All employees | All employees | All employees | All employees | All employees | Global grade 10 and above | Global grade 10 and above |
| **Premium Payments** | You (via payroll deductions) | You (via payroll deductions) | You (via payroll deductions) | You (via payroll deductions) | You (via payroll deductions) | You (via one lump-sum payroll deduction) | You (via payroll deductions) |
| **How Premiums are Determined** | Based on your election and whom you choose to cover | Based on your election, whom you choose to cover and tobacco use | Based on your election and whom you choose to cover | Based on whom you choose to cover | Based on your election, whom you choose to cover and tobacco use | Based on your election | Based on your salary |
| **Benefit Description** | Pays a benefit for inpatient and outpatient services for covered accidents | Pays a benefit upon initial diagnosis of a covered illness (cancer, heart attack, etc.) | Pays a benefit if you are hospitalized as a resident bed patient due to a covered condition or for injuries received in a covered accident | Provides monitoring of personal information and records, alerts when identity theft is in progress, help replacing lost wallets/ purses; reimburses up to $1 million for stolen funds | Provides guaranteed life insurance (no change in coverage or cost), plus the flexibility to use the policy early for long-term care or terminal illness needs | Helps cover high-cost damages when you or a dependent may be legally responsible | Supplements your existing basic Long-Term Disability (LTD) Insurance |
| **Coverage Details** | Benefit amount depends on the type of injury and the service you receive | Choose between $10,000 and $50,000 of coverage (in $5,000 increments); coverage for your spouse and child(ren) will be 50% of yours | Choose between the Basic Plan and the Premium Plan | Choose between the Benefit Essential and the Benefit Premier Plans; coverage for yourself and your dependents | Choose up to $300,00 in coverage for yourself; up to $70,000 in coverage for spouse/ domestic partner; up to $25,000 for child(ren) | Coverage begins when the amount you are required to pay by a covered lawsuit judgment exceeds the limits of liability under other insurance policies | Provides a tax-favorable disability "buy-up" option that includes bonus and commission dollars and coverage beyond the monthly maximum limit |
| **Payout** | Lump-sum cash | Lump-sum cash | Lump-sum cash | N/A | Varies depending on coverage and use of benefit | Paid to other parties or organizations directly | Monthly benefit |
| **Administrator** | Aetna | Aetna | Reliance Standard | NortonLifeLock | Unum | Chubb | Unum |

## Costs for Coverage

To see your premiums per pay period for any of our voluntary benefits, visit **mytevabenefits.com**.

# Real-World Examples: Voluntary Benefits

## Active Kids? Meet Jeff and Jill.

**Ages:** Mid-30s

**Family:** Married with two children

**Medical Plan: Option 1 with HRA**

**Voluntary Benefit:** Hospital Indemnity – Premium Plan

**Situation:** Jeff and Jill know a hospital stay for any family member is a possibility. That's why Jill elected the Premium Plan. After getting a concussion at recess, one of their kids is hospitalized overnight for observation. Jeff and Jill receive a $1,300 lump-sum, cash benefit from Reliance Standard ($1,000 for being admitted; $300 for one night in the hospital). They can use the money however they'd like, but they choose to put it towards their child's medical expenses.

## Worried About Privacy? Meet Javier.

**Age:** 45

**Family:** Single

**Medical Plan: Option 2 with HSA**

**Voluntary Benefit:** Identity Theft Protection

**Situation:** When Javier's tax refund check never shows up, he calls the IRS and finds out his refund has been sent to someone posing as him. Now Javier must prove his identity to the IRS. He calls NortonLifeLock and authorizes them to act on his behalf to recoup the stolen tax return and change key records with the government. Best of all, NortonLifeLock writes him a check for the tax refund so he doesn't have to wait for his money while the issue gets resolved with the IRS.

## Dealing with a Chronic Condition? Meet Amanda and Kristen.

**Ages:** Mid-40s

**Family:** Spouse

**Medical Plan: Option 3**

**Voluntary Benefit:** Critical Illness – $10,000 benefit

**Situation:** One night, Amanda's wife, Kristen, is rushed to the hospital with chest pains. A doctor confirms she had a heart attack. Amanda and Kristen receive a $10,000 lump-sum, cash benefit from Aetna. They can use the money however they'd like, but they choose to put it toward Kristen's medical expenses.

## Accident Prone? Meet Carmen.

**Age:** 35

**Family:** Single mom

**Medical Plan: Option 4**

**Voluntary Benefit:** Accident Insurance

**Situation:** During a soccer game, Carmen's daughter fractures her ankle. Under her Accident Insurance coverage, Carmen receives a lump-sum, cash benefit from Aetna for her daughter's injury. Carmen can use the money however she'd like, but she chooses to put it toward covering the medical expenses.

# Prescription Drugs

When you elect Teva medical coverage, you automatically receive prescription drug coverage through CVS Caremark.

| | Option 1 with HRA | Option 2 with HSA | Option 3 | Option 4 |
|---|---|---|---|---|
| **Retail (up to a 30-day supply)** | | | | |
| **Teva Generic & Brand** | $0 | $0 after deductible* | $0 | $0 |
| **Generic** | $6 | $6 after deductible* | $6 | $6 |
| **Brand Preferred**** | $30 | 85% after deductible* ($10 min.; $50 max.) | $30 | $30 |
| **Brand Non-Preferred**** | $50 | 85% after deductible* ($10 min.; $75 max.) | $50 | $50 |
| **Retail or Mail Order (90-day supply)** | | | | |
| **Teva Generic & Brand** | $0 | $0 after deductible* | $0 | $0 |
| **Generic** | $12 | $12 after deductible* | $12 | $12 |
| **Brand Preferred**** | $75 | 85% after deductible* ($20 min.; $100 max.) | $75 | $75 |
| **Brand Non-Preferred**** | $125 | 85% after deductible* ($20 min.; $150 max.) | $125 | $125 |
| | | | | |
| **Prescription Drug Out-of-Pocket Maximum** | $2,500 Individual $5,000 Family | Combined with medical | $2,500 Individual $5,000 Family | $2,500 Individual $5,000 Family |

** Deductible waived for certain preventive medications and prenatal vitamins. Contact your Teva Care Coordinator at (877) 922-6778 for a list of preventive medications.*

*** Log into your caremark.com account to see which brand-name prescriptions are preferred.*

## Maximum Limits for Specialty Medications

The maximum prescription fill or refill for specialty medications is 30 days. This limit supports the safe, clinically appropriate and cost-effective use of these prescriptions.

Specialty medications are products used to treat chronic, high-cost or rare diseases that tend to be more complex to maintain, administer and monitor than traditional drugs. Therefore, these drugs require closer supervision and monitoring of a patient's overall therapy.

Routine non-specialty maintenance medications can be filled with a 90-day supply. If you need a new prescription, your doctor can contact CVS Caremark directly at **(888) 265-7790**. Or, you can contact CVS Caremark at **(888) 265-7790** and ask them to contact your doctor on your behalf.

# Dental

Delta Dental of New Jersey is the provider of our dental coverage.
Dental coverage is a separate benefit (not included in our medical plans).

| Employee Premiums | Cost Per Pay Period |
|---|---|
| **Employee Only** | $9.61 |
| **Employee + Spouse** | $23.35 |
| **Employee + Child(ren)** | $19.22 |
| **Employee + Family** | $32.97 |

## Extra Support

Our dental plan provides extra assistance for those managing periodontal disease and those who have specific health conditions. The plan also offers extra coverage for bitewing X-rays for children and fillings on posterior teeth.

| | Dental PPO | |
|---|---|---|
| | In-Network | Out-of-Network |
| **Annual Deductible** | Employee Only: $50<br>Employee + 1: $100<br>Employee + Family: $150 | |
| **Class I: Preventive**<br>Oral exams, routine cleanings, fluoride treatments, sealants, full-mouth X-rays, bitewing X-rays, space maintainers | 100% covered;<br>no deductible | 100% of R&C covered;<br>no deductible |
| **Class II: Basic Restorative**<br>Fillings, root canal therapy, stainless steel crowns, gingivectomy, simple extractions, scaling and root planning, full and partial body impacts | 90% covered<br>after deductible | 80% of R&C covered<br>after deductible |
| **Class III: Major Restorative**<br>Crowns, dentures, bridges, inlays, onlays, osseous surgery, repairs to crowns and inlays | 60% covered<br>after deductible | 50% of R&C covered<br>after deductible |
| **Class IV: Orthodontia** | 50% child and adult | |
| **Lifetime Maximum for Orthodontia** | $2,000 per lifetime | |
| **Annual Benefit Maximum** | $2,000 per person | |

*Note: Delta Dental's Oral Health Enhancement Option enables you to receive up to four dental cleanings and/or periodontal maintenance procedures in any combination per benefit period if you have been treated for periodontal (gum) disease in the past. For the additional dental cleaning and/or periodontal maintenance procedures to be covered, you must have had periodontal surgery or periodontal scaling and planing in the past. Details on how to qualify can be found in your benefit booklet. In addition, members with defined medical conditions such as Diabetes, Cardiovascular Disease, Pregnancy or are undergoing certain Cancer treatments may qualify for up to two additional cleanings when certified by a physician or dentist.*

## Keep in Mind...

- To see if your dentist participates in the Delta Dental PPO or Premier network, go to **www.deltadentalnj.com**.
- Log on to the "My Smile" portal (or select Register to create an account) to check benefits, eligibility and claim status, opt for paperless statements, view or print an ID Card and use our cost estimator tool.
- The "Find a dentist" feature helps you locate a Delta Dental PPO or Premier network dentist in your area. Narrow your search by location, specialty, languages spoken and more.
- You can go to any dental care provider you choose; however, claims for services provided by dentists who are neither Delta Dental Premier, Delta Dental PPO dentists or Participating Specialists are paid based on the lesser of the dentist's actual charge or the prevailing fee. You would be responsible for the difference between the approved fee and the non-participating dentist's submitted charge.

# Vision

Aetna Vision℠ Preferred is the provider of our two vision plans. Vision coverage is a separate benefit (not included in our medical plans).

| Employee Premiums (Cost Per Pay Period) | Low Plan | High Plan |
|---|---|---|
| **Employee Only** | $1.75 | $3.32 |
| **Employee + Spouse** | $3.33 | $6.30 |
| **Employee + Child(ren)** | $3.50 | $6.64 |
| **Employee + Family** | $5.15 | $9.76 |

| | Low Plan | | High Plan | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Routine Eye Exam** (every calendar year) | $20 copay | $35 reimbursement | $0 copay | $35 reimbursement |
| **Eyeglass Lenses*** | $20 copay (available every calendar year) | $30 - $75 reimbursement (based on lens type) | $15 copay (available every calendar year) | $40 - $80 reimbursement (based on lens type) |
| **Contact Lenses*** | $150 allowance; 15% off remaining balance (available every calendar year) | $105 reimbursement (conventional and disposable) | $200 allowance; 15% off remaining balance (available every calendar year) | $135 reimbursement (conventional and disposable) |
| **Eyeglass Frames** | $150 allowance; 20% off remaining balance (available every two calendar years) | $75 reimbursement | $200 allowance; 20% off remaining balance (available every calendar year) | $110 reimbursement |

** You can use your vision coverage once every plan year to purchase either one pair of eyeglass lenses OR one order of contact lenses.*

## Keep in Mind...

- You can use your vision coverage once every plan year to purchase either **one** pair of eyeglass lenses OR **one** order of contact lenses.
- You will receive the greatest benefit—and save money—by using in-network providers for your eyeglass and contact lens needs.
- Visit **aetnavision.com** to search for in-network providers and get information on additional discounts.

# Health Care Flexible Spending Account (FSA)

You do not need to be enrolled in a medical plan through Teva to take advantage of a Health Care FSA.
When you enroll in **Option 1 with HRA**, **Option 3** or **Option 4**, you have access to a Health Care FSA. When you enroll in **Option 2 with HSA,** you have access to a Limited Expense Health Care FSA; see the **next page** for more details.

| What Is It? | How Does It Work? | What Can I Use It For? |
|---|---|---|
| The Health Care FSA allows you to set aside a portion of your salary, before taxes, to reimburse yourself for certain amounts spent for eligible medical expenses. | Contributions are made through payroll deductions over the course of the year.<br><br>You choose how to use these pre-tax dollars to pay for eligible medical expenses. | **These funds cannot be used to pay for dependent day care expenses. For those expenses, enroll in the Dependent Care FSA.**<br><br>Health Care FSA dollars can be used for:<br>• Deductible amounts<br>• Office visits and/or prescription drugs<br>• Coinsurance amounts<br>• Dental treatment and orthodontia<br>• Eyeglasses, contact lenses and solution<br>• Certain over-the-counter health care products and medications (prescription required)<br><br>For a list of eligible health care expenses, visit Meritain Health at account.meritain.com. |

## Key Health Care FSA Details

- **Eligibility**
  - Should you wish to participate in a Health Care FSA, you must actively enroll each year.
- **Funding**
  - You contribute to the Health Care FSA through pre-tax payroll deductions.
  - Contributions are made over the course of the year.
  - You may roll over up to $570 from 2022 to 2023; any remaining funds (even those rolled over from prior years), must be used on eligible expenses incurred on or before December 31, 2022, or the funds will be forfeited.
  - Rollover funds for Health Care FSAs are only available if you remain eligible for contributing to a Health Care FSA the following year based on your medical plan election. You cannot rollover Health Care FSA dollars to a Limited Expense Health Care FSA or vice versa (see **page 24** for details on Limited Expense FSAs).
  - Rollover Health Care FSA dollars will be available to you early in the second quarter of the following year.
- **Rules/Limits**
  - For 2023, you can set aside $120 to $3,050 in a Health Care FSA.
  - Health Care FSA dollars may be used for eligible medical, prescription drug, dental and vision expenses; the Health Care FSA debit card can be used for prescription drugs only.
  - You may not use FSAs to pay for otherwise eligible expenses incurred on behalf of a domestic partner or a domestic partner's children.
- **Administration**
  - The Health Care and Limited Expense FSAs are administered by Meritain Health.
  - If enrolled in a Teva medical plan and a Health Care FSA, you will receive a debit card from Meritain Health; this debit card can only be used to buy prescription drugs at a pharmacy.
  - Visit account.meritain.com for a full list of eligible expenses, claim forms, information and more.

## Example: Health Care FSA

This example shows how a Health Care FSA allows you to save pre-tax dollars while lowering your taxable income at the same time.

| | Without Health Care FSA | With Health Care FSA |
|---|---|---|
| **Annual Gross Pay** | $30,000.00 | $30,000.00 |
| **Pre-Tax Health Care FSA Contribution** | $0.00 | $1,000.00 |
| **Taxable Gross Pay** | **$30,000.00** | **$29,000.00** |
| **Federal Income Tax (15%)** | $4,500.00 | $4,350.00 |
| **FICA Tax (7.65%)*** | $2,295.00 | $2,218.50 |
| **Health Care Expenses** | $1,000.00 | $0.00 (Uses FSA funds) |
| **Net Take-Home Pay** | **$22,205.00** | **$22,431.50** |
| **Total Tax Savings** | **N/A** | **$226.50** |

** Note: The FICA tax may differ from 7.65%. Consult a tax advisor.*

## Keep in Mind...

Health Care FSAs provide an opportunity to use pre-tax dollars to pay for eligible medical expenses. These tax-advantaged accounts can stretch your health care dollars and limit what you pay out of your own pocket for health care. It can work in conjunction with **Option 1 with HRA**, **Option 3** or **Option 4**. Eligible claims will be paid from any HRA first and your Health Care FSA second. Questions? Call Meritain Health at **(800) 566-9305** (enter 9, then ext. 120-000-2614) or visit account.meritain.com.

## Limited Expense Health Care Flexible Spending Account

When you enroll in a Health Savings Account (HSA), the Limited Expense Health Care FSA lets you put away pre-tax dollars to pay for qualified dental and vision expenses only. The Limited Expense Health Care FSA works together with your HSA to cover eligible expenses. For 2023, you can set aside $120 to $3,050. You may roll over up to $570 from 2022 to 2023; any remaining funds (even those rolled over from prior years), must be used on eligible expenses incurred on or before December 31, 2022, or the funds will be forfeited.

# Dependent Care Flexible Spending Account (FSA)

You do not need to enroll in a medical plan through Teva to take advantage of a Dependent Care FSA.

| What Is It? | How Does It Work? | What Can I Use It For? |
|---|---|---|
| The Dependent Care FSA allows you to set aside a portion of your salary, before taxes, to reimburse yourself for certain amounts spent for eligible dependent day care expenses that are necessary for you to work. | Contributions are made through pre-tax payroll deductions over the course of the year. **The money you choose to set aside for 2023 accrues with each pay period**.<br><br>You choose how to use these pre-tax dollars to pay for eligible dependent care expenses. | This account is not for medical, health care or dental expenses for your dependents. For these expenses, enroll in the Health Care FSA.<br><br>Dependent Care FSA dollars can be used for:<br>• Child care or dependent care facilities<br>• Services in your home or someone else's home while you or your spouse is working, looking for work or attending school full-time<br><br>For a list of eligible dependent care expenses, visit Meritain Health at account.meritain.com. |

## Key Dependent Care FSA Details

- **Eligibility**
  - Should you wish to participate in a Dependent Care FSA, you must actively enroll each year.
  - You must be at work, at school or looking for work during the time your eligible dependent (under age 13) receives care.
  - You must also meet one of the following guidelines:
    - You are a single parent,
    - You have a working spouse,
    - Your spouse is a full-time student for at least five months during the year while you are working,
    - Your spouse is physically or mentally unable to provide for his/her own care, or
    - You are divorced or legally separated and have custody of your child most of the time, even though your former spouse may claim the child for income tax purposes.
- **Funding**
  - You contribute to the Dependent Care FSA through pre-tax payroll deductions.
  - If you are defined as a "highly compensated employee," your contributions may be limited either during the Annual Benefits Enrollment period or during the plan year. Participation by lower-paid employees must meet certain federal benchmarks for "highly compensated employees" to fully participate in the Dependent Care FSA. You will be notified if your contributions will be limited.
  - Contributions are made over the course of the year.
- **Rules/Limits**
  - For 2023, you can set aside $120 to $5,000 in a Dependent Care FSA (up to $2,500 if you are married and filing separately).
  - Unused Dependent Care FSA funds can be submitted to Meritain Health for reimbursement for expenses incurred on or before December 31, 2022.
- **Administration**
  - The Dependent Care FSA is administered by Meritain Health.
  - Visit account.meritain.com for a full list of eligible expenses, claim forms, information and more.

## Example: Dependent Care FSA

This example shows how a Dependent Care FSA allows you to save pre-tax dollars while lowering your taxable income at the same time.

| | Without Dependent Care FSA | With Dependent Care FSA |
|---|---|---|
| **Annual Gross Pay** | $30,000.00 | $30,000.00 |
| **Pre-Tax Dependent Care FSA Contribution** | $0.00 | $4,000.00 |
| **Taxable Gross Pay** | **$30,000.00** | **$26,000.00** |
| **Federal Income Tax (15%)** | $4,500.00 | $3,900.00 |
| **FICA Tax (7.65%)*** | $2,295.00 | $1,989.00 |
| **Dependent Care Expenses** | $4,000.00 | $0.00 (Uses FSA funds) |
| **Net Take-Home Pay** | **$19,205.00** | **$20,111.00** |
| **Total Tax Savings** | **N/A** | **$906.00** |

** Note: The FICA tax may differ from 7.65%. Consult a tax advisor.*

## Keep in Mind...

Dependent Care FSAs provide an opportunity to use pre-tax dollars to pay for eligible dependent care expenses. If you know you're going to incur dependent care expenses, you can set aside what you think you'll spend (up to the IRS limit) and reap the tax benefits in the process. Questions? Call Meritain Health at **(800) 566-9305** (enter 9, then ext. 120-000-2614) or visit **account.meritain.com**.

# Account Comparison Chart

Teva offers many accounts to help you stretch your health care dollars. See below for how these accounts compare and how to use them. **If you enroll in Option 2 with HSA, you are only eligible for a Limited Expense Health Care FSA to pay for eligible dental and vision expenses.**

| | Health Reimbursement Account (HRA) | Health Savings Account (HSA) | Health Care Flexible Spending Account (FSA) | Dependent Care Flexible Spending Account (FSA) |
|---|---|---|---|---|
| **Eligibility** | Enrollment in **Option 1 with HRA** | Enrollment in **Option 2 with HSA** | No medical plan enrollment required | No medical plan enrollment required |
| **Contributions** | Teva | Teva and you (pre-tax payroll) | You (pre-tax payroll) | You (pre-tax payroll) |
| **Automatic Contribution from Teva*** | $600 Employee Only<br>$1,200 Employee + Family<br>(**Option 1 with HRA** enrollees only) | $400 Employee Only<br>$800 Employee + Family<br>(**Option 2 with HSA** enrollees only) | N/A | N/A |
| **Maximum Employer/ Employee Contributions** | N/A | $3,850 Employee Only<br>$7,750 Employee + Family<br>(maximums are employee's and Teva's combined contributions) | $3,050<br>(minimum contribution of $120) | $5,000<br>($2,500 if married and filing separately)<br>(minimum contribution of $120) |
| **Uses** | Credits (if available) are automatically used for:<br>• Medical expenses<br>• Deductible amounts<br>• Coinsurance amounts | You choose how/when to use available funds for:<br>• Deductible amounts<br>• Office visits and/or prescription drugs<br>• Coinsurance amounts<br>• Dental treatment and orthodontia<br>• Eyeglasses, contact lenses and solution<br>• Certain over-the-counter health care products and medications (prescription required) | You choose how/when to use available funds for:<br>• Deductible amounts<br>• Office visits and/or prescription drugs<br>• Coinsurance amounts<br>• Dental treatment and orthodontia<br>• Eyeglasses, contact lenses and solution<br>• Certain over-the-counter health care products and medications (prescription required) | You choose how/when to use available funds for:<br>• Child care or dependent care facilities<br>• Services in your home or someone else's home while you or your spouse is working, looking for work or attending school full-time |
| **Rollover of Unused Funds to Next Year** | Yes (up to the in-network deductible in an HRA-eligible plan). For **Option 1 with HRA**, the rollover maximums ($900 for Employee Only; $1,800 for Family) are reduced to account for the automatic HRA contribution from Teva | Yes (unlimited) | Yes (up to $570; any remaining funds [even those rolled over from prior years], must be used on eligible expenses incurred on or before December 31, 2022, or the funds will be forfeited) | No (any unused 2022 funds can be submitted to Meritain Health for reimbursement of expenses incurred on or before December 31, 2022) |
| **Investment Options** | N/A | Contact Fidelity | N/A | N/A |
| **Portable (Yours to Keep)** | No | Yes | No | No |
| **Administrator** | Meritain Health | Fidelity | Meritain Health | Meritain Health |

** Prorated based on enrollment date in the plan.*

**You cannot roll over funds from one type of savings account to another.**

# Virtual Care Options

Teva provides a variety of convenient virtual care options through our strategic partnership with Amwell. To access some of these benefits, you and your family must be enrolled in a Teva medical plan.

## Virtual Visits

If you're enrolled in a Teva medical plan, Amwell lets you and your covered family members instantly connect with a doctor for a secure, online visit through your computer or smartphone—anytime of day or night, without an appointment.

Talk with trusted, U.S. board-certified doctors, therapists and nutritionists in non-emergency situations, including for behavioral health issues.

Doctors can review your history, answer questions, diagnose, treat and even prescribe medications you can pick up at your local pharmacy.

When you visit or call Amwell, double-check your account information to make sure your Meritain Member ID is correct in order to receive the right pricing.

To get started, visit teva.amwell.com, download the Amwell mobile app or call **(844) SEE-DOCS**.

## Virtual Second Opinions

The Clinic, in partnership with Amwell and the 3,500 experts at Cleveland Clinic, enables all employees (regardless of enrollment in a Teva medical plan) to receive a virtual second opinion on a diagnosis and have their medical case reviewed by doctors who can help determine an effective course of treatment—all at no cost.

You explain your situation to a Nurse Care Manager who matches you with doctors who confidentially review your case with your physician and suggest effective care options. Using the virtual second opinion process is completely confidential. By law, Teva will not be informed of individual employees who take advantage of the service.

To get started, visit teva.amwell.com or download the Amwell mobile app.

## Virtual Physical Therapy

In partnership with Amwell, we offer virtual physical therapy through Sword Health to employees and covered spouses/domestic partners who are enrolled in a Teva medical plan.

Sword Health provides head to toe support to help you prevent and alleviate all sorts of aches and pains. Sword Health can help you prevent pain before it starts, repair, recover and regain mobility after an acute injury, manage chronic conditions and prepare for and recover from an operation.

You also get:

- Exercise instructions and real-time feedback from a digital therapist
- Access to a licensed physical therapist who can answer questions and help you stay on track
- An entire resource center filled with videos to help you improve your mobility and flexibility and learn more about your condition

To enroll, visit teva.amwell.com or download the Amwell mobile app.

amwell®

# Financial Security

Financial security is more than just the money you make. It's about using the programs, tools and resources at Teva to make smart choices and build a secure future for yourself and your family.

## Life and Accidental Death & Dismemberment (AD&D) Insurance

Teva provides Basic Life Insurance coverage to employees who are regularly scheduled to work 30 or more hours per week—at no cost to you—so that your family is financially protected in the event of your death. The plan will pay your beneficiaries up to 1.5 times your annual salary (rounded to the next $1,000), up to plan maximum limits.

The company also provides Basic AD&D Insurance at no cost to you. If your death is the result of a covered accident, the plan will pay your beneficiary 1.5 times your annual salary (rounded to the next $1,000), up to the plan maximum limits. In the event of dismemberment in relation to a covered accident, you will receive a benefit based on an established schedule of benefits.

You also can purchase Optional Life Insurance and Optional AD&D Insurance to further protect your family.

# Optional Life Insurance

You can purchase optional protection for yourself, your spouse/domestic partner and your child(ren). Premiums for Optional Life Insurance are based on your age and level of coverage. The amount of your, your spouse's or domestic partner's Optional Life Insurance in force reduces over time due to age. Check the rates below and your desired level of coverage to ensure what you elect meets your needs.

## Coverage for You

You can purchase Optional Life Insurance beginning with $50,000, then in $100,000 increments, up to five times your annual salary or $1 million, whichever is less, for additional protection for yourself. Premiums for coverage will be deducted from your paycheck on an after-tax basis. Your combined Basic and Optional Life Insurance coverage cannot exceed $2 million.

## Coverage for Your Spouse or Domestic Partner

- If you elect optional coverage for yourself, you may purchase between $25,000 and $300,000 in coverage for your spouse or domestic partner.
- Coverage for your spouse or domestic partner cannot be more than 50% of the coverage you purchase for yourself.

## Coverage for Your Child(ren)

- If you elect optional coverage for yourself, you may purchase either $5,000 or $10,000 in coverage per child.
- All of your children from birth to age 25 are covered at the amount you purchase.
- You cannot purchase coverage for children of domestic partners.

For questions, call Reliance Standard at **(800) 351-7500**.

## Optional Life Insurance Rates

The rates featured are per $1,000 of coverage.

| Age Range | You | Your Spouse/Domestic Partner |
|---|---|---|
| Up to age 29 | $0.0400 | $0.0490 |
| 30-34 | $0.0570 | $0.0710 |
| 35-39 | $0.0640 | $0.0810 |
| 40-44 | $0.0830 | $0.1050 |
| 45-49 | $0.1250 | $0.1570 |
| 50-54 | $0.1870 | $0.2350 |
| 55-59 | $0.2960 | $0.3700 |
| 60-64 | $0.4570 | $0.5720 |
| 65-69 | $0.8760 | $1.0970 |
| 70 and older | $1.4190 | $1.7780 |

### Evidence of Insurability

Referred to as "proof of good health," Evidence of Insurability (EOI) may be required for purchasing Optional Life Insurance coverage for yourself or your spouse/domestic partner. During Open Enrollment or with a qualified life event, you can increase your life insurance by $100,000 (up to $300,000) without EOI.

If applicable, you will receive an email from Reliance Standard with the pre-populated EOI form that needs to be completed; spouse or domestic partner EOI forms will also be emailed to you. Benefits will be effective once the EOI form is accurately completed and approved by Reliance Standard.

Newly hired employees can purchase Optional Life Insurance coverage beginning with $50,000, then in $100,000 increments, up to five times your annual salary or $1 million, whichever is less. If you wish to purchase more than $300,000 of coverage for yourself, or any amount for your spouse/domestic partner, you must complete the EOI form.

# Optional Accidental Death & Dismemberment (AD&D) Insurance

You can also purchase Optional AD&D Insurance for yourself and your family (spouse/domestic partner and children included). Premiums are based on the amount of coverage you elect.

## Coverage for You

You can elect from $50,000 up to five times your annual salary or $1 million, whichever is less. Coverage amounts are in $50,000 increments.

## Coverage for Your Family

If you elect Optional AD&D Insurance for yourself, you may purchase coverage for your family.

### Coverage for your spouse or domestic partner

Coverage available up to:

- 60% of your coverage amount (spouse/domestic partner only) or
- 50% of your coverage amount (spouse/domestic partner plus child)
- Maximum: $300,000

### Coverage for your child(ren)

Coverage available up to:

- 25% of your coverage amount (child only) or
- 10% of your coverage amount (child plus spouse/domestic partner)
- Maximum: $50,000

## Optional AD&D Insurance Rates

The rates below are monthly for each $1,000 in coverage:

| | |
|---|---|
| **Employee Only** | $0.02 |
| **Employee + Family** | $0.035 |

### Interested in another life insurance option?

An additional life insurance coverage option for you and your family is Whole Life Insurance with Long-Term Care, or LTC, provided by Unum. There are distinct advantages to a life insurance policy that provides more flexibility for how and when you can use the benefit. See **page 17** for more details.

# Disability Insurance

Teva provides access to disability benefits to employees regularly scheduled to work at least 30 hours per week to help financially protect you and your family in the event you are disabled and can't work.

## Short-Term Disability

Teva provides Short-Term Disability (STD) coverage to protect your income in the event of a non-work-related injury or illness.

- STD coverage is offered at no cost to you.
- The plan pays 100% of your weekly salary, up to eight weeks, after a seven-day waiting period (there is no waiting period for Maternity Leave; STD benefits begin on the first day of leave).
- After the waiting period, our vendor partner, Matrix Absence Management, administers the coverage up until the 120th day of your disability (26 weeks).
- If you continue to be unable to perform your job duties solely because of an injury or illness, the plan will pay 66.67% of your salary during weeks 10 through 26.

**Note:** *All disability claims must be certified in writing by a specialist physician and be supported by objective diagnostic testing and appropriate treatment plans. Failure to provide the requested information may result in claims denial. In certain states (e.g., New York, New Jersey, Hawaii, Rhode Island and California), special state-mandated benefit rules apply.*

For questions, contact Matrix Absence Management at **(877) 202-0055**.

## Long-Term Disability

Long-Term Disability (LTD) coverage begins at the end of STD coverage.

- LTD coverage is offered at no cost to you.
- If approved by Reliance Standard, the plan pays 60% of your gross base earnings, up to a maximum monthly benefit of $15,000.
- Matrix Absence Management, our vendor partner, will automatically send you the forms to begin the process of filing for LTD benefits; these forms will be sent during your STD claim.
- Reliance Standard (sister company to Matrix Absence Management) is the insurer of our LTD benefits.

For questions, contact Matrix Absence Management at **(877) 202-0055**.

### For STD, file a claim with Matrix Absence Management one of three ways:

- Download the **Matrix eServices Mobile** app
- Visit **matrixabsence.com**
- Call **(877) 202-0055**

### Need more disability coverage?

If you are grade 10 or above, you can enroll in Supplemental Individual Disability Insurance (IDI) through Unum to supplement your existing basic Long-Term Disability (LTD) coverage. This benefit is only offered once a year during the Annual Benefits Enrollment period each fall. See **page 17** for more details.

# Teva 401(k) Savings Plan

Whatever you envision doing in your retirement years—relaxing, traveling, spending time with family, working part time—saving is a necessity, so take steps toward a healthy financial future now. The more carefully you plan and save, the more fulfilling and financially secure your future. That's why we offer the Teva 401(k) Savings Plan administered by Fidelity.

## Here's how it works:

- You can contribute between 1% and 75% of your 401(k)-eligible earnings, up to the annual IRS limit ($22,500 in 2023).
- You can increase or decrease your contribution at any time throughout the year.
- Teva will match your contributions dollar-for-dollar up to 6%.
- For newly hired employees, the company matching contributions from Teva will vest following three, 12-month periods of continuous service.
- If you do not enroll during your first 45 days, you will automatically be enrolled at a 4% pre-tax deferral.
- In addition to matching contributions, Teva will also provide a lump-sum contribution each year of 3.75% of your salary.
  - The lump-sum contribution from Teva is automatic—even if you don't make your own contributions.
  - To be eligible for the lump-sum contribution, you must be employed at the end of the plan year and have worked at least 1,000 hours that year.
  - The lump-sum contribution from Teva will vest following three, 12-month periods of continuous service.
- Employees age 50 or older (or turning age 50 in the calendar year) can make "catch-up" contributions; this rule allows you to contribute an additional $7,500 (above the IRS limit) to your Teva 401(k) Savings Plan account.
- Teva also offers a Roth contribution feature. Earnings on Roth contributions grow tax-free, and you do not pay taxes when you take a qualified distribution.*

Enroll, change your elections and/or choose how to invest your savings by calling Fidelity at **(866) 747-8382** or visiting **401k.com**.

** A qualified distribution is tax free if taken at least five years after the year of your first Roth contribution and you have reached age 59½, if you have become totally disabled, or if you die. If your distribution is not qualified, any withdrawal from your account will be partially taxable. These rules apply to Roth distributions only from employer-sponsored retirement plans. Additional plan distribution rules apply.*

## All About: Teva Wealth Coordinators

Teva Wealth Coordinators, powered by Fidelity, provide fully integrated person-to-person professional advice with seamless retirement readiness support—at no cost to you.
Questions? Call Fidelity at **(800) 603-4015** or visit **401k.com**.

# Employee Stock Purchase Plan (ESPP)

The Teva Employee Stock Purchase Plan (ESPP) allows you to invest up to 10% of your eligible earnings (up to $23,750 a year) to purchase common shares of Teva Pharmaceutical Industries Limited stock at 95% of market value. The money to purchase the stock is conveniently deducted from your paycheck after taxes.

You can enroll in this program on a quarterly basis. If you want to enroll or change your ESPP payroll contribution, log on to **computershare.com** and enter your Social Security number (SSN) or your user ID and password. If you wish to enroll, change or stop your contribution for an upcoming quarter, you must log on to the Computershare website prior to the beginning of the quarter.

| To Make Changes for: | Contact Computershare between: |
|---|---|
| Q1 2023: January 1 – March 31 | December 23 – January 5 |
| Q2 2023: April 1 – June 30 | March 17 – March 30 |
| Q3 2023: July 1 – September 30 | June 16 – June 29 |
| Q4 2023: October 1 – December 31 | September 15 – September 28 |

# Lifestyle

You can be physically healthy and financially stable, yet still run into times along life's journey when you need personal assistance. These programs can help you connect with others, ease potentially stressful situations and improve your overall wellbeing.

## Make a Better You

**Make a Better You**, our wellbeing program powered by Virgin Pulse, is offered at no cost to you. **You and your covered spouse/domestic partner can each earn up to $300 per year ($600 total) for participating in healthy activities and tracking your progress.**

Whether you want to lose weight, feel energized or live healthier than ever, **Make a Better You** provides you and your family with access to an easy-to-use wellbeing platform to help you get there.

Virgin Pulse offers tech-based tools that allow you to compete with friends and family (must be at least age 16 to join; parental consent required for family members under age 18), easily track your personal wellbeing journey and improve your overall quality of life with health tips and fun challenges that can build healthy habits.

Read more about the Virgin Pulse platform and join **Make a Better You** today!

## WW®

Teva partners with WW (formerly Weight Watchers) to help you reach your wellness goals. You and your spouse/domestic partner (if within our enrollment system and designated as a dependent) can take advantage of discounted pricing on multiple WW plan options designed to meet your needs. Visit weightwatchers.com/us/teva or call **(866) 204-2885** to get started. Use Employer ID: 15123986.

## Health Coaching Program

The Health Coaching Program helps you and your family reach your full potential and improve the way you feel—at no cost to you.

This program connects you with a personal health coach who will work with you by phone or online to help you set health goals and stay on track to achieve them. Your coach can help you:

- Lose weight
- Eat healthier
- Exercise more
- Quit tobacco
- Prevent disease
- Manage stress

**Available only to those who are enrolled in a Teva medical plan.** To participate in the Health Coaching Program, call **your Teva Care Coordinator at (877) 922-6778 or visit** **mytevahealth.com**.

## Tobacco Cessation Program

The Tobacco Cessation Program provides the extra support you need to kick your tobacco habit and stay tobacco free—at no cost to you. Teva pays the full cost of this service, so it's free to you and your family members ages 18 and older. **Available only to those who are enrolled in a Teva medical plan.** For more information, or to enroll, call **your Teva Care Coordinator at (877) 922-6778 or visit** **mytevahealth.com**.

# Work/Life Balance Support

The Aetna Resources for Living Employee Assistance Program (EAP) offers free, confidential help for individual and/or work-related issues—whenever you need it, 24/7. Whether you're trying to balance work and family life, looking for care for a child or an older relative or coping with a personal issue, our EAP can help.

Get support for any and all of the following issues:

- **Life:** stress, relationships, depression, grief and loss, divorce and separation, personal time, moving, home improvement, legal issues
- **Family:** homework helpline, parenting, finding child care, adoption, discipline and safety, teenagers, blended families, education, financial aid, caregiving
- **Money:** budgeting, debt, credit and collections, investing, car and home buying, bankruptcy, estate planning and wills
- **Work:** time management, career development, communication, job stress and burnout, relocation, networking, retirement planning, managing people, handling change at work

To learn more about the EAP, call **(866) 513-7249** or visit MyLifeValues.com (Login: **Teva**; Password: **EAP**).

If you are in need of continued professional counseling beyond the sessions allotted through the EAP, you can contact Amwell.

Amwell lets you and your family instantly connect with behavioral health professionals for a secure, online visit through your computer or smartphone—anytime of day or night, without an appointment.

Access to Amwell behavioral health professionals is unlimited. You can even choose to work with the same professional during each Amwell visit. Depending on your medical plan enrollment, this service is offered at no cost to you or for a nominal fee.

Visit teva.amwell.com or call **(844) SEE-DOCS**.

## All About: EAP

The Employee Assistance Program (EAP) offers confidential counseling on any challenging aspect of your life so you can be at your best—at work and at home. Call **(866) 513-7249** or visit MyLifeValues.com (Login: Teva; Password: EAP).

## Family, Fertility and Reproductive Health

Teva partners with leading providers to offer a variety of family planning and parenting programs.

- **Reproductive Health:** We have and will continue to cover abortion under our medical plan, including a travel allowance of up to $5,000 for those who need to travel to another state to receive abortion services. Our medical plan also covers gender reassignment surgery.
- **Ovia Health:** Ovia Health is transforming the way women and families are supported during any fertility, pregnancy or parenting journey. You and your spouse or domestic partner can receive personalized health insights, connect with a coach and view expert tips—all at no cost to you. To get started, download the Ovia Health app and enter "Teva" as your employer.
- **Progyny:** Our fertility benefit includes comprehensive coverage leveraging the latest technologies and treatments, access to high-quality care through a premier network of fertility specialists, and personalized support and guidance from your own dedicated Patient Care Advocate.

  As part of your Progyny benefit, Teva offers an adoption reimbursement of up to $20,000 per child to help offset your out-of-pocket costs, including legal and travel costs. Progyny Patient Care Advocates provide unlimited counseling throughout the adoption process, and offer information about what to expect, average costs, state specific laws and legal resources. A surrogacy reimbursement of up to $30,000 is also available.

  To learn more or get started, call **(833) 205-3999**.

## Child Care Tuition Discount Program

The Child Care Tuition Discount Program provides Teva families with a 10% discount on early childhood education programs through the largest network of child care locations in the U.S. With more than 2,000 full-time and before- and after-school child care centers across the country, you receive discounted access to programs with proven curriculums, hands-on learning, trained teachers and convenient locations. The discount is available at: CCLC® Child Care Centers, KinderCare® Learning Centers and Champions® Before- and After-School Programs.

Your discount is applied to standard weekly tuition rates. Registration is free, and the discount is available for children of all ages. Contact the center where you'd like to enroll directly for information about specific programs, availability and participation and to schedule a tour. Make sure you mention you're a Teva employee to ensure you receive the discount.

For more information, please visit careiseverywhere.com and search for child care centers near you. You can also call **(877) 914-7683** for more information.

## Auto & Home Program

Farmers GroupSelect℠ offers special rates, convenient payment options and personalized service when you apply to purchase auto, home and other property and liability insurance through Farmers. For more information, call **(800) 438-6381** or visit Farmers.

# Resources

## Teva Care Coordinators

Teva Care Coordinators—a third-party partner—are your personal health care team. When you reach out, you'll be connected with a person who will be your single point of contact every time you call. He or she will work with you and your doctors to make sure you get the best possible care for yourself and your family.

Contact a Teva Care Coordinator for help with:

- Claims, billing and benefits questions
- Finding in-network providers
- Nurse support to help you stay or get healthy
- Saving money on out-of-pocket costs
- Anything that will make the health care process easier for you!

You can also connect with a Teva Care Coordinator by visiting **mytevahealth.com**.

In case you need direct access to a provider, the contact information is listed below.

One Call. That's All!

**Teva Care Coordinators**
**(877) 922-6778**

## Health & Wellness

| Benefit | Provider Name | Phone Number | Website/Email |
|---|---|---|---|
| **Medical/Teva Care Coordinators** | Quantum Health | (877) 922-6778 | mytevahealth.com |
| **Prescription Drugs** | CVS Caremark | (877) 318-5134 | caremark.com |
| **Health Savings Account (HSA)** | Fidelity | (800) 544-3716 | netbenefits.com |
| **Flexible Spending Accounts (FSAs)** | Meritain Health | (800) 566-9305 (enter 9, then ext. 120-000-2614) | account.meritain.com |
| **Voluntary Benefits** | | | |
| – Accident Insurance | Aetna | (800) 607-3366 | myaetnasupplemental.com |
| – Critical Illness Insurance | Aetna | (800) 607-3366 | myaetnasupplemental.com |
| – Hospital Indemnity | Reliance Standard | (877) 202-0055 | matrixabsence.com |
| – Identity Theft Protection | NortonLifeLock | (800) 607-9174 | mynorton.com |
| – Whole Life with Long-Term Care | Unum | (800) 635-5597 | unum.com |
| – Excess Liability* | Chubb | (800) 252-4670 | teva@tompkinsins.com |
| – Supplemental IDI* | Unum | (800) 633-7490 | N/A |
| **Dental** | Delta Dental of New Jersey | (866) 328-1305 | deltadentalnj.com |
| **Vision** | Aetna Vision Preferred | (877) 973-3238 (control number: **659534**) | aetnavision.com |
| **Telehealth** | Amwell | (844) 733-3627 or SEE-DOCS | teva.amwell.com |
| **Healthcare Cost and Quality Tools** | Healthcare Bluebook | N/A | healthcarebluebook.com/cc/teva Mobile Code: **Teva** |
| **Virtual Second Opinions** | The Clinic | N/A | teva.amwell.com or via Amwell app |
| **Radiology Services**** | US Imaging Network | (877) 874-6385 | usimagingnetwork.com |
| **Virtual Physical Therapy**** | Sword Health | N/A | teva.amwell.com or via Amwell app |

** This benefit is only available to Global Grade 10 and above.*
*** Available to those enrolled in a Teva medical plan.*

## Financial Security

| Benefit | Provider Name | Phone Number | Website/Email |
|---|---|---|---|
| **Teva 401(k) Savings Plan** | Fidelity | (866) 747-8382 | 401k.com |
| **Teva Wealth Coordinators** | Fidelity | (800) 603-4015 | netbenefits.fidelity.com/planningcenter |
| **Employee Stock Purchase Plan (ESPP)** | Computershare | (877) 600-4505 | computershare.com |
| **Life and AD&D Insurance** | Reliance Standard | (800) 351-7500 | customercare.rsli.com |
| **Identity Theft Protection** | NortonLifeLock | (800) 607-9174<br>(9 a.m. to 7 p.m. ET)<br><br>(800) 543-3562<br>(Urgent After-Hours Support) | N/A |
| **Auto & Home** | Farmers GroupSelect | (800) 438-6381 | myautohome.farmers.com |
| **Leave of Absence** | Matrix Absence Management | (877) 202-0055 | matrixabsence.com |

## Lifestyle

| Benefit | Provider Name | Phone Number | Website/Email |
|---|---|---|---|
| **Make a Better You** | Virgin Pulse | (888) 671-9395 | join.virginpulse.com/teva |
| **Health Coaching/ Teva Care Coordinators*** | Quantum Health | (877) 922-6778 | mytevahealth.com |
| **Tobacco Cessation*** | Teva Care Coordinators | (877) 922-6778 | mytevahealth.com |
| **Employee Assistance Program (EAP)** | Aetna | (866) 513-7249 | MyLifeValues.com<br>(Login: Teva; Password: EAP) |
| **Behavioral Health** | Amwell | (844) 733-3627 or SEE-DOCS | teva.amwell.com |
| **Weight Watchers** | WW | (866) 204-2885 | weightwatchers.com/us/teva<br>(Employer ID: 15123986) |

** Available to those enrolled in a Teva medical plan.*

## Questions About Benefits Eligibility?

Call the Teva Benefits Service Center at **(800) 979-1733** (8:30 a.m.-8 p.m., ET, Monday-Friday).

# Glossary

### Annual Benefits Enrollment
The period of time during which individuals who are eligible to enroll in Teva benefits can enroll in a variety of coverage options.

### Annual Physical
A yearly wellness exam to review your current health status and create a plan for preventing disease and ensuring overall wellbeing.

### Children's Health Insurance Program (CHIP)
A program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance for low-income families with children.

### Coinsurance
A defined percentage of covered health care costs that an individual will be required to pay.

### Copayment (Copay)
A flat-dollar amount an individual pays to receive a covered health care service.

### Deductible
The amount of money an individual must pay for covered health care services before a health insurance plan will pay its share of expenses.

### Dependents
Individuals (spouse and/or other dependents) who you may cover under the medical, dental, vision, life and accidental death and dismemberment (AD&D) and other programs.

### Flexible Spending Account (FSA)
An account that gives employees the opportunity to set aside pre-tax funds for the reimbursement of eligible health care expenses or eligible child care expenses (depending on the FSA in which you choose to participate). FSAs are funded through pre-tax payroll deductions. Employees can use the money in this account to pay health insurance deductibles and copayments, or pay child care.

### Health Reimbursement Account (HRA)
An account funded entirely by Teva. The money in your account is used to pay for eligible health care expenses.

### Health Savings Account (HSA)
A tax-free account that allows an individual to save money for current and future qualified medical expenses.

### High-Deductible Health Plan (HDHP)
A health plan with a higher deductible and lower premium than traditional health plans. In-network preventive care is covered at 100% before the deductible is met; you are responsible for other expenses until the deductible is met. Certain limits apply for an HDHP to provide access to a Health Savings Account (HSA) that can be used to pay for—or save for—certain health care expenses.

### Out-of-Pocket Maximum
The maximum amount of money an individual must pay in coinsurance in a plan year before the health insurance begins to pay 100% of the allowed amount for covered health services.

### Premium
An individual's portion of the cost—often on a per-pay-period basis—for medical, dental, vision and other coverage options.

### Preventive Care
Health care services that are designed to detect and treat medical conditions and prevent avoidable illnesses. Preventive care guidelines are based on recommendations by the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices.

### Primary Care Physician
A physician: (a) who qualifies as a participating provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you to provide or arrange for medical care for you or any of your insured dependents.

### Specialty Medications
Products used to treat chronic, high-cost or rare diseases that tend to be more complex to maintain, administer and monitor than traditional drugs. Therefore, these drugs require closer supervision and monitoring of a patient's overall therapy.

### Specialty Pharmacy
A service that manages the handling of specialty drugs, including dispensing, distribution, reimbursement, case management and other services specific to patients with rare and/or chronic diseases.

# Legal Notices

## 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 July 31, 2022. Contact your State for more information on eligibility.**

**ALABAMA – Medicaid**
Website: http://myalhipp.com/
Phone: 1-855-692-5447

**ALASKA – Medicaid**
The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://health.alaska.gov/dpa/Pages/default.aspx

**ARKANSAS – Medicaid**
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

**CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program**
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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

**FLORIDA – Medicaid**
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

**GEORGIA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

**INDIANA – Medicaid**
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: http://www.indianamedicaid.com
Phone: 1-800-403-0864

**IOWA – Medicaid**
Website: http://dhs.iowa.gov/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

**KANSAS – Medicaid**
Website: https://www.kancare.ks.gov/
Phone: 1-785-296-3512

**KENTUCKY – Medicaid**
Website: https://chfs.ky.gov
Phone: 1-800-635-2570

**LOUISIANA – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331
Phone: 1-888-695-2447

**MAINE – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

**MASSACHUSETTS – Medicaid and CHIP**
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 617-886-8102

**MINNESOTA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

**MISSOURI – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

**MONTANA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Email: HHSHIPPProgram@mt.gov
Phone: 1-800-694-3084

**NEBRASKA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

**NEVADA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov
Phone: 1-800-992-0900

**NEW HAMPSHIRE – Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

**NEW JERSEY – Medicaid and CHIP**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
Phone: 1-800-701-0710

**NEW YORK – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

**NORTH CAROLINA – Medicaid**
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

**NORTH DAKOTA – Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

**OKLAHOMA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

**OREGON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

**PENNSYLVANIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

**RHODE ISLAND – Medicaid**
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

**SOUTH CAROLINA – Medicaid**
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

**SOUTH DAKOTA - Medicaid**
Website: http://dss.sd.gov
Phone: 1-888-828-0059

**TEXAS – Medicaid**
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

**UTAH – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

**VERMONT – Medicaid**
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

**VIRGINIA – Medicaid and CHIP**
Website: https://www.coverva.org/hipp/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

**WASHINGTON – Medicaid**
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022, ext. 15473

**WEST VIRGINIA – Medicaid and CHIP**
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

**WISCONSIN – Medicaid and CHIP**
Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

**WYOMING – Medicaid**
Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2022, 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

# HIPAA Privacy Notice

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Teva Pharmaceuticals USA, Inc. health plans. This information, known as protected health information, or PHI, includes almost all individually identifiable health information held by a plan—whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of this plan: Teva Pharmaceuticals USA, Inc. Omnibus Welfare Benefit Plan.

**The Plan's duties with respect to health information about you**

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It is important to note that these rules apply to the Plan, not Teva Pharmaceuticals USA, Inc. as an employer—that is the way the HIPAA rules work. Different policies may apply to other Teva Pharmaceuticals USA, Inc. programs or to data unrelated to the Plan.

## How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities and health care operations.

- Health care operations include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. We will not use your genetic information for underwriting purposes; **for example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.**

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes. The Plan may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you, as permitted by law.

## How the Plan may share your health information with Teva Pharmaceuticals USA, Inc.

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Teva Pharmaceuticals USA, Inc. for plan administration purposes. Teva Pharmaceuticals USA, Inc. may need your health information to administer benefits under the Plan. Teva Pharmaceuticals USA, Inc. agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. The Teva Benefits staff members are the only Teva Pharmaceuticals USA, Inc. employees who will have access to your health information for plan administration functions.

Here is how additional information may be shared between the Plan and Teva Pharmaceuticals USA, Inc., as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Teva Pharmaceuticals USA, Inc., if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Teva Pharmaceuticals USA, Inc. information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Teva Pharmaceuticals USA, Inc. cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Teva Pharmaceuticals USA, Inc. from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation, is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

## Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend or other person you identify who is involved in your care or payment for your care. Information about your location, general condition or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You will generally be given the chance to agree or object to these disclosures (although exceptions may be made—for example, if you are not present or if you are incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

**Workers' compensation**

Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws.

**Necessary to prevent serious threat to health or safety**

Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.

**Public health activities**

Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.

**Victims of abuse, neglect or domestic violence**

Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).

**Judicial and administrative proceedings**

Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information).

**Law enforcement purposes**

Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct and disclosures to provide evidence of criminal conduct on the Plan's premises.

**Decedents**

Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death and to funeral directors to carry out their duties.

**Organ, eye or tissue donation**

Disclosures to organ procurement organizations or other entities to facilitate organ, eye or tissue donation and transplantation after death.

**Research purposes**

Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project.

**Health oversight activities**

Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility and compliance with regulatory programs or civil rights laws.

**Specialized government functions**

Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities and disclosures to correctional facilities or custodial law enforcement officials about inmates.

**HHS investigations**

Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use or disclosure of your unsecured health information as required by law.

**Breach of unsecured PHI**

You must be notified in the event of a breach of unsecured protected health information. A "breach" is the acquisition, access, use, or disclosure of protected health information in a manner that compromises the security or privacy of the protected health information. Protected health information is considered compromised when the breach poses a significant risk of financial harm, damage to your reputation, or other harm to you. This does not include good faith or inadvertent disclosures or when there is no reasonable way to retain the information. You must receive a notice of the breach as soon as possible and no later than 60 days after the discovery of the breach.

## Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. Contact the Benefits staff at HR_Benefits@tevapharm.com for information on how to submit requests.

## Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition or death—or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid for the item or service, in full out of pocket.

## Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

## Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- the access or copies you requested;
- a written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan does not maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

You may request an electronic copy of your health information if it is maintained in an Electronic Health Record. You may also request that such electronic health information be sent to another entity or person, as long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any, must be reasonable and based on the Plan's cost.

## Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- make the amendment as requested;
- provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

## Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made:

- for treatment, payment or health care operations;
- to you about your own health information;
- incidental to other permitted or required disclosures;
- where authorization was provided;
- to family members or friends involved in your care (where disclosure is permitted without authorization);
- for national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- as part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You will be notified of the fee in advance and have the opportunity to change or revoke your request.

## Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

## Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via the annual Benefits Guide.

### Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You will not be retaliated against for filing a complaint. To file a complaint with the Plan, email the Plan's Privacy Official at **USPrivacy@tevapharm.com**.

### Contact

For more information on the Plan's privacy policies or your rights under HIPAA, email the Plan's Privacy Official at **USPrivacy@tevapharm.com**.

## HIPAA Special Enrollment Rights

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

The plan will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days—instead of 30—from the date of the Medicaid/CHIP eligibility change to request enrollment in the plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Also, 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 in a Teva plan. You must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or to learn more, contact the Teva Benefits Service Center at **(800) 979-1733.**

**Note:** The federal government has suspended certain timeframes for employee benefit plans, participants, and beneficiaries affected by the National Emergency for the COVID-19 outbreak. Thus, the 30 days or 60 days to request special enrollment have been temporarily suspended as a result of the National Emergency from March 1, 2020 until the earlier of (1) one year from the date you were originally eligible for the suspension relief, or (2) 60 days after the announced end of the National Emergency (called the "Outbreak Period").

## General Notice of COBRA Continuation Coverage Rights Under COBRA

### Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

### What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becomes entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

## You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Teva Benefits Service Center at **(800) 979-1733.**

## How Is COBRA 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. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment is terminated, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualified event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. This 18-month period of COBRA continuation coverage can be extended in two ways:

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

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the 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 **healthcare.gov**.

## Deadline Extensions Due to COVID-19 Pandemic

Due to the COVID-19 National Emergency, certain COBRA continuation coverage deadlines have been suspended for a period of time. In particular, the timeframes in which you must provide notification of certain qualifying events or elect COBRA continuation coverage and actually pay for that coverage. These deadlines have been temporarily suspended as a result of the National Emergency from March 1, 2020 until the earlier of (1) one year from the date you were originally eligible for the suspension relief, or (2) 60 days after the announced end of the National Emergency (called the "Outbreak Period").

## 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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at **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 **healthcare.gov**.

## Patient Protection Notice

The Teva Medical Plan generally allows 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, call your Teva Care Coordinator at **(877) 922-6778** or visit mytevahealth.com. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Teva Medical Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Teva Care Coordinator at **(877) 922-6778** or visit mytevahealth.com.

## Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of 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

Teva Pharmaceuticals USA, Inc.
Attention: Teva Benefits Department
400 Interpace Pkwy
Parsippany, NJ 07054
(215) 591-3000

# Important Notice From Teva Pharmaceuticals USA, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Teva Pharmaceuticals USA, Inc., and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (such as 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. Teva Pharmaceuticals USA, Inc. has determined that the prescription drug coverage offered by CVS Caremark is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Teva Pharmaceuticals USA, Inc. coverage will not be affected. The Teva Pharmaceuticals USA, Inc. prescription plan with CVS Caremark is your primary prescription coverage as long as you are employed as a full-time employee (benefit-eligible working 30 hours or more).

For 2023, Teva Pharmaceuticals USA, Inc. prescription coverage has copays of $6/$12 for non-Teva Generic prescriptions, $30/$75 for brand formulary prescriptions, and $50/$125 for brand non-formulary prescriptions. If your prescription is for a Teva product, you will not have to pay a copay under Option 1 with HRA, Option 3 or Option 4. For Option 2 with HSA, once you have met the medical plan deductible, you will pay the applicable copay for generic prescriptions, and for brand formulary and brand non-formulary prescriptions you will pay coinsurance. Once you have paid either $4,000/$8,000 out-of-pocket, depending on your medical plan tier, Option 2 with HSA will pay 100% of Reasonable and Customary care.

If you do decide to join a Medicare drug plan and drop your current Teva Pharmaceuticals USA, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back.

## When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Teva Pharmaceuticals USA, Inc., and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go 19 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

For further information, contact Beth Barrett at **(973) 987-7391**. **NOTE:** You will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Teva Pharmaceuticals USA, Inc. 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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

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

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

## The Women's Health and Cancer Rights Act

Covered women who have had or are going to have a mastectomy, while covered under a Teva medical plan, may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, 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 for all stages of mastectomy, including lymphedema.

Keep in mind, coverage is subject to the same annual deductibles and coinsurance applicable to other medical and surgical benefits provided under the plans.

## Special Note on Maternity and Newborn Infant Coverage

Federal law requires that Teva inform you each year that the Teva Medical Plan may not restrict benefits, or require you to obtain authorization from the plan, for any length of stay in a hospital in connection with childbirth, for mother or newborn, that is 48 hours or less following a standard delivery or 96 hours following a cesarean delivery. Also, don't forget to add your newborn to your medical coverage within 30 days.

## Make a Better You Wellbeing Program by Virgin Pulse Reasonable Alternatives

At Virgin Pulse, we recognize that it may be difficult for some members to fully participate and earn Points in the program due to medical conditions or disabilities. To ensure all members have equal opportunity to earn points and benefit from the program, we provide members with a reasonable alternative to earn the minimum standard of points. This program applies to the following individuals:

- **Members who are unable to achieve ideal targets due to a current or chronic medical condition**
- **Members who are unable to take measurements and/or track physical activity because of a disability**

Please reach out to our Member Services team via chat or phone (**888) 671-9395** (8:00 am – 9:00 pm Eastern Time M- F), and we will provide you with an "Alternative Program - Member Declaration" form. You will need to print and fill out the form according to the instructions.

Once completed, please fax it to us at the number listed on the bottom of the form. Once the form has been received, has been verified, and approved, an exception will be applied to your account and a confirmation email will be sent to you with further instructions.

## Separation Benefits Plan

**INTRODUCTION**

This Separation Benefits Plan outlines the separation pay and/or benefits available to the Company's eligible US-based, non-union employees. Employment separations will be managed in accordance with the guidelines outlined below and applicable law. Separation pay and/or benefits will only be provided to eligible employees if they execute (and do not revoke) a waiver and release to be prepared and provided by Teva ("Waiver and Release") and satisfy all other conditions as set forth below.

This Plan, as set forth herein, constitutes an employee welfare benefit plan within the meaning of Section 3(1) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Company intends that the Plan be administered in accordance with the applicable requirements of ERISA and the regulations under ERISA. This document constitutes both the plan document and the summary plan description of the Plan and is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under ERISA.

**ELIGIBILITY**

A full- or part-time US-based, non-union Teva employee who is eligible to receive separation pay and/or benefits in the following circumstances (subject to satisfaction of all other conditions set forth in this Plan):

- Elimination of position;
- Material change in job responsibilities that, for example, requires a significant change in skill requirements, or bona fide occupational qualifications or results in a reduction in Global Grade greater than one;
- Reduction in force; or
- Other instances, in Teva's discretion, as determined by the individual situation.

**INELIGIBILITY**

A full- or part-time US-based, non-union Teva employee who is ineligible to receive separation pay and/or benefits in the following circumstances under this Policy:

- Employee has a written employment contract which provides for separation, severance, or termination payments;
- Separation due to voluntary resignation;
- Separation due to voluntary retirement;
- Separation due to permanent disability;
- Separation due to employee's death;
- Separation due to excessive absences or lateness;
- Separation for misconduct, or violation of company policies, procedures, practices or Ethics and Code of Conduct;
- Separation for unsatisfactory performance;
- Refusal to accept another materially similar position, as determined by Human Resources, taking into account the employee's skills and experience, compensation level;
- The individual is a temporary or contingent worker (agency or otherwise), independent contractor, or vendor; or
- Separation because Teva contracted or outsourced the work the employee had performed for Teva and the individual is hired or offered employment by the Teva contractor, subcontractor or vendor to perform the same or similar services as the employee performed while employed by Teva.

**GENERAL**

Open and Available Positions. Employees selected for separation pay and/or benefits may be afforded an opportunity to apply for open and available positions which they are qualified for and capable of performing.

- To be eligible to apply for an open and available position, an employee's two (2) most recent performance evaluations must have been satisfactory ["Successful Performance"] or better.
- Employees who: a) have been issued any written warning within six months prior to the separation date; b) are currently on a Performance Consistency Plan; or c) are currently on a Performance Improvement Plan, will not be eligible to apply for open and available positions, regardless of qualifications.
- Employees who do not qualify for open and available positions and are otherwise eligible for separation pay and/or benefits under these guidelines will receive separation pay and/or benefits in accordance with this Plan.
- The opportunity to apply will run concurrent with any notice period or consideration period, not to exceed thirty (30) days. Thereafter any application will be considered as a "re-hire."

Employment Through Separation Date Required. Subject to executing and not revoking a Waiver and Release, separation pay and/or benefits will only be provided should an eligible employee remain in good standing in his/her position and satisfactorily performs all assigned duties and tasks through the last scheduled working day and subsequently terminates employment with Teva. If the employee accepts another position within Teva or terminates employment prior to the last scheduled working day, no separation pay and/or benefits will be offered.

Temporary Assignments. The acceptance of a temporary assignment, within Teva, by a displaced employee prior to separation will not affect the employee's eligibility for separation pay and/or benefits at the end of the temporary assignment should the employee satisfactorily perform all assigned duties and tasks through the last scheduled working day in a temporary assignment.

Mergers and Acquisitions; Divestitures; other Corporate Transactions. If the employee's position is eliminated because a business unit is sold by Teva and if the transaction agreement includes provisions specifically providing for the employment of affected employees by the purchaser, no separation pay and/or benefits will be provided by Teva unless the acquisition agreement between Teva and their employer provides otherwise. Likewise, if the employee's position is eliminated because the employee's duties are outsourced, and the employee is hired or offered a position by the contractor, subcontractor, or vendor to perform the same or similar services as the employee performed while employed by Teva, no separation pay and/or benefits will be provided by Teva irrespective of whether the employee has rejected the position offered.

Employees who join Teva due to Teva's acquisition of their employer shall not be entitled to separation pay and/or benefits under this Plan during the transition period of such acquisition, as determined by Teva, unless the acquisition agreement between Teva and their employer provides otherwise.

Re-Employment. In the event an employee seeks employment or re-employment with Teva or any parent, subsidiary, related or affiliated company, Teva and any parent, subsidiary, related or affiliated company are not obligated to employ or re-employ the employee. However, if an employee is hired and/or re-hired by Teva and/or its affiliates while receiving separation pay and/or benefits pursuant to this Plan, the employee's separation pay will be automatically stopped as of the Employee's new hire or re-hire date.

Waiver and Release Agreement. Receipt of separation pay and/or benefits, which may include separation pay, Transitional Health Coverage Allowance payment, and/or career transition services, is strictly contingent on the eligible employee both: a) returning all Company property at separation; and b) executing, abiding by, and not rescinding or revoking a Waiver and Release in the form provided by Teva. In no event will an employee be eligible for separation pay and/or benefits under this Plan who fails to execute the Waiver and Release.

WARN Notification. Under some circumstances the Company must provide notification to employees that will satisfy the requirements of the federal Worker Adjustment and Retraining Notification (WARN) Act, or similar state and/or local laws. To meet this notification requirement the Company may provide the required notice period or provide pay in lieu of notice if allowed by law in that circumstance.

**PROCESS**

Approval. Managers separating employees must obtain approval of their immediate supervisor(s), department Vice President and Human Resources before notifying employees that they are eligible for separation pay and/or benefits, subject to the terms and conditions of this Plan. Separations of Directors, Sr. Directors, or Vice Presidents (grades 15+) must be approved by the President of the business unit.

Separation Pay. The amount of separation pay will be based on length of service, calculated from the employee's Service Date to their separation date. Two (2) weeks separation pay will be paid for each year of service which would be achieved in the calendar year of separation, and is based upon the follow schedule:

| | Non-Exempt | Exempt - Up To GCA 17 | Exempt - GCA 18+ |
|---|---|---|---|
| **Service Factor** | 2 Weeks per year of service | 2 Weeks per year of service | 2 Weeks per year of service |
| **Minimum Separation** | 6 Weeks | 13 Weeks | 26 Weeks |
| **Maximum Separation** | 26 Weeks | 39 Weeks | 52 Weeks |

Employees with less than one (1) year of total service at the time of employment separation will be credited with at least one (1) year of service for the purpose of this Plan. Separation pay is calculated using the employee's base salary only (exclusive of incentive, bonus and commission payments or shift differential), "Base Pay" means (1) for salaried Employees, one fifty-second (1/52) of the Employee's annual base salary and (2) for hourly Employees, one fifty-second (1/52) of the Employee's annual base salary with annual base salary determined by taking the Employee's base hourly wage rate multiplied by the number of hours that represent the normal work week for the employee.

Transitional Health Care Allowance. Any employee who is actively enrolled in Teva's healthcare benefits (i.e., medical, dental, and/or vision) will be eligible for an additional benefit, the Transitional Health Care Allowance, which is based upon their benefits election at the time of their separation from employment. The Transitional Health Care Allowance is meant to assist an employee pay for healthcare benefits upon employment separation, not to exceed six (6) months.

Payment Schedule. All amounts paid under this Plan will be paid bi-weekly, and subject to all applicable deductions and offsets, including without limitation federal, state and local taxes as well as any state unemployment benefits. All Separation Payments will be made in accordance with the terms and conditions of the Teva Pharmaceuticals USA, Inc. Supplemental Unemployment Benefit Plan or Teva Pharmaceuticals USA, Inc. Employment Transition Plan, whichever is applicable (see below). All payments made under this Plan are processed and paid based upon the employee's election of either direct deposit or manual check, in accordance with all applicable federal, state and local laws, and in coordination with Company's payroll schedule.

Supplemental Unemployment Benefit Plan (SUB). Teva separation pay and, where applicable, Transitional Health Care Allowance, and other amounts payable to employee will be paid through the Teva Supplemental Unemployment Benefit Plan (the "SUB Plan"). The Teva Supplemental Unemployment Benefit Plan (the "SUB Plan") provides a structured payout of separation benefits to eligible employees who experience an involuntary loss of employment. Under this program, the employee will receive weekly SUB Plan payments which are equal to 100% of the weekly Base Pay, minus any unemployment insurance pay (commonly referred to as "unemployment pay") received from the state or federal government, for the weekly separation period. For each week the employee remains eligible, the employee will receive a payment from Teva for the SUB Plan payment and any applicable payment from the state or federal government for unemployment insurance pay. Added together, these two components will equal 100% of your weekly Base Pay. The Summary Plan Description for the SUB plan or Employment Transition Plan, whichever is applicable, can be provided upon request.

Unused PTO. Employees will be paid for their earned but unused PTO time, less all applicable deductions, for the year in which the employment separation occurs. Unused PTO time accruals will be paid as a lump sum and will not extend the employee's date of separation.

Given the level of responsibility and time required of Vice Presidents at Teva, the usage of PTO is flexible and not tracked. It is the expectation that a reasonable amount of PTO (not to exceed five weeks) will be taken. As there are no set PTO allocations for the VP, there is no payment made for unused time when a VP leaves the Company.

Earned Sales Commissions and/or Sales Bonuses. Employees will be paid for their sales bonuses and/or commissions calculated per the applicable incentive compensation plan document. All sales bonuses and commissions will be paid as a lump sum, less all applicable deductions, as soon as practical following the employee's separation date or according to the payment schedule associated with the earned sales commissions and/or sales bonuses.

Short-Term Incentive Program and Bonuses. An employee is not eligible for the Annual Incentive Bonus if employment terminates with separation pay and/or benefits prior to its payout, except if separation occurs on or after Feb 1st of the current calendar year in which the employee remains in good standing, in which case the employee is eligible for the prior year bonus only if bonuses are paid for active employees and the employee worked a minimum of 1,000 hours in the prior calendar year.

Benefits. Upon separation of employment, an employee must decide whether to elect continuation of benefits with Teva in accordance with the benefits extension provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), or obtain benefits from another provider. Benefits under COBRA may be paid for on a month to month basis. Employee will be sent information concerning COBRA continuation rights and responsibilities in connection with employee's separation from Teva.

Paid time off, Short-term Disability (STD), and Long-term Disability (LTD) eligibility terminate as of the employee's last day worked. Employees currently out on an approved Short-Term (STD) or Long-Term (LTD) disability leave prior to their date of employment separation, however will not lose such coverage due to the loss of Teva employment, but the continuation of such benefits will be subject to the terms, conditions, and limitations of the applicable plan(s).

All other Teva-provided benefits terminate as of the employee's date of employment separation or the last day of the month in which the employee terminates, according to the terms, conditions, and limitations of the particular benefit plan.

Career Transition Services. In some circumstances, Teva will select an organization to provide career transition services to separated employees at Teva's expense (if applicable). In no circumstance will Teva provide the employee with the cash value of the services in lieu of using those services.

Return of Company Property, Termination of Security Access. The Human Resources department will coordinate the collection of all Company property in connection with the employee's employment separation. All necessary communication for termination of telephone service, information technology and related accounts and services, and access to and from Company facilities will be handled directly by Human Resources.

Deductions. All payments made under this Plan are subject to applicable taxes and withholdings.

**PLAN ADMINISTRATION**

The "Plan Administrator" of the Plan is the Company. The Plan Administrator may appoint an individual or committee to act as its representative in this capacity. The Plan Administrator may adopt rules it deems consistent with the terms of the Plan and necessary or advisable. The Plan Administrator has full discretionary authority to construe and interpret the Plan's terms and to make factual determinations under it, including the authority to determine your eligibility for benefits, the reason for your employment termination, and the amount of benefits payable. Benefits under the Plan will be paid only if the Plan Administrator decides in its sole discretion that the person seeking benefits is entitled to them under the terms of the Plan. Any interpretation of the Plan made in good faith by the Plan Administrator, and any decision made in good faith on any matter within the discretion of the Plan Administrator will be binding on all persons.

Following a "Change in Control," (as defined in the Plan) the Plan Administrator must administer the Plan in a manner consistent with the administration of the Plan prior to the Change in Control.

Claims for Benefits. Benefits under the Plan will be paid to you and your beneficiaries without the necessity of formal claims. However, you or your beneficiaries may make a request for any Plan benefits to which you believe you are entitled. Any such request should be in writing and should be made to the Plan Administrator. Your written request for Plan benefits will be considered a claim for Plan benefits. The Plan Administrator will evaluate your claim to determine if benefits are payable to you under the terms of the Plan. The Plan Administrator may solicit additional information from you if necessary to evaluate the claim.

If the Plan Administrator determines the claim is valid, then you will receive a statement describing the amount of benefit, the method or methods of payment, the timing of distributions and other information relevant to the payment of the benefit.

Initial Benefit Determination. The Plan Administrator normally will determine whether your claim is approved or denied within 90 days of when it is received. However, if special circumstances require the Plan Administrator to take more time to decide your claim, you will be notified within the initial 90-day period of such special circumstances and the date by which you can expect decision. Any extension of time will not be longer than an additional 90 days.

If your claim is denied in whole or in part, you will be notified in writing. This written notice will tell you the specific reasons for the denial and refer to the Plan provisions on which the denial is based. The notice also will provide any additional information necessary to perfect the claim, and explain why such information is necessary. The notice also will describe the procedure for obtaining a review of the denial and the applicable time limits, including your right in file an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Appealing a Denied Claim. If your claim has been denied, you may file a written appeal and have your claim reviewed. You have 60 days to appeal from the time you are notified of the denial. You may examine any Plan documents related to your claim and you may submit written comments, documents, records and other information relating to your claim in your appeal.

The Plan Administrator normally will decide an appeal within 60 days after receiving it. If special circumstances require a longer period of time to decide your appeal, you will be notified within the initial 60-day period of the date you may expect a decision. This extension of time will be no longer than an additional 60 days.

The final decision of the Plan Administrator will be sent to you in writing. If your claim is denied on appeal, the notice will include the specific reasons for the denial and refer in the Plan provisions on which the decision is based. The Plan Administrator's review on appeal will give no deference to the initial determination, and will take into account all information you have submitted, even if that information was not submitted with your initial claim. You may have access to all information relevant to your claim, regardless of whether the information was considered in the Plan Administrator's final decision. You will also be informed of your right to file an action under Section 502(a) of ERISA.

Note that you must use and exhaust the Plan's administrative claims and appeals procedure before bringing suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner may also cause you to lose your right to sue regarding an adverse determination.

**YOUR RIGHTS UNDER ERISA**

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants will be entitled to:

- Receive information about the Plan and separation benefits offered under the Plan.
- Examine, without charge, at the Company's office and at other specified locations, all documents governing the Plan, and a copy of the latest annual report filed by the Plan with the U.S, Department of labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, upon written request to the Company, copies of documents governing the operation of the Plan, and copies of the latest annual report and updated summary plan description. The Company may make a reasonable charge for the copies.
- Obtain a statement telling you whether you have a right to receive a benefit and, if so, what your benefit would be if you stop working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

Prudent Action by Plan Fiduciaries. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants arid beneficiaries. No one, including your Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from exercising your rights under ERISA.

Enforce Your Rights. If your claim for a separation benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees, if you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**FUTURE OF THE PLAN**

The Company may amend the Plan, or alter, reduce or eliminate any benefit under the Plan, in whole or in terminate the Plan at any time. However, any amendment or termination of the Plan will not reduce the amount of benefits payable (if any) to you if you terminate employment before the amendment or termination.

**GENERAL PLAN INFORMATION**

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| **Plan Sponsor** | Teva Pharmaceuticals USA, Inc.<br>400 Interpace Parkway, Building 3<br>Parsippany, New Jersey 07054<br><br>A complete list of the employers participating in the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries. |
| **Plan Name** | Teva Pharmaceuticals USA, Inc. Separation Benefits Plan for Non-Union U.S. Employees |
| **Type of Plan** | Welfare plan |
| **Source of Funds** | Your Employer will pay all benefits under the Plan out of its general assets. Your Employer is not required to segregate on its books or otherwise any amount to be used to pay Plan benefits. To the extent you acquire a right to receive payments under the Plan, such right shall be no greater than the right of an unsecured general creditor of your Employer |
| **Company's Employer Identification Number** | 22-1734359 |
| **Plan Administrator** | Teva Pharmaceuticals USA, Inc.<br>400 Interpace Parkway, Building 3<br>Parsippany, New Jersey 07054 |
| **Agent for Service of Legal Process** | Plan Administrator |
| **Plan Year** | Calendar Year (January 1 – December 31) |
| **Controlling Law** | New Jersey (to the extent not preempted by Federal law) |