Otsuka



YOUR 2027 BENEFITS

Open Enrollment Guide

Open Enrollment period: October 26 – November 6, 2026

Otsuka Pharmaceutical Factory of America (OPFA) offers you and your eligible family members a comprehensive and valuable benefits program. This guide has been developed to assist you in learning about your benefit options and how to enroll through this Open Enrollment period.

This year will be a **PASSIVE** enrollment, meaning if you take no action you will be enrolled in the same plans you are currently enrolled in. **To make changes, you must take action by November 6, 2026.**

We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family. As a reminder, this is your annual opportunity to make changes to your benefits. Outside of Open Enrollment, you cannot make changes to your plans unless you experience a Qualifying Life Event.



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Benefits Eligibility & Enrollment

Who is eligible to elect benefits?

You may elect to enroll in the benefits described in this guide, if you are a **benefits eligible employee**. A benefits eligible employee is:

- A regular, full-time employee; or
- A part-time employee scheduled to work a minimum of **15 hours per week.**

Eligible Dependents

Please remember that only eligible dependents can be enrolled. Eligible dependents include:

- Your spouse or civil union partner*
- If under the age of 26, your natural child, adopted child, foster child, stepchild or grandchild (if court-ordered custody)
- Dependents over age 26 who are not able to support themselves due to a physical or mental disability

* *Medical, dental and vision coverage is available for employees with same-sex or opposite-sex domestic partnerships in states that do not recognize civil union partnerships. Coverage for dependent children of domestic partners is also available. However, the domestic partnership must be legally recognized by the state and the employee would need to present a certificate to certify such.*

When does coverage begin?

You must make elections during our Open Enrollment window running from October 26 – November 6, 2026. Benefits elected during this time period will then go into effect as of January 1, 2027.

Making Changes During the Plan Year: Qualifying Life Events

Unless you experience a Qualifying Life Event, you cannot make changes to your benefits until the next Open Enrollment period. Qualifying Life Events include:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan

You must notify Human Resources within 31 days of experiencing a Qualifying Life Event.

How to Enroll

To ensure your benefit election changes are processed, please complete and return your completed benefits enrollment form to **HR@Otsuka-America.com**.

For Your Health	For Your Wealth	For Your Lifestyle
• Medical and prescription drug insurance • **Enhanced!** Dental insurance • Vision insurance • Flexible Spending Accounts (FSAs) • Health Savings Account (HSA) • Critical illness insurance • Accident insurance • Hospital indemnity insurance • Cancer care support	• Short-Term Disability insurance (STD) • Long-Term Disability insurance (LTD) • Basic life and accidental death and dismemberment (AD&D) insurance • Supplemental life insurance • Retirement 401(k) savings plan • Whole life insurance with long-term care	• Identity theft insurance • Legal insurance • Pet insurance • Lyra Behavioral Health

Medical Benefits

Administered by Anthem

OPFA offers several medical plan options to help you and your family find the right coverage. All plans include prescription drug coverage.



What's new for 2027:

Anthem is removing age limits for certain covered cancer screenings. Eligible screenings will continue to be covered based on plan terms and applicable preventive care guidelines.

	Anthem PPO		Anthem HSA Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	**$500 / $1,500**	$2,000 / $6,000	**$1,750 / $3,500**	**$1,750 / $3,500**
Employer HSA Contribution (Individual/Family)	N/A		$800/$1,600	
Annual Out-of-Pocket Maximum (Individual/Family)	$1,500 / $4,500 (Deductible included)	$5,000 / $15,000 (Deductible included)	$2,700 / $5,400 (Deductible included)	$5,400 / $10,800 (Deductible included)
Preventive Care	100% covered	Plan pays 70%*	100% covered	70% covered
Primary Care Physician (PCP) Visit	$20 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*
Specialist Visit	$40 copay	Plan pays 70%*	Plan pays 90%*	Plan pays 70%*
Inpatient Hospital	Plan pays 90%*	$100 per admission, then plan pays 70%*	Plan pays 90%*	Plan pays 70%*
Outpatient Surgery/ Ambulatory Surgery Centers	Plan pays 90%*	$50 per facility visit, then plan pays 70%*	Plan pays 90%*	Plan pays 70%*
Urgent Care Facility	Plan pays 90%*		Plan pays 90%*	Plan pays 90%*
Emergency Room	Plan pays 90%*		Plan pays 90%*	Plan pays 90%*

* *After deductible*

Note: This table includes only a partial list of covered services. Please refer to your Summary Plan Description (SPD) for a complete description of each plan.

See the following page for the monthly paycheck deductions for the medical/prescription plans.

Prescription Drug Benefits

Administered by Anthem

If you elect one of the medical plans, you and your eligible dependents will automatically receive the corresponding prescription drug coverage outlined below.

	Anthem PPO	Anthem HSA Plan*
In-Network Retail Pharmacy		
Up to a 30-day supply		
Generic Medications	$10 copay	$10 copay
Formulary/Brand Medications	$20 copay	$30 copay
Non-Formulary Medications	$35 copay	$50 copay
Specialty Medications	$50 copay	$50 copay
In-Network Mail-Order Pharmacy		
Up to a 90-day supply		
Generic Medications	$20 copay	$20 copay
Formulary/Brand Medications	$40 copay	$60 copay
Non-Formulary Medications	$70 copay	$100 copay
Specialty Medications	$100 copay	$100 copay

** Once annual medical deductible is met the following copays will apply.*

Note: This table includes only a partial list of covered services. A more complete description of coverage is provided in the applicable Summary Plan Description (SPD) for each plan. In addition, the following Otsuka products are fully covered:

The Anthem plan covers the following Otsuka-US-branded drug at 100%: Abilify Maintena, Abilify MyCite, Abilify, Abilify Asimtuffi, Abilify Suspension IV Busulfex, Dacogen, Inqovi, Jynarque, Rexulti, Lonsurf, Nuedexta, Samsca, Rejoyn, Voyxact, Simtriyo, Balversa, Kisqali, Femara, and Fisqali & Femara.

The following Otsuka-branded medical devices and procedures are covered under the Anthem medical benefit and are not considered prescription drugs for purposes of the pharmacy benefit: Paradise Renal Denervation (RDN) System.



Telemedicine

Administered by Anthem

(for members enrolled in an Anthem medical plan)

Livehealth Online:

Get access to a doctor online 24/7 at **no cost** to you for commonly treated conditions. Please visit **www.anthem.com/ca** to get started.

When you need medical advice, but don't have the time or want the cost associated with a trip to the doctor's office, you have access to video visits through Anthem.

These can be done in just minutes with no travel necessary. It's quick, convenient, and saves you money. Doctors are available to treat many common medical conditions at times that are convenient for you.

Get care for:

- Cold, flu, and sinus infections
- Urinary tract infections
- Trauma and grief counseling
- Nausea and vomiting
- Headaches and migraines
- Insomnia, depression, and mood swings
- Asthma, allergies, and rashes
- Stress and anxiety

Getting Started:

1. Register and log in.
2. Once you register, your username and password are the same for **anthem.com/ca** and the Sydney Health app.
3. Select **Care**, then choose Virtual Video Visit with a provider.
4. Under **Virtual Video Visit**, be sure to select the Livehealth Online option.

Controlling Healthcare Costs

The rising cost of health insurance is a concern for all of us. Keeping costs to a minimum contributes to lower premiums in future years.

Here are tips on how you can help lower the cost of health insurance:

- **Use network providers.** You will receive a higher level of benefits if you use providers who participate in the network.
- **Use our virtual care program, Life Health Online.** Available for members enrolled in either HDHP or PPO plan at no cost!
- **Avoid unnecessary trips to the emergency room.** Ensure you have a Primary Care Physician, know where your closest Urgent Care facility is, and sign up for Telemedicine.
- **Consider seeing your family physician rather than a specialist.** Family physicians can often provide the same level of care for a variety of illnesses and conditions.
- **Exercise and maintain a proper diet.** The healthier you are, the less vulnerable you are to disease; therefore, reducing doctor's visits and prescription medicines.



Enhanced!
Dental Benefits

Administered by Delta Dental

Below is an overview of what Delta Dental offers.

Enhanced Dental Benefit:

Delta Dental's Next Stage™ Women's Health program provides additional support for women during pregnancy and menopause. The program includes enhanced dental benefits and access to selected partner resources designed to support overall well-being during these important life stages. Log in to your online Delta Dental account and select **Benefits Programs** to find registration details.

Delta Dental PPO
(All states)

	In-Network / Out-of-Network
Calendar Year Deductible (Individual/Family)	$50 / $150
Annual Benefit Maximum (Per patient)	$2,000
Preventive Services	Plan pays 100%
Basic Services	Plan pays 80% after deductible
Major Services	Plan pays 50% after deductible
Orthodontia Benefits	Plan pays 50% after deductible
Orthodontia Lifetime Maximum	$2,000

Note: This table includes only a partial list of covered services. Please refer to your Summary Plan Description (SPD) for a complete description of each plan.

Note: PPO reimbursement is based on PPO contracted fees for PPO Providers, Premier Contracted Fees for Premier Providers and Program Allowance for Non-Delta Dental Providers.



Vision Benefits

Administered by VSP



Vision coverage through VSP is available to ensure you get the personalized care your eyes need with low out-of-pocket costs. The chart below provides an overview of what the vision plan covers.

VSP Vision Plan

	In-Network	Out-of-Network
Vision Exam (Once every calendar year)	$10 copay	Up to $40 reimbursement
Lenses (Once every calendar year) Single Vision Bifocal Trifocal Lenticular	$20 copay	 Up to $40 reimbursement Up to $60 reimbursement Up to $80 reimbursement Up to $80 reimbursement
Frames (Once every 2 calendar years)	$180 allowance for frame of your choice, then 20% off amount over allowance	Up to $80 reimbursement
Contact Lenses (once every calendar year) Elective Non-Elective	 $150 allowance Covered in full	 Up to $110 reimbursement Up to $210 reimbursement

Note: This table includes only a partial list of covered services. Please refer to your Summary Plan Description (SPD) for a complete description of each plan.



Employee Contributions

Monthly Deductions



Reminder!

As we strive to offer best in class benefits, we continue to cover Medical, Dental, and Vision insurance costs at 100% to ensure you can have the best possible coverage for you and your family.

Medical, Dental, and Vision benefits are available at no cost to employees who enroll and their enrolled dependents. This means that you and your family can access quality care and preventive services without monthly payroll deductions.

Medical/Prescription Monthly Payroll Deductions

	Anthem PPO	Anthem HSA Plan
Employee Only	No cost	No cost
Employee + Spouse/Domestic Partner	No cost	No cost
Employee + Child(ren)	No cost	No cost
Family	No cost	No cost

Dental Monthly Payroll Deductions

	Delta Dental PPO
Employee Only	No cost
Employee + Spouse/ Domestic Partner	No cost
Employee + Child(ren)	No cost
Family	No cost

Vision Monthly Payroll Deductions

	VSP Vision Plan
Employee Only	No cost
Employee + Spouse/ Domestic Partner	No cost
Employee + Child(ren)	No cost
Family	No cost

Savings Account Offerings

OPFA offers an array of health-related accounts. You can contribute to the accounts you're eligible for and use the money to pay for expenses and save on taxes too. Here's a quick overview of the accounts.

	Health Savings Account (HSA)	Limited Purpose Healthcare Flexible Spending Account (FSA)	Healthcare Flexible Spending Account (FSA)	Dependent Care Flexible Spending Account (FSA)
Pairs with which medical plan	Anthem Blue Cross HSA	Anthem Blue Cross HSA	Anthem Blue Cross PPO	Any plan
Your annual contributions*	You and family can contribute up to: • Single: $4,500 • Family: $9,000 • Catch-up (for age 55+): $1,000	You and family can contribute up to: • Single: $3,500 • Family: $3,500	You and family can contribute up to: • Single: $3,500 • Family: $3,500	Between $100 to $7,500, or up to $3,750 if you are married and file separate tax returns
OPFA annual contributions*	• Single: $800 • Family: $1,600	N/A	N/A	N/A
Balances roll over year-to-year	Yes - all your savings carry over, including into retirement	You have a grace period to get reimbursed for qualified health care expenses incurred in the 2.5 months following the end of the calendar year (by March 15, 2028)	You have a grace period to get reimbursed for qualified health care expenses incurred in the 2.5 months following the end of the calendar year (by March 15, 2028)	You have a grace period to get reimbursed for qualified health care expenses incurred in the 2.5 months following the end of the calendar year (by March 15, 2028)
Expenses you can pay for with money in account	All eligible healthcare, including dental and vision; Long-Term Care premiums are also eligible	Eligible dental and vision expenses	All eligible healthcare, including dental and vision	Eligible child daycare and elder care expenses
When available to use	As the money is deposited into your account each pay period	100% of your annual election on January 1 after Annual Enrollment	100% of your annual election on January 1 after Annual Enrollment	As the money is in your account per pay period
How to access	anthem.com/ca	anthem.com/ca	anthem.com/ca	anthem.com/ca
Receive a debit card	Yes	Yes	Yes	Yes

** Combined HSA contributions cannot exceed the annual IRS limits and highly compensated employees earning more than $165,000 annually will be limited to $4,000.*

Note: Employer contributions to an HSA are considered taxable income in some states, including California and New Jersey.

Refer to IRS Publication 969 to learn more about HSAs and FSAs at:
irs.gov/forms-pubs/about-publication-969

Flexible Spending Accounts (FSA)

Administered by Anthem

Flexible spending accounts provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

Healthcare FSA

The Healthcare FSA allows you to set aside pre-tax dollars via payroll deductions to pay for qualified healthcare expenses for you and your dependents. The annual maximum amount you may contribute is $3,500 per calendar year. **Note:** The 2027 contribution limit is an estimate, pending confirmation from the IRS.

The Healthcare FSA can be used for:

- Doctor office copays
- Non-cosmetic dental procedures (crowns, dentures, orthodontics)
- Prescription contact lenses
- Glasses and sunglasses
- LASIK eye surgery
- Certain over-the-counter medications
- Menstrual care products

Dependent Care FSA

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care expenses. For 2027, the annual maximum contribution limit is $7,500 (Or $3,750 if married and filing separately). If you are considered a Highly-Compensated Employee, your limit will be $4,000. For 2027, that category will include anyone with an annual salary of $165,000 or more.

The Dependent Care FSA can be used for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

See IRS Publications 502 and 503 for a complete list of eligible FSA expenses.



Limited Purpose FSA

If you are enrolling in the High Deductible Health Plan (HDHP) and elect the HSA, the IRS rules prohibit you from participating in the Healthcare FSA. However, you may elect up to $3,500 in a Limited Purpose FSA, which can be used for dental and vision expenses only.

Use-It-or-Lose-It!

Be sure to calculate your FSA contributions carefully. Flexible Spending Accounts operate under a use-it-or-lose-it rule, meaning that money not used by the end of the plan year does not rollover and must be forfeited, per IRS regulations. Additionally there is a 2 1/2 month grace period allowing you until March 15th of the following year to incur eligible expenses and submit for reimbursement.

Health Savings Account (HSA)

Administered by Anthem

The HSA is available to employees enrolled in the Anthem HSA medical plan. An HSA is a great way to save money by allowing you to set aside pre-tax dollars, via payroll deductions, to efficiently pay for qualified healthcare, dental and vision expenses.

HSA Advantages

- **Security:** Your HSA can provide a savings buffer for unexpected or high medical bills.
- **Investing:** Once your HSA balance reaches an excess of $1,000 you can invest your money.
- **Flexibility:** You can use your HSA to pay for current medical expenses, including your deductible and expenses that your insurance may not cover, or you can save your funds for future medical expenses, such as:
  - Health insurance or medical expenses if unemployed
  - Medical expenses after retirement (before Medicare)
  - Out-of-pocket expenses when covered by Medicare
  - Long-term care expenses and insurance
- **Portability:** Accounts are completely portable, meaning you can keep your HSA even if you:
  - Change jobs
  - Change your medical coverage
  - Become unemployed
- **Ownership:** There is no 'use-it-or-lose-it' rule. The funds roll over from year to year and remain in your account until they are used or withdrawn.

HSA Triple-Tax Advantages

HSA contributions are tax deductible, you can spend the money tax-free, and any growth is tax free. Once you turn 65, you can use your Health Savings Account (HSA) funds for anything you want, including non-qualified medical expenses, without paying an additional 20% federal tax penalty. However, you will still need to pay ordinary income tax on the withdrawals.

HSA Qualified Healthcare Expenses

You can use the funds in your HSA to pay for qualified healthcare expenses such as:

- Doctor visits
- Dental and vision care
- Prescription medications
- Chiropractic services
- Hearing aids and batteries
- Over-the-counter (OTC) medications
- Menstrual care products
- Acupuncture

HSA Contributions

OPFA will contribute an annual amount of $800 for an individual or $1,600 for an employee and 1 or more dependents into your HSA account. Contributions will be made every pay period into your HSA account, starting from your effective date of coverage.

	Individual	1 or more dependents
Semi-Monthly	$33.33	$66.66

The maximum amount that can be contributed to the HSA in a tax year is established by the IRS. For 2027, the contribution limits are:

- $4,500 for individual coverage
- $9,000 for family coverage
- Annual catch-up contribution (age 55+): $1,000

Disability Benefits

Administered by Lincoln Financial

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. These benefits are provided at no cost to you — OPFA pays for 100% of the cost of coverage.

Short-Term Disability (STD)

Short-Term Disability is a type of disability insurance coverage that can help you remain financially stable should you become injured or ill and cannot work.

After seven calendar days of continuous disability, you may receive 60% of your average weekly wages to a maximum benefit of $3,000 per week.

This benefit can be paid for up to 26 weeks of continuous disability.

Short-Term Disability Benefit	
Benefit Amount	60%
Maximum Weekly Benefit	$3,000
Elimination Period	7 days
Duration of Benefits	26 weeks

Long-Term Disability (LTD)

Long-Term Disability insurance protects workers in the event they become disabled for a prolonged period prior to retirement. The LTD plan provides you with income continuation in the event your illness or injury lasts beyond 26 weeks.

This helps ensure you have a continued income if you are unable to work due to a covered sickness or injury. You may receive 60% of your pre-disability earnings to a maximum benefit of $15,000 per month.

Long-Term Disability Benefit	
Benefit Amount	60%
Maximum Monthly Benefit	$15,000
Elimination Period	26 weeks
Duration of Benefits	Social Security Normal Retirement Age



Life and AD&D Benefits

Administered by Lincoln Financial

Life and Accidental Death & Dismemberment (AD&D) insurance provides protection to those who depend on you financially in the event of your death or an accident that results in death or serious injury.

Basic Life and AD&D

Life insurance can help provide for your loved ones if something were to happen to you.

OPFA provides eligible employees with group life and AD&D insurance. OPFA pays for the full cost of this benefit and enrollment is automatic.

Basic Life and AD&D Benefit		
	Basic Life	**Basic AD&D**
Benefit Amount	2x annual base earnings	5x annual base earnings
Benefit Maximum	$1,500,000	$1,500,000
Benefit Reduction	Reduces to 50% at age 70	Reduces to 50% at age 70



Voluntary Life

While OPFA offers basic life insurance, some employees may be interested in additional coverage based on their personal circumstances.

Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself, for your spouse, or your dependent child(ren)* as outlined in the chart below.

Voluntary Life Benefit	
Employee Benefit	Increments of $10,000 to the lesser of 6x annual earnings or $1,500,000, whichever is less
Spouse Benefit	Increments of $5,000, up to a maximum of 100% of employee election or $250,000
Dependent Child(ren)	Increments of $2,500, up to a maximum of $20,000

* *Employee coverage must be elected in order to elect coverage for spouse/domestic partner or dependent child(ren). Evidence of Insurability (EOI) is required for coverage beyond $20,000 up to the Guaranteed Issue amount (GI).*

Voluntary Whole Life with Long-Term Care

Administered by The Standard

This plan not only offers the financial security of a whole life policy but also presents a strategic solution to safeguard your assets from unexpected Long Term Care expenses. With this benefit, you have the peace of mind that your financial future is protected, especially in states contemplating long-term care taxation changes. **Don't wait for the uncertainties of the future; secure your financial well-being today.**

Plan Features

- **Guaranteed Acceptance:** No physical exams are required to apply for employee coverage up to $200,000 and for spouse coverage up to $30,000.*
- **Family Coverage:** You can purchase coverage for yourself and your spouse.
- **Portable Coverage:** You can take your policy with you if you leave the company or retire.
- **Coverage for Your Needs:** You can purchase the precise amount of coverage that is right for you.
- **Policy Builds Cash Value:** Policy builds cash value.
- **Riders:** Included riders are accelerated death benefit for long-term care and accelerated death benefit for terminal illness or condition of up to 75% of the elected amount.
- **Locked-In Rates:** No premium increase as you age.**

Note: The premium cost for this benefit is determined by your age, tobacco status, and the amount of coverage you elect.

What Is Long-Term Care (LTC) Coverage?

LTC pays for services to care for you when you can no longer perform activities of daily living on your own.

These activities can range from help at home with meal preparation and housekeeping to personal care services like bathing, dressing, eating, and moving around. Care is typically received at home, in a nursing home, or in an assisted living facility (which is a home-like setting that offers safety and security).

If the insured is certified as chronically ill by a licensed health practitioner, the policy pays a monthly benefit equal to 4% of the death benefit after the 90-day elimination period while the insured is receiving qualified long-term care services. The extension feature may continue payments for up to 50 months. Once the benefit period ends, the restoration benefit reinstates the death benefit and cash value to their pre-acceleration amount.

> **Example:** *If your life insurance benefit is $60,000, your monthly LTC benefit would be $2,400, and your total LTC benefit is $120,000 including the LTC extension benefit.*

* *Plan eligibility rules apply*

** *You will have one opportunity to enroll in this plan. If you decide to elect a different coverage amount in the future, you would have to cancel existing coverage and re-elect the plan at the next open enrollment event for a different amount. You can elect coverage for your dependents in the future if you don't elect coverage for them at the initial enrollment.*

Life Insurance Comparison Chart		
Company-Paid Life	**Voluntary Supplemental Life**	**Whole Life Insurance**
100% company-paid	Employee pays the premium and it increases as you age	Employee pays the premium and rates do not increase
Death benefit only	Death benefit only	Death benefit and included riders
Coverage ends when you leave the company	Coverage ends when you leave the company	You can keep the policy as long as you pay the premiums
Coverage for employee only	Coverage is available to you, your spouse, and dependent child(ren)	Coverage is available to you and your spouse

Voluntary Benefits

Administered by Lincoln Financial

An unexpected illness or injury can disrupt every facet of your life, including your physical, emotional, and financial well-being. These benefits are designed to help strengthen your overall benefits package and provide additional protection for you and your family.

Voluntary Critical Illness Insurance

We know that everyone has different needs when coping with a critical illness. With Critical Illness insurance, you get a benefit paid directly to the covered person, unless otherwise assigned, if they are diagnosed with a covered critical illness, such as cancer, heart attack, or stroke.

This plan can help ease some of your financial worries so you can stay focused on your health. You choose how to spend or save your benefit.

It can be used for expenses, such as:

- Paying for child care or help around the house
- Travel costs to see a specialist
- Medical treatment and doctor visits
- Copays and deductibles
- Prescription drug costs

Rates and More Information

The premium cost for this benefit is determined by your age, tobacco status, and elected coverage amount. Coverage is available in the following tiers:

$10,000, $20,000, $30,000, and $40,000. For more information about Critical Illness coverage, **click here**.

Health Screening Benefit

The voluntary plans each provide a benefit if you or your covered dependents complete a covered health screening such as a physical exam, total cholesterol blood test, mammogram, lipid panel, and more.

The Critical Illness, Accident, and Hospital Indemnity plans each provide a **$100 benefit** per covered person, per calendar year.



Voluntary Benefits (continued)

Administered by Lincoln Financial

Voluntary Accident Insurance

Accidents happen and they can affect more than just your physical health. With Accident insurance, you get a benefit to help pay for costs associated with a covered accident or injury. You may utilize the payments as you best see fit.

Accident insurance covers:

- Initial & emergency care
- Hospitalization
- Fractures & Dislocation
- Follow-up care

Rates and More Information

For monthly rates, refer to the chart below. For more information about Accident coverage, click here.

Voluntary Accident Plan Monthly Rates	
Employee Only	$7.05
Employee + Spouse/Domestic Partner	$12.76
Employee + Child(ren)	$16.85
Family	$22.56

Hospital Indemnity

A hospital stay can happen at any time, and it can be costly. Hospital Indemnity insurance helps you and your loved ones have additional financial protection.

With hospital indemnity insurance, a benefit is paid directly to the covered person, unless otherwise assigned, after a covered hospitalization resulting from a covered injury or illness.

It can be used for expenses, such as:

- Copays
- Deductibles
- Coinsurance
- Unexpected costs
- Child care
- Follow-up services
- Help for the home

Rates and More Information

For monthly rates, refer to the chart below.
For more information about Hospital Indemnity coverage, click here.

Voluntary Hospital Indemnity Plan Monthly Rates	
Employee Only	$11.63
Employee + Spouse/Domestic Partner	$26.92
Employee + Child(ren)	$22.21
Family	$36.95

Pet Insurance

Administered by Wishbone

Nobody wants to imagine their pet getting sick or injured - but when it comes to your pet's health, it's best to expect the unexpected.

Wishbone Pet Insurance is accepted at any vet in the U.S., including emergency hospitals. Their simple online claims process means you get your money back fast, whether it's for routine care or an accident.

With Wishbone, protecting your pet's health and your finances has never been easier!

Available Wishbone Plans

Wishbone offers different plan options to fit your budget. Enroll in the plan below for maximum coverage.

Accident & Illness Coverage: For the unexpected

- 90% reimbursement
- $250 deductible
- $25,000 annual limit
- Includes lost pet recovery service and 24/7 pet telehealth.
- Rates based on your pet's age, breed & zip code.

Getting Started

Get a quote and enroll today at **www.wishboneinsurance.com/otsuka-us**.



Legal/ID Theft Plans

Administered by MetLife & Norton

MetLife Legal Plan

This Legal Plan provides cost-effective legal assistance that members can use to proactively handle expensive legal matters. We know personal finances are a top stressor for working adults. The MetLife legal plan provides the mental and emotional security that comes with knowing an attorney is helping with your legal matters.

Benefits and features include:

- No copays, deductibles, or claim forms when using a network attorney for a covered matter.
- Unlimited consultations even for matters not covered under your plan.
- Access to MetLife's website for all employees, enrolled or not, to see coverages and attorney network as well as use of the self-help document library.

Monthly Rates

MetLife Legal Plan covers you, your spouse, and your dependents for $16.50 per month.



Norton ID Theft Insurance

Digital thieves constantly discover new ways to extract your personal information, open credit accounts in your name, sell your sensitive data on the dark web, and take over your financial accounts. Norton offers comprehensive identity theft insurance that monitors multiple gateways into your identity and credit while also alerting you of fraudulent activity.

Protection Services Include:

- Credit reports monitoring
- Court records monitoring
- Bank account takeover monitoring
- Sex offender monitoring
- Criminal bookings monitoring
- Credit application monitoring
- Real time authorization notifications
- Change of address monitoring
- Child Social Security number monitoring
- Full service identity restoration services
- Social Security number trace

Enhanced Features

- **Income Tracking:** View checking, savings, and investment accounts in one place to monitor income in real time.
- **Spending Tracker:** Categorize expenses and watch spending to stay on budget.
- **Spending Insights:** Review spending trends by category to make smarter financial decisions.

New Feature Highlight:

Genie Scam Protection Pro helps stop scammers before they reach employees, protecting them across text messages, phone calls, emails, and websites.

Monthly Rates

Employee Only: $9.49; **Family:** $17.98

Behavioral Healthcare

Administered by Lyra

Lyra provides care for your emotional and mental health how, when, and where you need it, at no cost to you. Whether you're feeling stressed, anxious, or depressed, support from Lyra can get you back on your feet.

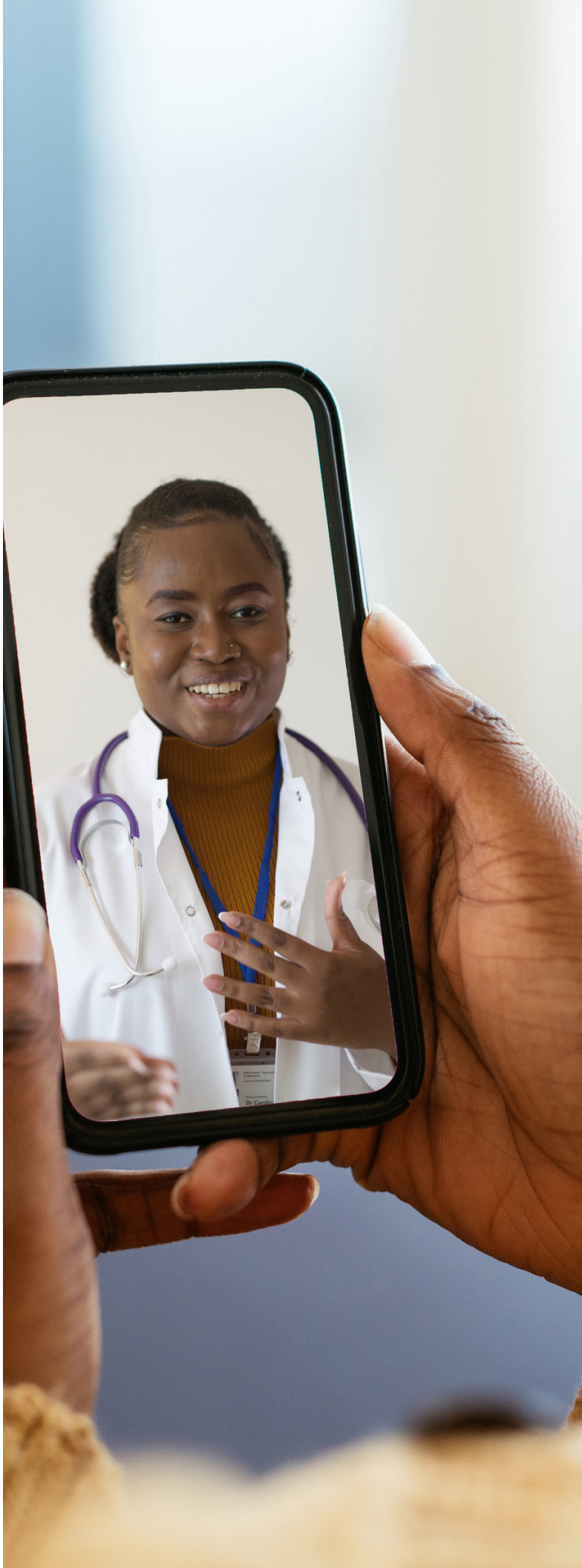
All OPFA employees and their eligible dependents have access to mental health coaching and short-term therapy from Lyra. Sign up easily online and Lyra will match you to care and providers specific to your needs.

Meet with a mental health coach or therapist via live video, live messaging, phone, or in-person up to 16 sessions for each eligible person per calendar year.

Here are some details on each of our care options:

- **Guided Self-care with a Coach:** Get started quickly with a care plan crafted by your Lyra coach to learn new mental health strategies at your own pace.
- **Mental Health Coaching:** Get to the root of your challenges with ongoing coaching sessions via live messaging or live video and between session support.
- **Mental Health Therapy:** Lyra's therapists are experts at diagnosing and treating mental health conditions like depression, eating disorders, or PTSD and provide support via live video or in person.
- **Mental Wellness Tools:** Access selected mental wellness tools with self-led support on topics like meditation, stress, and sleep. Easily available on-demand, anytime, anywhere – all on your mobile device or computer.

For more information about Lyra, go to otsuka.lyrahealth.com or call 877.467.1893.



Cancer Care Support

Administered by Transcarent

How to Access:

Download the Transcarent app or visit **member.transcarent.com**. It only takes a few minutes to activate your account!



Cancer is a growing concern for all of us. Your OPFA benefits include Cancer Care Support through Transcarent, a resource available to employees and covered dependents enrolled in an Anthem medical plan.

Transcarent provides expert guidance, tools, and support at every stage – from prevention and early detection to treatment, survivorship, and caregiver support.

What you can expect with Transcarent:

High Quality Treatment

Access to vetted providers who meet the highest standards of care and outcomes, including providers outside the regular health plan network.

Expert diagnosis through AccessHope

- **Cancer support team:** Virtual support from expert oncology nurses to help organize your thoughts, questions, and concerns.
- **Expert advisory review:** A specialist from a top cancer center can review your treatment plan and provide recommendations.
- **Proactive case reviews:** Claims are monitored and flagged for expert review when appropriate.
- **Personalized Screening Plans:** Get recommendations based on your age, family history, and health risks.

Survivorship & Workplace Support

End-to-end support for individuals navigating cancer, with dedicated guidance throughout treatment and recovery.

Caregiver Support

Resources and education designed to support caregivers in their critical role.

401(k) Retirement Plan

Administered by Fidelity

About the Retirement Plan

- **Eligibility:** Immediate upon hire.
- **Enrollment:** First pay period of the next month after hire; new employees are auto-enrolled at a contribution percentage of 6% pre-tax (or you can elect 0% to waive participation). New hires are auto-enrolled 36 days from the date of hire unless you actively enroll or waive election.
- **Employee Contributions:** Up to 60% of eligible compensation per pay period, on a pre-tax, Roth and/or after-tax basis (excludes bonuses and overtime).

Employer Match

OPFA matches your 401(k) contributions dollar-for-dollar, up to 6% of your eligible compensation, per pay period. To make sure you can take full advantage of the company match even if you reach your IRS contribution maximum before the end of the year, OPFA provides a year-end true-up.

Vesting Schedule (for Employer-Matching Contribution)	
Less than 1 year	0%
1 year	25%
2 years	50%
3 years	75%
4 years	100%

401(k) Federal Contribution LImits for 2027*	
Standard Contribution Limit	$24,500
Catch-Up Contribution (those age 50+ by December 31, 2027)	$7,500
Super catch-up limit for individuals between 60 and 63	$11,250

** Limits listed are for 2026. At publication, the IRS had not yet released 2027 limits.*

New 401(k) Bonus Deferral Option for 2027

Beginning January 1, 2027, you can defer all or a portion of your eligible bonus into the OPFA 401(k) savings plan – giving you another way to save for retirement beyond your regular paycheck contributions.

What to Know

Your current regular paycheck deferral election will not automatically apply to eligible bonus pay. If you would like to defer all or a portion of your 2027 bonus (or any future eligible bonus) to the 401(k) savings plan, you'll need to make a separate bonus deferral election.

OPFA's company matching contribution will continue to be based on eligible base salary only, with a match up to 6% of eligible base salary.

What to Do

- Decide how much of your eligible bonus you would like to defer.
- Choose whether to save on a pretax, Roth, and/or after-tax basis.
- Consider how your bonus deferral could affect your annual 401(k) limits. If you reach the IRS limit or maximize the company match before year-end, Fidelity can help you understand other plan savings options, such as after-tax or catch-up contributions, if eligible.
- Make a separate bonus deferral election through Fidelity at **www.401k.com** or by calling **800.835.5097** between 8:30am and 8:30pm ET at least 30 days before your bonus payout date.

For More Information:

Please review the 401(k) guidebook available through the Human Resources Department regarding any of the plan provisions.

For enrollment, customer service, fund performance and prospectus information, contact Fidelity at **800.835.5097**, or visit **www.401k.com**.

Carrier Contacts

Your Benefit Resources

Benefit	Carrier	Phone	Website
Medical/Prescription	Anthem	833.807.1875	www.anthem.com/ca
Dental	Delta Dental	800.422.4234	www.deltadentalins.com
Vision	VSP	800.877.7195	www.vsp.com
Spending Accounts	Anthem	833.807.1875	www.anthem.com/ca
Short-Term and Long-Term Disability	Lincoln Financial Group	800.842.3728	www.lincolnfinancial.com
Basic/Supplemental Life and AD&D	Lincoln Financial Group	800.842.3728	www.lincolnfinancial.com
Critical Illness, Hospital Indemnity & Accident	Lincoln Financial Group	800.842.3728	www.lincolnfinancial.com
Whole Life Insurance with Long-Term Care	The Standard	800.521.3535	www.standard.com/ahlevb/otsuka
Pet Insurance	Wishbone Pet Insurance	N/A	www.wishboneinsurance.com/otsuka-us
Legal Insurance	MetLife	800.821.6400	www.legalplans.com
Identity Theft Insurance	Norton	800.607.9174	my.norton.com
Behavioral Health	Lyra	877.467.1893	www.otsuka.lyrahealth.com
Cancer Care Support	Transcarent	888.541.3160	member.transcarent.com
401(k) Retirement Plan	Fidelity	800.835.5097	www.401k.com

Legal Notices

About this Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual summary plan descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. OPFA reserves the right to make changes at any time to the benefits, costs, and other provisions relative to benefits.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the OPFA Health and Welfare Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the OPFA Health and Welfare Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

If you have any questions, please contact OPFA, Human Resources, 475 North Martingale Road, Suite 1000, Schaumburg, IL 60173

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you 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 of the mastectomy, including lymphedema.

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

- **Anthem Blue Cross PPO:** $500/$1,500 (single/family in-network) and 10% coinsurance (in-network) and $2,000/$6,000 deductible (single/family out-of-network) and 30% coinsurance (out-of-network).
- **Anthem HDHP with HSA:** $1,750/$3,500 (single/family in-network) and 10% coinsurance (in-network) and $1,750/$3,500 (single/family out-of-network) and 30% coinsurance (out-of-network)

Newborns' and Mothers' Health Protection Act Disclosure

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

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted and you will continue to pay the same amount as if you were not absent. If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact Human Resources at HR@otsuka-america.com for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service connected illnesses or injuries, as applicable.

Medicare Part D Notice of Creditable Coverage

Your Options

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. OPFA has determined that the prescription drug coverage offered by the Medical Plans through Anthem/Kaiser is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

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

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

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage:

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

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

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

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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:

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- www.socialsecurity.gov
- or call: 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).

Date:	October 2026
Name of Entity/Sender:	OPFA
Contact:	Scott Cavanaugh
OAI Address:	475 North Martingale Road, Suite 1000, Schaumburg, IL 60173
Phone Number:	628-998-1435

Your ERISA Rights

As a participant in the OPFA benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits
You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents— including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage
You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have credible coverage from another plan. You should be provided a certificate of credible coverage, free of charge, from your group health plan or health insurance issuer when:
  - You lose coverage under the plan;
  - You become entitled to elect COBRA continuation coverage;
  - You request it up to 24 months after losing coverage.

Prudent Actions 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 plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and 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 obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court 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 administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court.
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

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. This should occur if the court finds your claim frivolous.

Assistance With Your Questions
If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices.

Or you may write to the: Division of Technical Assistance and Inquiries Employee Benefits Security Administration U.S. Department of Labor 200 Constitution Avenue, NW Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee and Employer Hotline of the Employee Benefits Security Administration at: 866-444-3272. You may also visit the EBSA's web site on the Internet at: https://www.dol.gov/agencies/ebsa.

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.

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 (www.healthcare.gov). 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

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- 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 happen:

- 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."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to OPFA, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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's becoming 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 or 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: OAI Human Resources or COBRA Administrator.

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. Any qualified beneficiary who does not elect COBRA within the 60-day election period specified in the election notice will lose his or her right to elect COBRA.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. When the qualifying event is the death of the employee, the employee's 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 8 months before the date on which his employment terminates, 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 8 months). Otherwise, when the qualifying 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. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Continuation Coverage Rights Under COBRA

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.

The disability extension is available only if you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of the date of the Social Security Administration's disability determination; the date of the covered employee's termination of employment or reduction in hours; and the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction in hours.

You must also provide this notice within 18 months after the covered employee's termination or reduction in hours in order to be entitled to this extension. You must provide the notice by contacting Human Resources at HR@otsuka-america.com.

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.

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the

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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 https://www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

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
For further information regarding the plan and COBRA continuation, please contact:

OPFA, 475 North Martingale Road, Suite 1000, Schaumburg, IL 60173

Summaries of Benefits and Coverage (SBCs)

As required by the Affordable Care Act, Summaries of Benefits and Coverage (SBCs) are available on the OAI website. If you would like a paper copy of the SBCs (free of charge), you may also call OAI benefits department at 415-217-8470.

OPFA is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

Glossary

Affordable Care Act and Patient Protection (ACA)
Also called Health Care Reform, the ACA requires health plans to comply with certain requirements. The ACA became law in March 2010. Since then, the ACA has required some changes to medical coverage—like covering dependent children to age 26, no lifetime limits on medical benefits, reduced FSA contributions, covering preventive care without cost-sharing, etc, among other requirements.

Brand Name Drug
The original manufacturer's version of a particular drug. Because the research and development costs that went into developing these drugs are reflected in the price, brand name drugs cost more than generic drugs.

Coinsurance
A percentage of costs you pay "out-of-pocket" for covered expenses after you meet the deductible.

Copayment (Copay)
A fee you have to pay "out-of-pocket" for certain services, such as a doctor's office visit or prescription drug.

Deductible
The amount you pay "out-of-pocket" before the health plan will start to pay its share of covered expenses.

Employer Contribution
Each month, the company provides you with an amount of money that you can apply toward the cost of your health care premiums. The amount of the employer contribution depends on who you cover. You can see the amount you'll receive when you enroll. If you're enrolling as a new hire, the employer contribution amount will be prorated based on your date of hire.

Generic Drug
Lower-cost alternative to a brand name drug that has the same active ingredients and works the same way.

High-Deductible Health Plan (HDHP)
High-deductible health plans (HDHPs) are health insurance plans with lower premiums and higher deductibles than traditional health plans. Only those enrolled in an HDHP are eligible to open and contribute tax-free to a health savings account (HSA).

Health Savings Account (HSA)
A health savings account (HSA) is a portable savings account that allows you to set aside money for health care expenses on a tax-free basis. You must be enrolled in a high-deductible health plan in order to open an HSA. An HSA rolls over from year to year, pays interest, can be invested, and is owned by you—even if you leave the company.

Out-of-Pocket Maximum
The most you pay each year "out-of-pocket" for covered expenses. Once you've reached the out-of-pocket maximum, the health plan pays 100% for covered expenses.

Plan Year
The year for which the benefits you choose during Annual Enrollment remain in effect. If you're a new employee, your benefits remain in effect for the remainder of the plan year in which you enroll, and you enroll for the next plan year during the next Annual Enrollment.

Preventive Care
Health care services you receive when you are not sick or injured—so that you will stay healthy. These include annual checkups, gender- and age-appropriate health screenings, well-baby care, and immunizations recommended by the American Medical Association.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. 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://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

Legal Notices

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
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/medicaid/plans-programs/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website:
https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

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: http://dhcfp.nv.gov
Medicaid 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. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP)
Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

Legal Notices

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/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, 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



Otsuka

OPFA reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and the actual plan documents, the actual plan documents will prevail. If you have any questions about your guide, contact Human Resources.