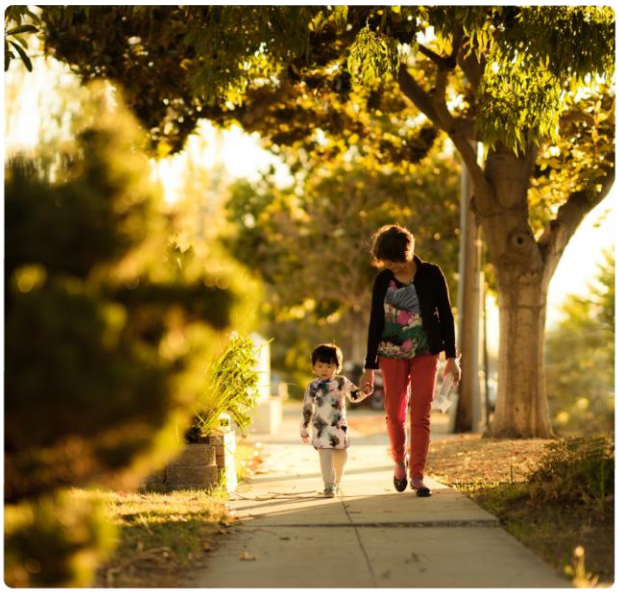
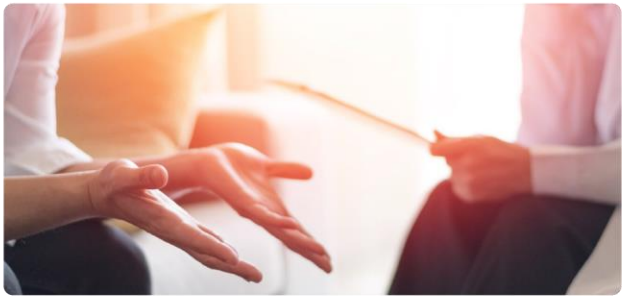
PLASCORE, INC.

2024 EMPLOYEE BENEFITS GUIDE

2024





PLASCORE®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Benefit Guide **Contents**

SUMMARY OF BENEFITS **FOR EMPLOYEES**

Who is Eligible?

Full-time employee (working 30 hours/week) with Plascore are eligible for most benefits on their date of hire.

Plascore has an annual open enrollment period for employees to add or make changes to their insurance benefit elections. If changes are not made during open enrollment, a qualifying event would need to occur in order to be eligible to add or change benefit elections at any other point during the plan year.

How to Enroll/Re-Enroll for 2024 Benefits

If you are not making any changes to your health, dental or vision plans, Paycom will automatically carryover your 2023 plan choices to 2024. If you are adding or changing a health, dental or vision plan, you must login to Paycom and make your choices. **If you are enrolling into a Flexible Spending Account (FSA), you MUST log in and make your contribution choice. FSA elections must be made each year.**

On **November 19**, Open Enrollment will close, and your choices will be locked in for the entire year of 2024, unless you have a qualifying event. We will not be following up with employees; it is your responsibility to make your elections.

Qualifying Life Events

Qualifying life events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for the Employee, termination of adoption proceedings, or change in spouse's benefits or employment status.

Employees electing coverages due to a qualifying life event must do so within 31 calendar days of the event.

Our employees are our most valuable asset.

That's why at Plascore, we are committed to a comprehensive benefit program that helps our employees stay healthy, feel secure, and maintain a work/life balance.

FEELING SECURE

- Disability Insurance
- Life and Accidental Death & Dismemberment
- Assistance Program
- 401(k)

STAYING HEALTHY

- Medical, Telemedicine, Dental, and Vision Care
- Health Savings & Flexible Spending Accounts

WORK/LIFE BALANCE

- Vacation
- Holidays
- Tuition Reimbursement
- Jury Duty
- Funeral Leave

Questions? Contact:

Chris-Ann Martini

616-748-2207

CONTACT **INFORMATION**

For general information, please contact Human Resources.

Medical and Prescription Drug		
Priority Health	800-942-0954	www.priorityhealth.com
Health Savings Accounts (HSA)		
Mercantile Bank	616-406-3700	http://www.mercbank.com/hsa Email: HSASupport@mercbank.com
Telemedicine		
Spectrum Health (MI Employees) MD Live (Outside of Michigan)	844-322-7374 800-400-6354	App: Spectrum Health App: MD Live
Dental		
Delta Dental	800-524-0149	www.deltadentalmi.com
Vision		
VSP	800-877-7195	www.vsp.com
Flexible Spending Accounts (FSA)		
WEX	866-451-3399	Email: customerservice@wexhealth.com Submit Forms: forms@wexhealth.com
Life, AD&D, Voluntary Life, Short-Term And Long-Term Disability		
Mutual Of Omaha	800-775-8805	www.mutualofomaha.com
Employee Assistance Program		
Pine Rest EAP (formally EAC)	800-227-0905 800-442-0809	eaccares.com www.pinerest.org
Disability		
Mutual Of Omaha	800-316-2796	www.mutualofomaha.com
401(k) Plan		
Principal	800-547-7754	www.principal.com
Additional Benefits		
Benefit Lingo And Legal Notices		

MEDICAL AND **PRESCRIPTION DRUG PLAN**

Eligibility: Employees working 30+ hours/week are eligible on their date of hire. If you do not elect coverage when first eligible, you may enroll with a qualifying event or during the open enrollment period.

Spousal Surcharge: If your spouse has qualifying coverage available from their employer, a $50/pay period surcharge will be applied to your premium.

Virtual Doctor: Need to talk to a doctor but the timing is bad, or you don't feel well and don't need to go to the emergency room. Take advantage of a virtual doctor visit with Spectrum Health, available 24/7. Call **844.322.7374** or login into your MyHealth account at www.priorityhealth.com and select the Virtual Care tile. There is also a mobile app available, just search for Spectrum Health.
Outside of Michigan, MDLive can help. You can download the app or call 800.400.6354 to access medical, mental health and substance use care.

High Deductible Health Plan (HDHP): With a HDHP, the deductibles must be met before the plan begins to pay (except for preventive care which is paid at 100%). The coinsurance and copay costs track toward the out-of-pocket amounts. The HDHP has aggregate deductibles and out-of-pocket maximums (OOP). If you are a family plan, the overall family deductible must be met before the plan begins to pay.

Pre-Deductible Prescription Drugs: Certain drugs that meet the criteria for being "preventive" as determined by the IRS may be covered prior to satisfying your HDHP deductible. Applicable copayments described in your prescription drug coverage would apply. Your HDHP deductible will not consider any of the copays you make for these "preventive" drugs.

Plascore provides an HSA contribution for employees in the HDHP (see page 8). The Plascore contribution matches are done bi-weekly. Employees are automatically enrolled in the HDHP unless you opt out of coverage.

Traditional Plans (HMO & PPO): These plans have embedded deductibles and out of pocket amounts. Meaning for the family amounts that a member will not exceed the individual deductible and/or out of pocket as listed in the benefit summary on page 7.

Copays and coinsurance and prescription cost track toward the out-of-pocket amounts.

How to Find an In-Network Provider:

- To find or verify if your provider is in the network, call **800.942.0954**
- To search online: priorityhealth.prismisp.com
- Or go to www.priorityhealth.com and click on Find a Doctor, choose medical plan, enter zip code and search radius then select your search criteria.

2024 EMPLOYEE **BI-WEEKLY CONTRIBUTIONS**

A tobacco surcharge of $30/pay period applied to employees who use tobacco. Spousal surcharge of $50/pay period applied if spouse has available coverage through their employer.

	Single			Double			Family		
Salary	**<$55k**	**$55k-$89k**	**$90k+**	**<$55k**	**$55k-$89k**	**$90k+**	**<$55k**	**$55k-$89k**	**$90k+**
HMO	$35.17	41.87	$50.24	$84.40	$100.48	$120.58	$105.50	$125.60	$150.72
PPO	$39.29	$54.26	$65.48	$94.30	$130.22	$157.16	$117.87	$162.78	$196.45
HDHP	$1.32	$6.61	$13.21	$3.17	$15.86	$31.71	$3.96	$19.82	$39.64

2024 PRIORITY HEALTH **MEDICAL PLANS**

Benefits	HMO	PPO		HDHP	
	In Network	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Deductible	$500 Single $1,000 Family	$1,000 Single $2,000 Family	$2,000 Single $4,000 Family	$3,000 Single $6,000 Family	$5,000 Single $10,000 Family
Coinsurance	20%	20%	40%	20%	40%
Out of Pocket Coinsurance	$6,000 Single $12,000 Family	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family	$5,000 Single $10,000 Family	$8,000 Single $16,000 Family
Out of Pocket Maximum	$7,350 Single $14,700 Family	$7,350 Single $14,700 Family	$14,700 Single $29,400 Family	$5,000 Single $10,000 Family	$8,000 Single $16,000 Family
Virtual Visit	$0 copay	100% covered	Deductible-Coinsurance	Deductible - Coinsurance	Deductible-Coinsurance
Office Visit – Primary Care	$30 copay	$30 copay	Deductible - Coinsurance	Deductible - Coinsurance	Deductible - Coinsurance
Office Visit - Specialist	$45 copay	$45 copay	Deductible - Coinsurance	Deductible - Coinsurance	Deductible - Coinsurance
Urgent Care	$60 copay	$75 copay	Deductible - Coinsurance	Deductible - Coinsurance	Deductible - Coinsurance
ER	$150 copay after deductible	$150 copay after deductible	$150 copay after deductible	Deductible - Coinsurance	Deductible - Coinsurance
Preventive Care: Routine Physical, Well Child Care, Routine Mammogram, Routine Pelvic & Pap Test, PSA test, Colonoscopy	100% covered	100% covered	Deductible - Coinsurance	100% covered	Deductible - Coinsurance

Prescription Drug Benefit			
	HMO	**PPO**	**HDHP**
Formulary:	Traditional	Traditional	Traditional
Tier 1:	**$10 copay**	**$10 copay**	**$10 copay after deductible**
Tier 2:	**$30 copay**	**$30 copay**	**$20 copay after deductible**
Tier 3:	**$60 copay**	**$60 copay**	**$40 copay after deductible**
Tier4:	**$30 copay**	**$30 copay**	**$20 copay after deductible**
Tier5:	**$60 Copay**	**$60 copay**	**$40 copay after deductible**
Mail Order provides 3-month supply for 2x the copays listed above for **Tiers 1 through 3**. Visit priorityhealth.com and search Approved Drug List to see a list of covered drugs.			

PriorityHealth

Livongo by Teladoc Health

Livongo is a free program through Priority Health that provides simplified diabetes management. If you qualify, you will receive an advanced blood glucose meter and as many test strips as you need, all paid for by Plascore. You will also receive:

- Personalized tips with each blood sugar check
- Real-time support when you're out of range
- Strip reordering right from your meter
- Optional alerts to keep contacts in the loop
- Send a Health Summary Report directly from your meter
- Automatic uploads mean no more paper logbooks

Getting Started:

- Text "**GOSTARTNOW**" to 85240 to learn more
- Visit: **Join.Livongo.com/STARTNOW/hi**
- Call 800-945-4355 and use the registration code: **STARTNOW**

Priority Health REWARDS Cost Estimator

See and compare your costs before you receive care. You might earn a VISA rewards card of $50 to $200.

- Scan the QR code with your phone's camera to log in or sign up for a Priority Health member account to access the Cost Estimator.
- Enter a procedure name and search for locations where that service is available. From the location pricing list, select a facility to see your personal out-of-pocket estimate.
- You can also compare costs at facilities in your network and in some cases, narrow your search by selecting a specific provider.
- You save on procedures by choosing the best value options.

PriorityMOM™

Finding out you are pregnant is very exciting but leaves you filled with questions.

PriorityMOM™, which stands for Maternity Offering for Members, is a Priority Health program designed to help you and your family navigate health care costs and coverage throughout your pregnancy and beyond. The goal? To promote healthier pregnancies and support you with resources during this exciting time in your life.

How It Works

1. If you are an expectant mother and an eligible Priority Health member, we will send you a personalized email to join the PriorityMOM program. You can also sign up for PriorityMOM directly at **priorityhealth.com/joinprioritymom**.
2. Once you opt-in to the program, you will receive a welcome gift that contains a blood pressure cuff, a baby sleep sack, a program overview, and a forehead thermometer (gift for second-time PriorityMOM participant)
3. Throughout your pregnancy, you will receive information around your costs and coverage as well as educational resources. If you have high-risk conditions, you will receive additional outreach to help manage your conditions.
4. At the end of the program, you will receive a $50 gift card when you complete the program survey.

Virtual Care

Receive 24/7 access to board-certified doctors through the convenience of a phone or video visit. Virtual care is great for non-emergencies like cold & flu symptoms, allergies, pink eye, sinus problems, skin problems and more.

Download the Priority Health App and either create an account or log in to get started.

Outside of Michigan, download the MDLive app.

See more details on page 11.

PHARMACY BENEFITS – **YOUR QUESTIONS ANSWERED**

To help you transition smoothly onto your new plan, we've answered some frequently asked questions about your upcoming benefits.

When will I receive a member ID card?

Shortly after you enroll, you will receive a Priority Health member ID card in the mail. Starting on the date your plan goes into effect, you can create a member account at priorityhealth.com to get full access to your account information and tools.

Does my current provider participate in my new plan?

Use the Find a Doctor tool on our website to search for providers who participate in your plan. You can easily search for providers by category or by specialty, location and plan type.

Are my prescriptions covered?

Search for your prescriptions on the Approved Drug List (ADL) on our website. To find out if your prescriptions are covered, select the Approved Drug List in the menu. From there:

- Select *Employer Group & Employee*.
- Select *Traditional* when asked for the type of drug list.
- Search for medications alphabetically by name or by therapeutic class—like antihistamines, for example.
- Remember to pay attention to the tier your prescriptions fall into. You can also reference the plan documents provided at your open enrollment meeting to help determine your costs.

What if my prescription isn't on the Approved Drug List?

If your medication isn't on our Approved Drug List, please contact your doctor to discuss your options for similar medications that are covered under your plan. Your medication may be covered in a different form than you are currently using. For example, we may cover your current prescription in capsule form instead of pill form, or ointment instead of cream for topicals.

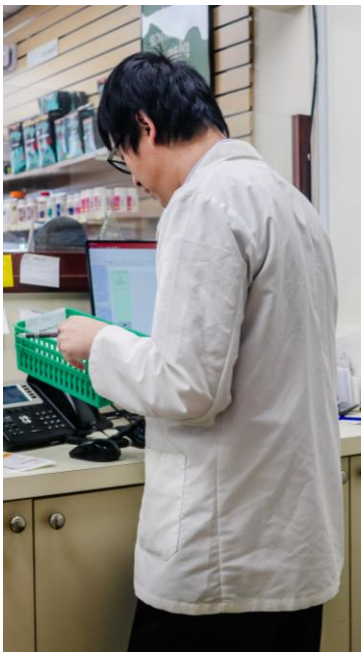
Under your new plan, some medications have additional requirements before your prescription can be filled.

- *Prior authorizations:* Prior authorizations must be approved in advance for a drug to be covered. Prior authorization approval forms are available on our website. Your doctor can submit requests to us via phone or fax.
- *Step therapy:* Some medications require step therapy, which means trying other drugs in the same category that are proven to be safe and effective, lower-cost alternatives. Your current prescription may be covered if the alternatives suggested aren't effective or your doctor deems it medically necessary. If you've completed step therapy requirements in the past, your provider can send us the information for review.

What if my prescription isn't covered and my doctor can't switch my medication right away after my new plan goes into effect?

For the first 120 days of your Priority Health plan, you may be able to get a one-time, 30-day supply of your current medication to last you until your doctor can transition you.

During this timeframe, if the pharmacist says your refill is not covered, you can ask them to check for the transitional fill code on your member record. Typically, you can receive a 30-day supply unless your medication has a quantity or dosage limits.



If, under your new plan, your prescription requires prior authorization or step therapy, you will receive a follow-up letter from us indicating if you need to meet these requirements before filling your next prescription.

HEALTH SAVINGS ACCOUNT **(HSA)**

Who Can Have an HSA?

Any adult can have an HSA if you:

- Have coverage under a qualified Consumer Driven Health Plan (CDHP)
- Have no other first-dollar coverage (not covered under another medical plan that is NOT a CDHP)
- Are not entitled to (enrolled in) Medicare benefits; or
- Cannot be claimed as a dependent on someone else's tax return

If you choose to enroll in the CDHP option, and you are eligible, you may open an HSA through Mercantile Bank. They can be reached at **(616)-406-3700**.

How Does it Work?

When you incur a qualified medical expense, you may use your bank provided debit card to pay for those expenses. You will then retain your receipt or explanation of benefits in order to prove your eligible expenses. You may also pay for expenses out of your personal account and reimburse yourself at a later date by withdrawing funds from the HSA. Benefits to owning a Health Savings Account include funds roll over from year to year, members can change their contributions throughout the year, and accounts are completely portable – they go with you if you ever leave employment with Plascore.

Examples of Eligible HSA Expenses:

- Copays
- Deductibles
- Coinsurance
- Eyeglasses
- Contacts and contact solution
- Lasik
- Sunscreen
- Bandages
- First aid kits
- Pregnancy/fertility tests
- Prenatal vitamins
- Breast pump & supplies

HSA Contributions

Contributions to your HSA can be made by you and there is a matching contribution from Plascore. The employee is responsible for setting up their own HSA account. You can do so at https://www.mercbank.com/personal/accounts/ under HSA options. You can make contributions to your HSA each year that you are eligible. Your combined total contribution for 2024 can be no more than:

Plascore Contribution:

- Single = $500
- Double = $750
- Family = $1,000

Your Contribution:

- Single Coverage: $3,650
- Double Coverage: $7,550
- Family Coverage: $7,300
- Catch-Up Single Contribution (55+): $1,000

2024 HSA Details

- **Can I change my contributions in 2024?** Yes, speak with HR for details.
- **Are there cash withdrawals?** Yes, however, these amounts could be subject to taxes & penalties if used for non-eligible health expenses.
- **Rollover of unused funds?** Yes, all unused funds will roll over.
- **Is a debit card provided?** Yes
- **Where is my account set up?** Your account is with Mercantile Bank and is owned by you.

To check your Health Savings Account Balance, log on to https://www.mercbank.com/hsa, email: HSASupport@mercbank.com or call 616-406-3700

A Health Savings Account (HSA) is an account funded by pre-tax dollars to help you save and/or pay for future medical expenses. The funds in the account roll over from year to year and can be used as an additional option for retirement savings.

TELEMEDICINE – **SPECTRUM HEALTH APP**

IMPORTANT BENEFIT: During this past year the virtual doctor's visits have been instrumental in keeping our employees healthy and in contact with a doctor.

Spectrum Health app is a service for you and your eligible dependents, if you are enrolled in one of our medical plans, you have 24/7/365 access to U.S. board-certified doctors and pediatricians by phone or online video.

Those members in the HMO & PPO Plan can use Spectrum Health for a $0 copay!

If you are enrolled in the CDHP, per IRS regulations you will have to fulfill the deductible first and then you will have a $0 copay, but this option is still less expensive than an office, urgent care, or emergency room visit.

Resolve many of your medical issues: Spectrum Health can diagnose, recommend treatment, and prescribe medication, when appropriate, for many common medical issues. For example; pink eye, allergies, cold and flu, earache, or sinus issues.

- Speak with U.S. board-certified doctors: Our network includes the highest quality, state-licensed doctors.
- Use it anywhere, anytime: On vacation? Stuck at home with sick kids? 3:00 a.m. and need care now? No problem. **Spectrum Health doctors are available 24/7/365 via phone and online video consults.**

Spectrum Health does not replace the primary care physician. Spectrum Health does not guarantee that a prescription will be written. Spectrum Health app operates subject to state regulation and may not be available in certain states. Spectrum Health does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Spectrum Health physicians reserve the right to deny care for potential misuse of services.

HOW IT WORKS

Connect with Spectrum Health by downloading the app, logging in with your MyHealth credentials or calling **844-322-7374**. You will be asked a few health questions and to describe your current symptoms. Then you will be connected to a provider.

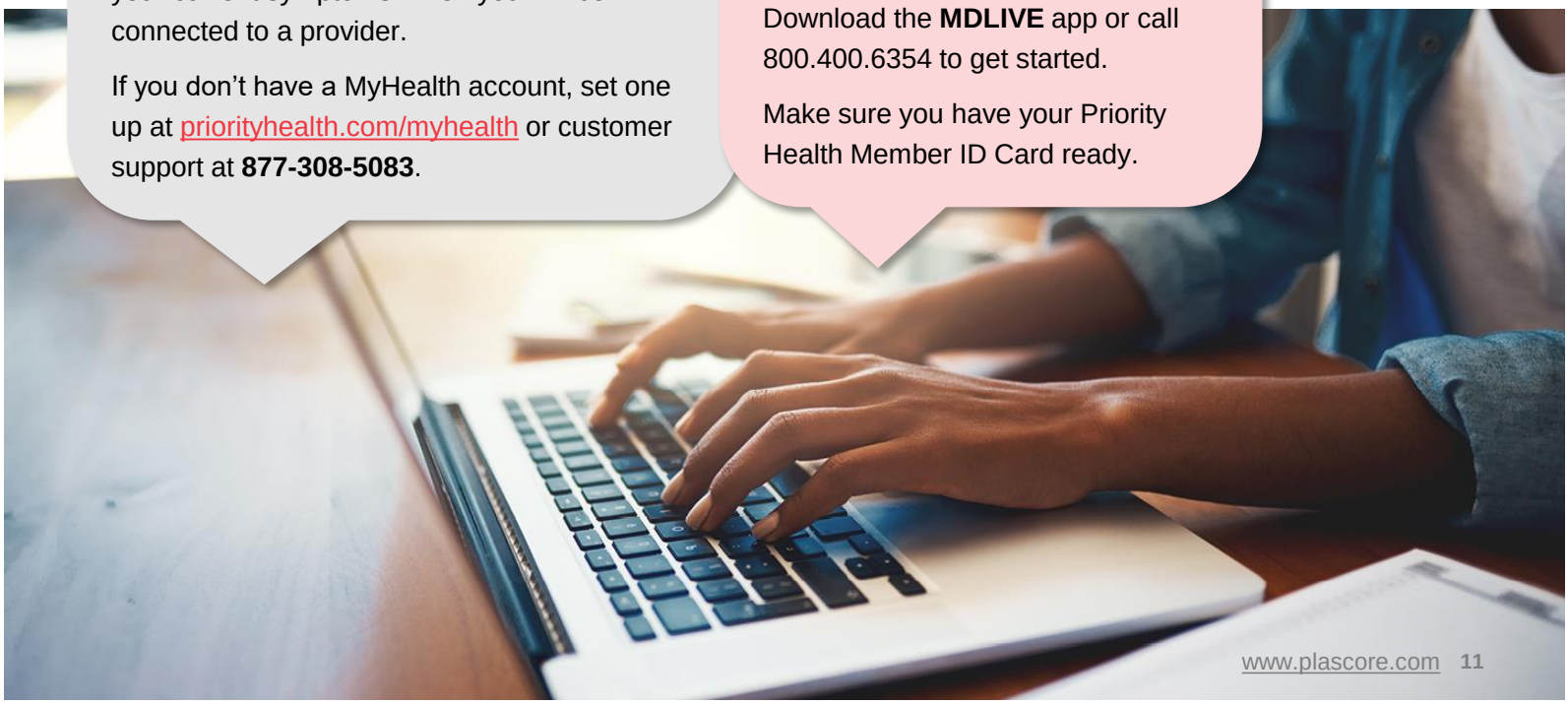
If you don't have a MyHealth account, set one up at priorityhealth.com/myhealth or customer support at **877-308-5083**.

OUTSIDE OF MICHIGAN?

If you are currently traveling or living outside of Michigan, you can access MDLive for medical, mental health, and substance use care.

Download the **MDLIVE** app or call 800.400.6354 to get started.

Make sure you have your Priority Health Member ID Card ready.



DEPENDENT ELIGIBILITY **AND MID-YEAR CHANGES**

What are the age requirements for my dependents to be eligible for benefits?

Dependents are eligible for the following benefits, through the end of the month in which they turn 26 years, regardless of student, marital, or access to other insurance:

- Health, Dental and Vision Insurance
- Voluntary Life Insurance

After my initial eligibility period, when can I make changes to my benefit plan elections?

- We offer an open enrollment period each year where you can elect, discontinue, add or delete dependents, effective for the beginning of the next plan year. Open enrollment is typically in November.
- Under the IRS regulations, mid-year changes cannot be made to most pre-tax benefit elections, unless you have a qualifying event. If you have a qualifying event, you have 31 days in which to make corresponding coverage changes. Please contact HR if you experience a qualifying event.

Benefits that are impacted by these IRS regulations include:

Health, Dental, and Vision Insurance and Flexible Spending Account

Benefits that you can make changes to at any time during the year include:

Health Savings Account and/or 401(k)

Examples of qualifying event include, but are not limited to:

Birth/adoption of a child, dependent reaching age 26 or dependent becoming disabled, marriage, divorce or legal separation, or gain or loss of other coverage.

DENTAL

Eligibility: Employees working 30+ hours/week are eligible on their date of hire.

Dental coverage is voluntary, and 100% employee paid.

If you do not elect dental coverage when first eligible, you may enroll with a qualifying event or during the open enrollment period.

How To Find An In-Network Provider:

Visit www.deltadentalmi.com to locate an in-network provider, click on quick links “Find a Dental Provider” and enter your location or zip code. To speak to a representative, call **800-524-0149**.

Bi-Weekly	2024 Rate
Employee Only	$12.13
Employee + Spouse	$23.24
Employee + Child(ren)	$30.89
Family	$47.57

DELTA DENTAL®

Benefit	PPO & Premier Network	Nonparticipating Dentist*
Preventive Services Exams, cleanings, fluoride & space maintainers	100% covered. No deductible.	100% covered. No deductible.
Deductible	$0	$0
Basic Services Fillings, crown, gum disease, root canals & extractions	50% coinsurance	50% coinsurance
Major Services Bridges, implants & dentures	50% coinsurance	50% coinsurance
Annual Maximum	$1,000 per individual	$1,000 per individual
Orthodontic	50% coinsurance Lifetime maximum - $1,000 Available to covered dependent children up to age 19	50% coinsurance Lifetime maximum - $1,000 Available to covered dependent children up to age 19

**When you receive services from a nonparticipating dentist, the percentages in this column indicate the portion of Delta Dental’s nonparticipating dentist fee that will be paid for those services. The nonparticipating dentist fee may be less than what the dentist charges and you are responsible for that difference.*

VISION

Eligibility: Employees working 30+ hours/week are eligible on their date of hire.

Vision coverage is voluntary, and 100% employee paid.

If you do not elect vision coverage when first eligible, you may enroll with a qualifying event or during the open enrollment period.

Customer Service

VSP: **800-216-6248**

Mon.-Fri. 5am to 8pm (PST)
Sat 7am to 8pm (PST)
Sun 7am to 7pm (PST)

www.vsp.com

Benefit	In-Network
Exam	$10.00 copay, 1 covered exam every 12 months
Materials	$25 copay
Frames	$130 plan allowance
Lenses	Covered in full after $25 materials copay for Single Vision, Bifocal, Trifocal, Lenticular. 1 set of lenses every 12 months Progressive: up to the providers contracted rate for trifocal lenses, you are responsible for any balance
Contacts	$130 plan allowance Fit and Follow Up member cost up to $60
Laser Vision Correction	Discounts Available

2024 Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Vision Plan	$3.65	$6.47	$6.60	$10.64
Note: Vision insurance premiums are paid 100% by the Employee.				

Online In-Network Options

Eyeconic.com is an in-network online eyewear store. Which means you won't have to pay the full price now, then wait to be reimbursed later. Your vision benefits will be applied directly to your online order.

Eyeconic FAQ:
www.vsp.com/eyewear-questions.html

FLEXIBLE SPENDING ACCOUNTS **(FSA)**

What is a Flexible Spending Account (FSA)?

FSA's are tax-advantaged financial accounts that allow Employees the option to annually elect to have a portion of earnings set aside pre-tax to pay for qualified childcare or medical expenses.

Benefits

By anticipating health care and dependent care costs for the upcoming year, participants can lower their taxable income.

Medical Expense FSA:

This program lets Employees pay for specific IRS-approved medical care expenses not covered by their insurance plan using pre-tax dollars. The maximum annual contribution that may be allocated to a medical FSA is **$3,200**. Rollover of unused funds up to **$640**.

Examples include, but are not limited to:

- Hearing services; including hearing aids and batteries
- Vision services; including contact lenses, contact lens solution, eye exams and eyeglasses
- Dental services; including orthodontia
- Chiropractic services
- Acupuncture treatment

Limited Medical Expense FSA:

If you are enrolling with the HDHP and HSA and would like to set aside additional funds into a flexible spending account, you must enroll with the Limited Medical Expense FSA. The Limited Medical FSA is for dental and vision expenses only.

Dependent Care FSA:

Employees apply pre-tax dollars towards qualified dependent care expenses.

Qualifying dependents could be children under the age of 13 requiring daycare, dependent children of any age who are physically or mentally incapable of self-care, or elderly dependents who reside with the Employee and require adult day care services. To be considered a qualifying dependent the Employee must claim the person requiring care on their federal tax return.

The maximum annual contribution amount that may be allocated to a dependent care FSA is $5,000 (or $2,500 if married and filing separately).

Examples include, but are not limited to:

- 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)

FLEXIBLE SPENDING ACCOUNTS **(FSA)**

BENEFITS DEBIT CARD

The benefits debit card is the fastest and most convenient way to pay for eligible expenses. Just one debit card is all you need for your benefits regardless of how many plans you have with us.

BENEFITS MOBILE APP & PARTICIPANT PORTAL

Access your benefits 24/7 with the WEX mobile app. Our app is free, convenient and offers real-time access to all your benefits accounts. With our benefits mobile app you can:

- Get instant updates on the status of your claims.
- File a claim and upload documentation in seconds using your phone's camera.
- Scan an item's bar code to determine if it's an IRS Code Section 213(d) eligible expense.
- Report a card as lost or stolen, which cancels the card and ships you a new one.
- Log in through face recognition or fingerprint (depending on your phone).
- Check your balance and view account activity.
- Reset login credentials.

DON'T HAVE A SMARTPHONE?

Go to **www.wexinc.com,** hover over Solutions and select Participants/

Employees. This page provides login buttons for accessing your online account, along with helpful resources like a benefits knowledge base, a link to current eligible expenses, and chat.

Have questions?

Our Participant Services team is available Monday - Friday 6:00 a.m. to 9:00 p.m. Central time.

Questions when enrolled: 1-866-451-3399

Questions before you enroll: 1-844-561-1337

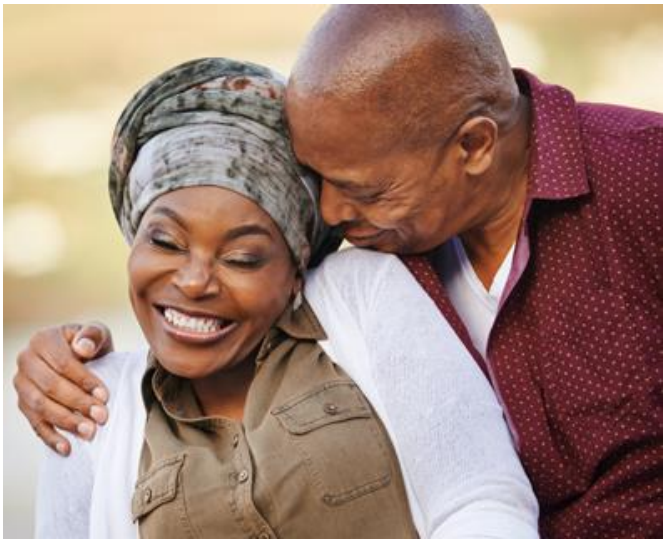
Email a question: customerservice@wexhealth.com

Submit a form: forms@wexhealth.com

Live chat: go to www.wexinc.com, hover over Solutions and select Participants/Employees.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT **(AD&D)**

Basic Life & AD&D Insurance



Plascore provides this benefit at no cost to its Employees for basic life and AD&D coverage. Benefit amount is set at one times your annual earnings to a maximum of $150,000. If the coverage exceeds $50,000, a portion of the premium may be included in the Employee's taxable income.

As you get older, the amount of life and AD&D insurance will be reduced according to the following schedule:

At Age 65 - reduce to 65% of the original amount of insurance

At Age 70 - reduce to 50% of the original amount of insurance

Voluntary Life Insurance (Post Tax Benefit)

Employees who want to supplement the basic group life & AD&D insurance benefits may purchase additional coverage. After-tax premiums are paid completely by you through payroll deduction. If you do not enroll when you are first eligible, you may opt to purchase coverage at any time, but it will be subject to approval by Mutual of Omaha.

Employee Coverage

Elections can be made in increments of $10,000, up to a maximum of $200,000 not to exceed 3x your annual salary.

If you have a qualifying event and you are enrolled in the plan on the date of the event, you may purchase coverage on your spouse/child per the plan guidelines with no questions asked (up to the guaranteed limits), provided you make that election within 31 days of the event.

Spousal Coverage

Increments of $5,000, not to exceed 100% of the Employee's coverage or $50,000.

Dependent Children Coverage

Elections can be made for $10,000 not to exceed 100% of the Employee's coverage.

Voluntary life insurance is portable, meaning you can continue the policy after you cease to be an employee of Plascore, and provides a Living Care Benefit of 75% of your benefit amount up to $150,000.

Life and AD&D Coverage is offered through Mutual of Omaha;

To contact call **800-775-8805** or visit www.mutualofomaha.com

When contacting them, please have your policy number available:

Life and AD&D: GLUG-B9MQ

Voluntary Life: GVTL-B9MQ

Mutual of Omaha

EMPLOYEE ASSISTANCE PROGRAM **(EAP)**

Employee Assistance Program

Employees are provided, at no additional charge through your benefit plan, a service that can help you find solutions for everyday challenges at work and home as well as for more serious issues involving emotional and physical well-being. Examples of employee assistance are;

- Depression, grief, loss and emotional well-being
- Family, marital and other relationship issues
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family

You have multiple ways to access this service, one national and the other local:

PINE REST Christian Mental Health Services

Call 800-442-0809 or

visit eaccares.com

Pine Rest Christian Mental Health Services formerly Employee Assistance Center (EAC):

EAC is a local resource, West Michigan based provider. You can visit their website at www.eaccares.com or call them at **800-442-0809**. They have offices in Holland, Grand Haven, Grandville and Grand Rapids.

DISABILITY **BENEFIT**

Eligibility

Employees working 30+ hours per week are eligible for short term and long-term disability coverage provided by Plascore on your date of hire. Available vacation time may be used during the 14-calendar day waiting period.

Benefits

In the event an eligible Employee becomes disabled due to a non work-related injury or illness, disability income benefits are available.

Disability Insurance is offered through Mutual of Omaha;

To file a claim, you have the following options and please contact Human Resources.

Call: 800-877-5176

Online:
www.mutualofomaha.com/customer-service

In forms tab, select your state, click on “Get Forms”. Under “Disability Forms” select “Short Term Disability Claim Form”

Short Term	Benefit
Benefits Begin	After 14 consecutive days of disability
Benefit Duration	Up to 24 weeks
Percentage of Income Replaced	70% of pay up to a maximum of $600 per week

Long Term	Benefit
Benefits Begin	After 180 consecutive days of disability
Occupational Definition	Own occupation for 24 months
Pre-Existing Definition	3 months prior to benefits start date 12 months waiting period before benefits start
Benefit Duration (Age at Disability)	Less than age 61 – to SSNRA Age 62 – SSNRA or 3 years 6 months Age 63 – SSNRA or 3 years Age 64 – SSNRA or 2 years 6 months Age 65 – 2 years Age 66 – 1 year 9 months Age 67 – 1 year 6 months Age 68 – 1 year 3 months Age 69+ – 1 year
Percentage of Income Replaced	60% of your monthly earnings
Maximum Benefit	$6,000 per month
Mental Health/Drug & Alcohol Benefit Duration	24 months

Mutual of Omaha

401(K) **PLAN**

Eligibility

401(k) Elective Deferral Contributions Eligibility Requirements for 401(k) Elective Deferral Contributions You may join the plan as an active participant for purposes of 401(k) elective deferral contributions on the first day of the month on or after you meet these requirements:

- You are an eligible employee.
- You have 30 days of Entry Service.

Benefit

Plascore will match 50% of the first 6% Employees contribute to their account. This match is contributed each paycheck. Employer contributions are vested based on the schedule below.

Maximum Contributions

2024 Annual Contribution Limit = $23,000

Age 50+ Catch-up Contribution = $7,500

Vesting

Plascore's contributions are vested based on the following schedule.

<2 Years	2 Years	3 Years	4 Years	5 Years	6 Years
0%	20%	40%	60%	80%	100%

Principal is our 401(k) provider;

To change the deferral rate, the default investment, or to identify your beneficiary, go to www.principal.com or to contact call **800-547-7754**

MICHIGAN – MI TRISHARE CHILD CARE

MI Tri-Share Child Care Program assists qualifying employees with child care costs. Through this innovative new approach child care expenses are shared by the employer, the employee, and the State of Michigan, with each contributing one-third of the cost.

In addition to assisting working parents with child care costs, the program helps employers in attracting and retaining talent, and helps child care providers stabilize their business through consistent payments. The program is open to all employers headquartered in the Goodwill Hub five-county region.

To qualify, employees must have an income between 200% and 325% of the Federal Poverty Level. For more information, reach out to Human Resources.

Household Size	Monthly Income
Two Person	$3,052 to $4,959
Three Person	$3,838 to $6,237
Four Person	$4,625 to $7,516
Five Person	$5,412 to $8,794
Six Person	$6,198 to $10,072
Seven Person	$6,985 to $11,351
Eight Person	$7,772 to $12,629
Each additional family member	+$787 to $1,278

Goodwill Industries of West Michigan is a designated MI Tri-Share Child Care Hub administering the program to businesses located in Muskegon, Ottawa, Oceana, Newaygo, Lake, and Mason counties. Goodwill's partner in delivering the program in Ottawa County is Ready for School, a school-readiness nonprofit serving Ottawa County communities.

OTHER **BENEFITS**

Vacation

Plascore recognizes that quality time away from work is important. We offer full time employees up to 6 weeks away from work. Your seniority with Plascore will determine what portion of the 6 weeks is paid vacation and what portion is unpaid vacation. The combined time of paid vacation and unpaid vacation may not exceed 6 weeks in one calendar year. Unpaid vacation must be taken in full week increments.

Bereavement Paid Leave

Full time employees are paid regular compensation for the death of a family member depending on the situation. See policy for “family” definition.

Immediate family members: Not to exceed a total of 40 hours or 5 days

Other family: Not to exceed a total of 24 hours or 3 days

Jury Duty

Employees who are required to serve on a jury will be paid their regular compensation for the time they are absent from work. See handbook for more details.

Tuition Reimbursement

Plascore Employees are eligible for tuition reimbursement benefits. Plascore believes that continuing education is important to our employee’s success. That is why we offer up to 100% reimbursement up to $5,000 per calendar year.

Profit Sharing

Quarterly bonus based on company profitability.

HOLIDAYS

Employees are eligible upon hire for the following paid holidays, depending on employees work schedule.

Hourly Employees who work on the holiday will also receive Holiday pay and time-and- a-half pay for the hours worked.

- New Year’s Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day

Questions about benefits may be directed to Human Resources. These pages highlight certain provisions of the plans illustrated and are intended to be a guide for Employees and prospective Employees for informational purposes only. If there is a difference between this document and the plan documents/booklets, the plan documents will govern.

BENEFITS **LINGO**

Knowing and understanding your benefits is important to choosing the path that is best for your and your family. The definitions below will assist you in understanding your coverages and help you make an informed decision.

Brand Name Medications: Drugs that are patented, manufactured and distributed by only one pharmaceutical manufacturer.

Coinsurance or Cost Sharing: The cost of a health expense that is shared between you and the plan after you pay your deductible. For example, the Plascore plan's share of most expenses is 80% and your share (coinsurance amount) is 20%.

Copayment (Copay): A set dollar amount you pay toward an expense, such as an office visit or prescription drug. The remaining cost is covered by the plan.

COBRA: The Consolidated Omnibus Budget Reconciliation Act allows you and/or covered dependents to extend health, dental and/or vision coverage beyond the date on which eligibility would normally end. You pay the full premiums plus a 2% administrative fee for this continuation coverage.

Deductible: The amount of money you must pay toward health, prescription drug for each family member each year before benefits are reimbursable in most cases. After you have paid your deductible, future expenses are covered at the coinsurance or copayment amount. Copayments do not count toward the deductible. You can submit claims for reimbursement of deductible, coinsurance and copayment amount.

FSA (Flexible Spending Account): An FSA is often set up through an employer plan. It lets you set aside pre-tax money for common medical costs and dependent care. FSA funds must be used by the end of the year. Employees are eligible to carryover $500/year.

Generic Medications: Drugs that are manufactured, distributed and available under a chemical name without patent protection. A generic drug must have the same active ingredient as its brand name counterpart. Generic drugs typically cost less than brand name drugs.

Non-preferred or Non-Formulary Drugs: Brand name medications that are not on the Preferred List because less expensive and effective alternatives are available. Non-Preferred medications require a higher copayment.

Out-of-Pocket Maximum: Generally, the most you will have to spend each plan year for each covered family member is the annual deductible, plus the copayments plus the coinsurance. Once you've met the out-of-pocket maximum on yourself or a covered dependent, the plan pays 100% of most remaining expenses for you or the dependent for the rest of that plan year.

Primary Care Physician (PCP): Under the Priority Health HMO plan a primary care physician is required. A PCP is a general or family practitioner, an internal medicine doctor, a pediatrician, an OB/GYN, or a behavioral health practitioner.

Preferred or Formulary Drugs: A list of drugs that are periodically reviewed and updated by a committee of physicians, pharmacist and other health professionals for effectiveness and cost effectiveness. Each plan has its own Preferred Drug List. Often, brand drugs that have generics available will not be on the formulary list to encourage individuals to purchase the less expensive generic.

Reasonable and Customary Fee: The lower of the actual charge for the services or supplies or the usual charge of most other doctors or other providers of similar training or experience in the same geographic area for the same or similar services or supplies as determined by the medical carrier.

Network Provider/In-Network Provider: A healthcare provider who is part of a plan's network.

Non-Network Provider/Out-of-Network Provider: A healthcare provider who is not part of a plan's network. Costs associated with out-of-network providers may be higher or not covered by your plan. Check with your provider to verify that Priority Health is accepted.

LEGAL **NOTICES**

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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Corina Wickerham 616-748-2213.

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, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov

LEGAL **NOTICES**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA– Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.Colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-prgroam-hipp Phone: 678-564-1162 ext 2131	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

LEGAL **NOTICES**

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website:http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://www.coverva.org/en/famis-select http://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-432-5924

LEGAL **NOTICES**

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

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

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

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Paperwork Reduction Act Statement

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

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

LEGAL **NOTICES**

Important Notice About Your Prescription Drug Coverage and Medicare

If you or any of your eligible dependents are eligible for Medicare, or will soon become eligible for Medicare, please read this notice. If not, you can disregard this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Plascore 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. Plascore has determined that the prescription drug coverage offered by the Plascore Medical Plan 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 Plascore coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop your current Plascore 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 Plascore 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 at (616)-748-2209. 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 Plascore changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **1-800-772-1213 (TTY 1-800-325-0778).** Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Contact Name: Chris-Ann Martini

Position/Office: HR Manager

Address: 615 N. Fairview Street, Zeeland, MI 49464

Phone Number: **616-748-2207**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance; the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2021 open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1, 2019, through Dec. 15, 2019. Individuals must enroll or change plans prior to Dec. 15, 2019, for coverage starting as early as Jan. 1, 2021. After Dec. 15, 2019, you can get coverage through the Marketplace for 2021 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Chris-Ann Martini, Human Resources Manager, at **616-748-2207** or **chris-ann.martini@plascore.com**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

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

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the 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: Human Resources Dept.

How is COBRA continuation coverage provided?

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

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

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Contact Chris-Ann Martini in the Human Resource department at Plascore, Inc., 615 N. Fairview St, Zeeland, MI, 49461, phone **616-748-2207.**

HIPPA Notice

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

This Notice of Privacy Practices ("Notice") applies to Protected health Information (defended below) associated with Group Health Plans (defined below) provided by PLASCORE to its employees, its employee's dependents and as applicable, retired employees. This Notice describes how PLASCORE, collectively we, us, or our may use and disclosed Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law.

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") to maintain the privacy of Protected Health Information and to provide individuals covered under our group health plan with notice of our legal duties and privacy practices concerning Protected health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change their terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be mailed to all policyholders then covered by the Group Health Plan. Copies of our current Notice may be obtained by contacting PLASCORE at the telephone number or address below.

DEFTINITIONS

Group Health Plan means, for purposes of this Notice, the employee benefits plans that we provide to our employees, employee dependents and, as applicable, retired employees

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all the ways we are permitted or required to use and disclose PHI will fall with one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose your PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining coverage under the group health plan, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Uses and Disclosures for Payment – We may make requests, uses and disclosures of your PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process or pay claims. We may also disclose your PHI for the payment purposes of a health care provider or a health plan.

Family and Friends Involved in Your Care – If you re available and do not object, we may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share limited PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process your claims. At times it may be necessary for us to provide certain of your PHI to one or more of these outside person or organizations.

Accounting for Disclosures of Your PHI – You have the right to receive an accounting of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your accounting requests must be in writing and signed by you or your representative. Accounting request forms are available from us at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting your request within the same 12-month period.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Right to a Copy of the Notice – You have the right to a paper copy of this Notice upon request by contacting us at the telephone number or address below.

Complaints – If you believe your privacy rights have been violated, you can file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact PLASCORE'S Privacy or HR Office by writing to this address:

ATTN: PRIVACY OFFICE/Chris-Ann Martini
PLASCORE, INC.
615 N. FAIRVIEW RD.
ZEELAND, MI 49464

Or by calling this telephone number:

616-772-1220

EFFECTIVE DATE
This Notice is effective immediately.

NOTES

NOTES

ABOUT THIS GUIDE

This benefit summary provides selected highlights of Plascore Inc. employee benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the Company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Plascore Inc. reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.