TriStar

Engineered Plastic Solutions

YOUR GUIDE TO

Employee Benefits

2023 Plan Year

TriStar

Engineered Plastic Solutions

Questions, Problems or Concerns

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- If you require further assistance contact AssuredPartners. TriStar has partnered with AssuredPartners as our benefits administrator for expert assistance with benefit related questions, plan procedures, life events and claim issues.
- **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Important Contact Information

Carrier	Group #	Web / Email	Phone
Medical and Prescription Cigna	00626060	www.mycigna.com	1-866-494-2111
Dental Cigna	00626060	www.mycigna.com	1-866-494-2111
Vision Cigna	00626060	www.mycigna.com	1-866-494-2111
Health Savings Account Paylocity		Contact your HR Manager for questions, adds and updates to your HSA Account	
Flexible Spending Account **Dependent Care Flexible Spending Account** Paylocity		Contact your HR Manager for questions, adds and updates to your FSA Account	
Basic Life and AD&D Insurance **Voluntary Life Insurance** Guardian	00578156	www.guardiananytime.com	1-888-482-7342
Disability Guardian	00578156	www.guardiananytime.com	1-888-482-7342
401(k) Retirement Plan Ameritas (Platform) Managed Wealth Strategies, LLC (Financial Advisor)		https://accounts.ameritas.com/login www.managedwealthstrategies.com	1-800-277-9739 508-466-7814
Employee Assistance Program (EAP) Guardian		https://worklife.uprisehealth.com/	1-800-386-7055
If you have benefit related questions: Richard Cedrone, TriStar CEO Lauren Barkley, AssuredPartners		RCedrone@TStar.com Lauren.Barkley@AssuredPartners.com	1-508-925-7450 803-795-4652

Welcome to your 2023 Employee Benefits!

TriStar Plastics Corp. takes into consideration our employees' evolving needs, as well as ensuring a level of security and protection when making decisions regarding the benefits program being offered.

We recognize the important role employee benefits play as a critical component of an employee's overall compensation. We also strive to maintain a benefits program that is competitive within our industry.

This benefits guide, together with other enrollment materials, are provided to help you understand your benefit choices and navigate through the Open Enrollment / New Hire process. Before you enroll, please read this guide to become familiar with the benefit options. Your decisions will impact your benefit selections and what you pay for these benefits.

If you have any benefit related questions, please contact Richard Cedrone or our contact at AssuredPartners, Lauren Barkley.

Richard Cedrone, TriStar CEO

1-508-925-7450

RCedrone@TStar.com

Lauren Barkley, AssuredPartners

803-795-4652

Lauren.Barkley@AssuredPartners.com

What's Inside

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). TriStar Plastics Corp. reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

For all benefits you must enroll within 30 days from your date of hire.

Eligibility

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

When Benefits Become Effective

Coverage for most benefit plans are effective on the first day of the month following your date of hire. Part time employees, dependents of part time employees, temporary employees and students in a co-op program are not eligible for participation in the medical, dental or vision group insurance programs.

Eligible Dependents

Your dependents are eligible to participate in TriStar's benefit plans. Your eligible dependents include*:

- A spouse to whom you are legally married.
- A domestic partner.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage in order to provide beneficiary information for your company-paid life insurance.

Pre-Tax Benefits: Section 125

TriStar's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, and vision coverage on a pre-tax basis. When you use pre-tax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after-tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, and vision you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

You must notify the Company within 30 days from the life event status change in order to make a change in your benefit selections.

Benefit Changes *continued...*

Event	Action Required	Results If Action Not Taken
New Hire:	Make elections within 30 days of hire date. Documentation is required.	You and your dependents are not eligible until the next annual Open Enrollment.
Marriage:	Your new spouse must be added to your elections within 30 days of the marriage date. A copy of the marriage certificate must be presented.	Your spouse is not eligible until the next annual Open Enrollment period.
Divorce:	The former spouse must be removed within 30 days of the divorce. Proof of the divorce will be required. A copy of the divorce decree must be presented.	Benefits are not available for the divorced spouse and will be recouped if paid erroneously.
Birth or adoption of a child:	The new dependent must be enrolled in your elections within 30 days of the birth and adoption, even if you already have family coverage. A copy of the birth certificate, footprints, or hospital discharge papers must be presented. Once you receive the child's Social Security Number, be sure to contact AssuredPartners to update your child's insurance information record.	The new dependent will not be covered on your health insurance until the next annual Open Enrollment period.
Death of a spouse or dependent:	Remove the dependent from your elections within 30 days from the date of death. Death certificate must be presented.	You could pay a higher premium than required and you may be overpaying for coverage.
Your spouse gains or loses employment that provides health benefits:	Add or drop health benefits from your elections within 30 days of the event date. A letter from the employer or insurance company must be presented.	You need to wait until the next annual Open Enrollment period to make any change.
Loss of coverage with a spouse:	Change your elections within 30 days from the loss of coverage. A letter from the employer must be provided.	You will be unable to enroll in the benefits until the next annual Open Enrollment period.
Changing from full-time to part-time employment (without benefits) or from part-time to full-time (with benefits):	Change your elections within 30 days from the employment status change in order to receive COBRA information or to enroll in benefits as a full-time employee. Documentation from the employer must be provided.	Benefits may not be available to you or your dependents if you wait to enroll in COBRA. Full-time employees will have to wait until the annual Open Enrollment period.

If you experience a Life Event Status Change

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to AssuredPartners. The change will be inactive until proper documentation is received and approved. For assistance processing life event status changes, you can contact Richard Cedrone (**RCedrone@TStar.com** or **1-508-925-7450**) or our contact at AssuredPartners, Lauren Barkley (**Lauren.Barkley@AssuredPartners.com** or **803-795-4652**).

Medical Coverage

HSA Open Access (HSA 5500)

The HSA Open Access Plus (OAP) Plan is a High Deductible Health Plan with coinsurance and deductibles. The benefit of this plan is that you will be eligible to enroll in and contribute to a Health Savings Account (HSA). With an HSA your contributions are pre-tax so any amount you contribute is deducted from your taxable income at the end of the year. The money in your HSA can be spent on eligible healthcare expenses including coinsurance, prescriptions, dental treatment, and more.

Under this plan, both you and your family can see any in-network provider, including specialists, without a referral. You are not required to choose a primary care physician.

Prescription Coverage

Your prescription drug benefit is part of your medical plan. The prescription drug formulary generally lists many drugs and ranks them in groups described as tiers. Copayments and/or coinsurance is determined by the tier in which the health plan will pay for, and prefer you use.

To find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies, log on to **www.mycigna.com** or call **866-494-2111**.

Medicare Part D

The prescription drug benefit is creditable coverage. Medicare-eligible participants need not enroll in a separate Medicare D drug plan.

	HSA Open Access (HSA 5500)	
	In-Network, You Pay:	**Out-of-Network, You Pay:**
Prescription Deductible	**Combined with Medical**	**Combined with Medical**
Retail Copay - up to 30-day supply Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	 $10.00 $30.00 $60.00	50%
Home Delivery Copay - up to 90-day supply Tier 1: Generic Tier 2: Preferred Brand Tier 3: Non-Preferred Brand	 $30.00 $90.00 $180.00	Not covered

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Save money with Generic Drugs

Generic drugs are made with the same active ingredients and produce the same effects in the body as their brand-name equivalents. That's because they're held to the same federal standards for safety and performance as the brand names. Because they're not branded, generics can sell for 30 percent to 80 percent less than their brand-name equivalents.

Medical Plan Summary

	HSA Open Access (HSA 5500)	
	In-Network, You Pay:	**Out-of-Network, You Pay:**
Deductible (Individual / Family)	**$5,500 / $11,000**	**$15,000 / $30,000**
HSA Eligible?	Yes	
Out-Of-Pocket Maximum (Individual / Family)	$6,450 / $12,900	$20,000 / $40,000
Preventive Services Well-Child Care Adult Physical Examination Breast Cancer Screening Pap Test	No charge	30% AD
Office Visits	No charge AD	30% AD
Virtual Visits	No charge AD	Not covered
Emergency Room	No charge AD	No charge AD
Urgent Care Centers	No charge AD	30% AD
Lab, X-Ray, Diagnostic (non-hospital)	No charge AD	30% AD
Advanced Radiological Imaging (MRI, MRA, CAT Scan, PET Scan)	No charge AD	30% AD
Hospital (Inpatient / Outpatient)	No charge AD	30% AD
Ambulance (emergency)	No charge AD	No charge AD
Therapy Services (Outpatient) Physical, Speech, Occupational 20 visits/year	No charge AD	30% AD
Chiropractic 20 visits/year	No charge AD	30% AD
Mental Health / Substance Use Disorder (Inpatient / Outpatient)	No charge AD	30% AD
Home Health Care 60 visits/year	No charge AD	30% AD
Durable Medical Equipment	No charge AD	30% AD

AD - After deductible

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost	HSA Open Access (HSA 5500)
	Monthly / Bi-Weekly
Employee Only	$120.00 / $55.38
Employee + Child(ren)	$240.00 / $110.77
Employee + Spouse	$250.00 / $115.38
Family	$375.00 / $173.08

Health Savings Accounts

If you enroll in the Open Access HSA Medical Plan, you are eligible to open and use a Health Savings Account (HSA). An HSA is a financial account that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the IRS. The account is similar to a traditional savings account with a debit card. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

How You Save With an HSA

As an HSA user, you will save in several ways:

- HSA contributions are not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed

HSA Funds Remain Yours to Grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave the company.

You Can Win With an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a high deductible health plan (HDHP).
- You have no other health coverage or Health Care Flexible Spending Account.
- You are not enrolled in Medicare Part A or Part B.
- You cannot be claimed as a dependent on someone else's tax return.
- You are not active in the military and not receiving health benefits under TRICARE.
- You are a U.S. resident and not a resident of Puerto Rico or American Samoa.
- You have not participated in Veterans benefits within the last 3 months.(Employee must wait at least three (3) months after last receiving VA benefits before they are eligible to elect and open an HSA account.)

2023 HSA Annual Contribution Limits

$3,850 for individual coverage **$7,750 for all other coverage tiers**

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Dental Coverage

Cigna DPPO

The dental plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at **www.myCigna.com**, or by calling **866-494-2111**.

	Dental DPPO	
	In-Network	**Out-of-Network***
Calendar Year Maximum (Class I, II, III, IX Expenses)	Year 1: $1,200 Year 2: $1,350 Year 3: $1,500 Year 4: $1,650 Class I Applies	Year 1: $1,200 Year 2: $1,350 Year 3: $1,500 Year 4: $1,650 Class I Applies
Calendar Year Deductible Per Individual / Per Family	$50 / $150	$50 / $150
Class I Expenses - Preventive & Diagnostic Care Oral Exams, Cleanings, Routine X-Rays, Fluoride Application	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care Fillings, Simple Extractions, Anesthetics, Repairs (Bridges, Crowns, Inlays and Dentures)	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care Crowns, Inlays, Onlays, Dentures, Bridges, Stainless Steel/Resin Crowns, Root Canal Therapy	50%, After Deductible	50*, After Deductible
Class IV Expenses - Orthodontia Coverage for Eligible Children Only Lifetime Maximum	50%, No Ortho Deductible $1,200	50%, No Ortho Deductible $1,200
Class IX Expenses - Implants Calendar Year Maximum	50%, After Deductible $1,200	50%, After Deductible $1,200

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost	**Dental DPPO**
	Monthly / Bi-Weekly
Employee Only	$7.55 / $3.49
Employee + Child(ren)	$15.15 / $6.99
Employee + Spouse	$18.58 / $8.58
Family	$30.29 / $13.98

*Out-of-Network Providers & Balance Billing

Under the DPPO, the plan pays the same amount to out-of-network providers as it would for in-network providers. Please note that providers that do not participate with your insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.

Vision Coverage

Cigna Vision Plan

As a vision care member, you'll receive access to great eyes doctors, quality eyewear and lower out-of-pocket costs. To find an in network provider, visit **www.MyCigna.com**. At your appointment, tell them you have coverage with Cigna.

There is no ID card necessary. The carrier will handle the rest—there are no claim forms to complete when you see a vision provider!

	Description	In-Network	Frequency
Vision Exam	Focuses on your eyes and overall wellness	$5 copay	Every 12 months
Materials		$10 copay	
Frame	$180 retail allowance for a wide selection of frames	Covered in full	Every 24 months
Lenses	Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children under age 19	Covered in full	Every 12 months
Lens Options	Standard progressive lenses Standard anti-reflective Standard scratch coating	Up to $65 Up to $45 Up to $17	Every 12 months
Contacts (instead of glasses)	$150 allowance for elective contacts; Therapeutic covered in full	Up to $60	Every 12 months

Out-of-Network Provider Coverage:

Exam . . . . . up to $45
Frame . . . . . up to $100
Single Vision Lenses . . . . . up to $32
Lined Bifocal Lenses . . . . . up to $55
Lined Trifocal Lenses . . . . . up to $65
Progressive Lenses . . . . . up to $65
Contacts . . . . . up to $210

This summary is for informational purposes only. For specific benefit information, please refer to the applicable insurance contract.

Plan Cost	Vision Plan
	Monthly / Bi-Weekly
Employee Only	$1.67 / $0.77
Employee + Child(ren)	$4.28 / $1.55
Employee + Spouse	$3.35 / $1.98
Family	$7.83 / $3.61

Basic Life and AD&D

Life insurance provides financial protection for your family in the event of your passing. TriStar offers all employees life and accidental death and dismemberment insurance through Guardian. TriStar covers the full cost of this benefit.

Basic Life Benefit Amount: $25,000

AD&D Benefit Amount: Equal to Life amount

Your benefit amount will reduce by 35% at age 65; 50% at age 70; 65% at age 75; and 80% at age 80. Benefits terminate upon retirement.

Plan Cost: 100% Employer Paid

Voluntary Life and AD&D

Increase Your Coverage

You may elect to increase your life insurance coverage for yourself, your spouse and your dependent children – all at an affordable group rate provided by Guardian.

Employee Voluntary Life/AD&D Insurance

Benefit Amount: increments of $10,000

Guaranteed Issue: $100,000

Maximum Benefit: $250,000

Spousal Voluntary Life/AD&D Insurance

Benefit Amount: increments of $5,000

Guaranteed Issue: $25,000

Maximum Benefit: $250,000

Spouse amount cannot exceed 100% of the employee's Voluntary Life benefit.

Dependent Child Voluntary Life/AD&D Insurance

Benefit Amount: $5,000, $10,000

Guaranteed Issue: $10,000

Maximum Benefit: $10,000

Child amount cannot exceed 100% of the employee's Voluntary Life benefit.

Disability

Short-Term Disability

TriStar offers self-funded Short-Term Disability to all its full-time regular employees. Your accumulated PTO time will first be utilized then 60% of weekly earnings are payable upon the employee's regular pay schedule.

Benefits Start: 8th day for accident or illness

Benefit Duration: 12 weeks

Long-Term Disability

Long-Term Disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. Eligibility for long-term benefits are generally defined as, due to sickness or accidental injury which you are receiving appropriate care and treatment; are complying with your treatment requirements and unable to earn more than 80% of your predisability earnings.

Benefits Start After: 90 days

Benefit Amount: 60% of predisability monthly earnings

Maximum Benefit: $10,000 / month

Benefit Duration: The later of your SSNRA* or the Maximum Benefit Period.

Plan Cost: 100% Employer Paid

**SSNRA means the Social Security Normal Retirement Age in effect under the Social Security Act on the Policy Effective Date.*

Pre-Existing Condition Limitations

The carrier will not pay benefits for any period of Disability caused or contributed to by, or resulting from, a Pre-existing Condition. A "Pre-existing Condition" means any Injury or Sickness for which you incurred expenses, received medical treatment, care or services including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before your most recent effective date of insurance.

The Pre-existing Condition Limitation will apply to any added benefits or increases in benefits. This limitation will not apply to a period of Disability that begins after you are covered for at least 12 months after your most recent effective date of insurance, or the effective date of any added or increased benefits.

Employee Assistance Program

Uprisehealth provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day-to-day basis.

- Unlimited free telephonic consultation with an EAP counselor available 24/7
- Referrals to local counselors - up to three sessions free of charge
- State-of-the-art website featuring over 3,400 helpful articles on topics like wellness, training courses, and a legal and financial center

Uprisehealth can offer support with:

Health
- Healthy Living
- Stress Management
- Mental Health
- Diet and Fitness
- Overall Wellness

Family
- Parenting Support
- Child and Elder Care
- Learning Programs
- Special Needs Help

Financial
- Legal Issues
- Will Preparation
- Taxes and Debt
- ID Theft Services
- Financial Planning Tools and Assistance

For more information about Uprisehealth, visit https://worklife.uprisehealth.com/ or call 1-800-386-7055.

Employer Code: 578156

Employer Name: Tri-Star Plastics

Access Code: Matters

Plan Cost: 100% Employer Paid

401(k) Retirement Savings

TriStar's 401(k) Plan is serviced by Ameritas and managed through Managed Wealth Strategies.

Eligibility: You will be eligible to begin participation on the first day of the month following your hire date.

Employer Match: TriStar matches employee's 401(k) contributions $0.50 on the dollar up to 4% of income. You must make employee deferral contributions to be eligible to receive matching contributions.

Vesting of Employer Contributions: Your interest in TriStar's contributions to your account will become 100% vested when you attain the plan's normal retirement age of 65 or the 6th anniversary of your participation in the plan, if that is later than age 65, or in the event of your death or disability.

MWS
Managed Wealth Strategies, LLC

TriStar's Personal 401(k) Support and Financial Planning

Managed Wealth Strategies, LLC is proud to work with TriStar to provide you with an understanding of options & benefits your 401(k) provides.

We have been providing professional advice in the executive benefit and personal planning market throughout the Northeast for more than 30 years. We specialize in providing uncommon knowledge using a unique process that begins with careful listening to our client's dreams, goals, and financial concerns.

The Living Balance Sheet®

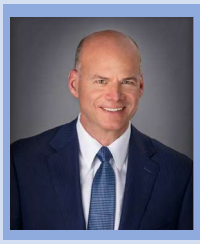
Above: All Tri Star Employees will have the opportunity to utilize The Living Balance Sheet *to promote smarter savings habits and easy tracking of your money- all on your own personalized Living Balance Sheet webpage.*

Additional Personalized Services Offered Using The Living Balance Sheet:

Protection Planning | **Wealth Management** | **Personal & Business Planning** | **Cash Flow Strategies**

We strive to provide our clients with the best advice based on their particular situation. No matter what stage of life you are in or who you are, we will tailor a program designed specifically for you. Over time, we will adjust your program as changes in life and business occur.

Meet Your Advisor:



Mark W. Smiley
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Time Off/PTO

Holidays: TriStar provides nine paid company holidays each year plus an extra floating day for your birthday.

PTO Days: PTO accrual begins with the first day of hire. Monthly accrual rates are determined by the employee's anniversary date. A new employee accrues the entire 10 hours of PTO time for the first month of service regardless of the day of the month the employee is hired. An employee must be in active pay status on the last working day of the month to earn vacation for that month. PTO time accrues at a rate of 10 hours each month of full-time service up through the first five years of continuous employment.

Accrual rates thereafter are as follows:

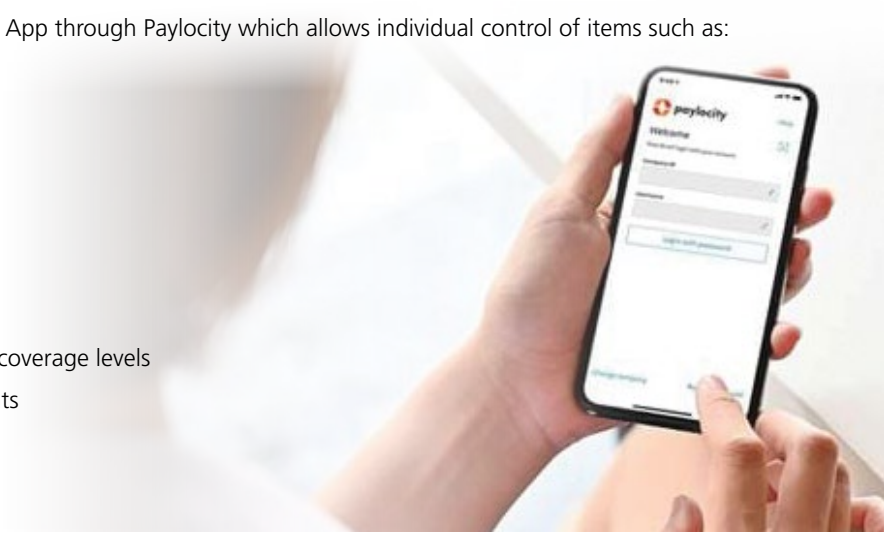
Years Completed	Hours Accrued per Month	Yearly Total
0 - 5	10.00	15 Days
6 - 10	13.34	20 Days
Over 10	16.66	25 Days

PTO is not earned while an employee is on a leave of absence. Part-time and Temporary employees are not eligible for PTO hours.

Employee Portal

TriStar offers an employee portal and mobile App through Paylocity which allows individual control of items such as:

- View your current paycheck online
- View your paycheck history
- Request PTO time and view your balance
- View your historical W2's
- Adjust your withholdings
- Change your address
- View your total compensation statement
- View and elect your current benefits and coverage levels
- Access company news and announcements



paylocity

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices *continued...*

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events 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.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

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, 2022. Contact your State for more information on eligibility –

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

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

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

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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943 / State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health- plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health- insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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

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

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
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

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

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://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
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

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

MINNESOTA – 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

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

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/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
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

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

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

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

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

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

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP- Program.aspx
Phone: 1-800-692-746

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

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

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

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

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

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

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

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

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, 2022, or for more information on special enrollment rights, contact either:

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

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

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit **https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families**.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in TriStar's medical plan, then PPACA may have little effect on you. TriStar's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by TriStar, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See **https://www.healthcare.gov/have-job-based-coverage/**).

If you are not eligible to enroll in TriStar's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: **healthcare.gov**).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit **healthcare.gov** or call **800-318-2596**.

TriStar

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