My Health and Wellness Benefits 2017
for HealthFitness Regular, Full-Time Associates based in the United States

Helping people increase well-being through better health and greater financial security.
Welcome to open enrollment for your 2017 benefits. I encourage you to set aside some time to review this benefits booklet as you make these important benefit elections.

For 2017, we continue to offer three high deductible health plans that can be paired with a health savings account: HDHP Premier, HDHP Essential and HDHP Balanced. These consumer-directed health plan designs help all of us better understand the real cost of healthcare, which promotes more personal accountability for our healthcare choices. You can learn more about each of these plans in this booklet.

Copay Eliminated for Preventive Therapy Drug List
I’m also pleased to share that we have eliminated the copay for drugs on the Preventive Therapy Drug List, which includes hundreds of medications for chronic conditions like diabetes, asthma, hypertension and many more. That means that prescriptions on this list will be covered at 100 percent starting in 2017. By making it easier to fill your preventive drug prescriptions, hopefully you’ll be more likely to comply with your doctor’s orders, which reduces the risk of future medical needs.

New Rates for 2017
As you may know, we self-insure our medical coverage to save money. As a result, claims experience directly impacts the cost of the medical plan, and we have seen an increase in utilization and the medical claims cost over the past year. We apply a generous company subsidy and then determine premium rates based on our cost-sharing methodology. While continuing to offer competitive benefits, employee premium rates will increase in 2017. However, because we reduced medical premium rates in 2016, the new rates are only slightly above those from 2015.

Informative Online Courses
When it comes to learning about our benefits, the Healthy and Wise site offers the most robust information, including four online courses designed specifically for associates. The newest course offering, Understanding Your Prescription Benefits, helps you make the most of your benefits and outlines the steps you can take to save the most money when you visit the pharmacy. I encourage you to check out this new course and, if you haven’t already done so, view the three other courses on the Healthy and Wise site.

As you know, being better informed can have a positive effect on your health, well-being and your “bottom line.” I encourage you to take advantage of these opportunities to learn more – and discuss your choices with your family – before you make open enrollment elections starting Nov. 1.

Be well,

Joe Pray
Healthy and Wise
Take Action to Make Informed Choices

Choosing your benefits is an important responsibility. In order for us to better serve you this open enrollment period, we ask that all associates take the time to review and submit their open enrollment event in Workday. Please review the materials thoroughly, join a webinar and visit the Healthy & Wise site for more resources. Contact the Benefits Team if you have any questions – we’re here to help!

Tips for a Successful Open Enrollment

- Before making your benefit selections, be sure to discuss your choices with your family.
- You can access this benefits booklet from home by logging onto eCentral at http://eCentral.hfit.com.
- Starting on Tuesday, Nov. 1, you can enroll on Workday to select your benefits. https://www.myworkday.com/trustmark/
- Make your elections on Workday no later than 11:59 p.m. Eastern time on Monday, Nov. 14.
- If you are adding a qualified partner (domestic partner, civil union or other qualified relationship) to your benefits for the first time, refer to the benefits eligibility and taxation chart on page 30 for more information on the requirements.
- A new enrollment or increase in Supplemental Life or Dependent Life will require evidence of insurability (EOI). The link to complete the online proof of good health form is located on page 26, and on eCentral. The deadline to complete your health statement is November 30.
- HSA and FSA elections do not carry over into the new plan year. While HSA contributions can be added or changed at a later date, you cannot make an FSA election after open enrollment closes without a qualified change in family status. See page 21 for more information.

Important Dates

Make Your Enrollment Elections on Workday
Nov. 1-14

Remember, deadlines are firm and cannot be extended.

WEBINARS Further your understanding and ask questions

Attend an informational webinar to learn more about the medical plans, how the plans work with a health savings account (HSA), your prescription benefits and managing your healthcare expenses.

Each one-hour webinar includes a presentation and Q&A session.

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Information to access webinars:
https://hfit.pgimeet.com/JHasler

USA: 1-719-955-1371

Guest Passcode: 216761

Message from the Benefits Team

Choosing your benefits is an important responsibility. In order for us to better serve you this open enrollment period, we ask that all associates take the time to review and submit their open enrollment event in Workday. Please review the materials thoroughly, join a webinar and visit the Healthy & Wise site for more resources. Contact the Benefits Team if you have any questions – we’re here to help!

Kristine Kuter
Benefits Administrator
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(952)897-5242

Jodi Hasler
Benefits / Workers’ Compensation Manager
jodi.hasler@hfit.com
(952)897-5250

Your Benefits Team
What’s New in 2017

New Online Course Helps Explain Your Rx Benefits

We are pleased to introduce our next online course called Understanding Your Prescription Benefits. This new course joins our roster of interactive benefits courses accessible from the Healthy and Wise site.

The course will help you understand how your prescription benefits work with a High Deductible Health Plan. You’ll gain a better understanding of the different types of prescription coverage, and how you can take steps to save money even before you visit the pharmacy. Learn more about your prescription benefits on page 17.

No Copay for Prescriptions on the Preventive Therapy Drug List

Medicines on the Preventive Therapy Drug List will no longer be subject to a copay. In general, generic drugs on this list are covered at 100 percent. Some brand name drugs may require step therapy or prior authorization prior to being covered at 100 percent. This change is another way for you to stretch your healthcare dollars and focus on improving your personal health. For more information, see the Prescription Drug Coverage section on page 17 of the booklet.

3D Mammograms Covered Under Preventive Care Benefit

Starting in 2017, digital breast tomosynthesis, commonly known as 3D mammograms, will be covered at 100 percent under the preventive care benefit when you visit a network provider. Learn more about 3D mammography coverage in a special section about Preventive Care Benefits on page 4.

Higher Maximum HSA Contribution for Employee-Only Coverage

For 2017, the total of company and employee contributions to a health savings account (HSA) by those with employee-only coverage will increase to $3,400, up from $3,350. This maximum includes the $500 company contribution. The $6,750 maximum contribution for those with family coverage will not change and also includes the employer contribution of $1,000.

Teladoc Fee Change Starting July 1

The fee to use Teladoc will increase from $40 to $45 on July 1, 2017. Teladoc is a national network of U.S. board-certified doctors available on demand 24 hours a day, 365 days a year to diagnose, treat and prescribe medication for many medical issues. Associates pay the fee upfront and Teladoc will submit the claim to CoreSource.

3.
Preventive Care Coverage at 100 Percent

One of the best ways to ensure you stay healthy is to get regular preventive care from your medical provider. You’ll enjoy peace of mind knowing that the Trustmark Companies medical plan provides generous 100 percent coverage of the following in-network preventive care services.

In-Network Routine and Preventive Care

In-network routine and preventive care is care that is not required due to illness or injury and has been recommended by your provider. Coverage guidelines related to age and frequency may apply.

- **Annual medical exam** – Routine preventive exams, by a network provider are covered each year (which can also be a routine gynecological exam). Be sure that your provider codes the visit as routine so the preventive care benefit will apply.

- **Pap smear** – A pap test is covered once per year beginning at the recommended age by your provider.

- **Mammogram** – The plan covers one preventive or diagnostic mammogram per year. The recommended start date is age 40. Women who are at high risk for developing breast cancer may need to begin getting mammograms earlier and more frequently. Beginning in 2017, the plan covers 3D mammograms at the age recommended by your provider.

- **Colonoscopy including prep kit** – There’s no reason to avoid getting your colonoscopy starting at age 50 because if there is a need for an additional procedure (such as the removal of polyps), the cost of the procedure is still covered at 100 percent under the preventive care benefit.

- **Prostate exam** – The plan covers one prostate exam and prostate-specific antigen (PSA) blood test when recommended by your provider.

- **Routine immunizations** – Immunizations for children, flu vaccinations, shingles immunizations and others are covered by the plan. If you receive the shot from your medical provider, the provider will submit the claim to the plan. If you receive the shot from the pharmacy, you may need to pay out of pocket and submit your bill to the plan for reimbursement.

- **Prenatal, pregnancy and postnatal care** – Having a healthy baby is important. The plan provides 100 percent coverage of the cost of prenatal vitamins and folic acid supplements (covered under the prescription plan with a prescription and filled at the pharmacy). In-network gestational diabetes screenings are also covered at no charge.

Review the Schedule of Benefits and Summary Plan Document for more information as well as the U.S. Preventive Services Task Force (USPSTF) A & B recommendations.

These recommendations change throughout the year so speak with your provider and contact CoreSource if you have questions about preventive care benefits.

Prescriptions Covered at 100 Percent

**Women’s and Routine Preventive Drugs**

Preventive drugs including aspirin therapy, tobacco cessation products, prescription contraception, as well as others, are covered at 100 percent. Please see the Preventive Therapy Drug List on eCentral or visit the Caremark website at [www.caremark.com](http://www.caremark.com) for specific brands.

**Colonoscopy Prep Kit**

Specific brands of the colonoscopy prep kit from the pharmacy are covered at 100 percent. Please see the Preventive Therapy Drug List for the brands.

“I was diagnosed with a very early stage breast cancer at the age of 41 after my annual mammogram. Without that screening, I wouldn’t have known I had cancer and if I had waited, things might have gotten worse. Having had that experience, I now make sure I have all the recommended preventive screenings – which includes my annual mammogram. I am so happy it’s covered at 100 percent by our medical plan.” – Erica F.
Healthy and Wise
Take Action to Make Informed Choices

What Can My HSA Funds Pay For?
The tax-free dollars you save in an HSA can be used to pay for IRS-qualified medical expenses. These include:
- Medical expenses before and after you meet your health plan deductible
- Dental care services
- Vision care services
- Prescription services
- Over-the-counter medications prescribed by your doctor
- Certain medical equipment

If I don’t put my own money into my health savings account, is the company contribution enough?
Possibly. Many associates take advantage of their high deductible plan’s lower premiums by putting the difference in their health savings account. In addition to building up the balance which can be used for future medical expenses, this provides another vehicle for pretax savings.

If I am enrolled in a high deductible plan, am I still in a PPO network?
Yes, all three medical plans take advantage of a preferred provider network, so you’ll be able to receive negotiated discounts when you visit network providers. Of course, you are also free to visit non-network providers, and the out-of-network deductible and out-of-pocket maximum will apply.

Feel Under the Weather? Try a Clinic or Teladoc
If you have a straightforward condition, like a sore throat, pink eye or ear ache, you can get care for less by going to an in-store clinic. Retail clinics, like those at CVS, Walgreens and Target, allow you to see someone the same day. Visit your network website to see if your local clinic is in the network. Or try the services of Teladoc, outlined on page 10.

How can I get the best deal on lab work?
Talk to your doctor. When your doctor orders lab tests, try to use an independent lab rather than a hospital lab, which can increase your costs for lab work. The choice may result in keeping more money in your pocket. Also, talk to your doctor about sending labs drawn in the office to another in-network provider.

Can I reimburse myself from my health savings account for medical expenses I paid?
Yes, you can write yourself a check from your HSA account or take the deduction at tax time.

Is the money in my health savings account “use it or lose it” like the FSA?
No. The money in your HSA account does not have an annual deadline to “use it or lose it.” The money (including the annual contribution) is yours and you may continue to use it for healthcare expenses even if you are no longer enrolled in a qualified high deductible plan.

“For me, the key to having a high deductible health plan is to build up the balance in my health savings account. In addition to the $1,000 company contribution, I make additional contributions each payday. When someone in my family has a pre-deductible expense, I use the balance in my account to pay for it by writing a check or using the HSA Bank debit card that draws from my health savings account. I don’t have to worry about where the money will come from.” ~ Pete S.
Maximize Your Healthcare Dollars

All of us are looking for ways to stretch our dollars. The actions you take can help you save money on your medical care.

BEFORE YOUR VISIT:

Understand Your Plan Benefits and Options

Review the Medical Summary Plan Description on eCentral.

Look over the language for the service you will be receiving:

- How is it covered?
- Are there limits on care?
- Are there exclusions on care or exceptions for coverage?

Consider a lower cost option:

- The Castlight website and mobile app provide you with information about the cost of medical services and provider quality information prior to accessing services.
- Teladoc is a convenient and low cost way to speak to a doctor anytime.

AFTER YOUR VISIT:

Validate Your Expenses

Always compare your explanation of benefits (EOB) to your provider bill to avoid paying more than your share.

- You should not be “balance billed” for the in-network discounted amount.
- Check to be sure claims are not processed as out-of-network in error. For example, anesthesia services for in-network inpatient surgery are covered at the in-network level.
- Make sure the claim is processed at the correct coverage level (for example, routine vs. diagnostic services).

Tip!

Your medical bills may contain costly errors. Some experts say 30 to 40 percent of medical bills contain mistakes, while others claim the error rate is closer to 80 percent. A typo in a billing code can overcharge you thousands of dollars, so it’s important to carefully examine your doctor bills and EOBs. For hospital bills, ask the facility for a detailed, itemized statement of all of your charges.

How to Right the Wrong Bill

1. Contact your provider if something seems questionable.
2. Call the CoreSource number on your medical ID card for claims assistance.
3. Contact a member of the Benefits Team if you still have questions.
Qualified Plan Changes

After you make your annual enrollment elections, you may not change your elections unless you have a qualified change in status as permitted by federal regulations and your employer’s plan.

Elections may be changed if a loss or gain of eligibility of coverage occurs due to the following reasons:

- **Change in family status:**
  - Marriage or divorce
  - Gain or loss of a dependent
  - Dependent satisfies or ceases to satisfy eligibility requirements
  - Termination or commencement of employment
  - Change in work schedule that affects eligibility
  - Change in residence or worksite that affects eligibility

- **Taking or returning from a leave of absence under the Family and Medical Leave Act of 1993**

- **Significant change in the coverage or cost of the spouse’s benefits during spouse’s open enrollment period**

- **Associate purchases coverage through a state or federal health insurance marketplace**

- **A court order, judgment or decree**

- **Entitlement to Medicare or Medicaid, or enrollment in a state child health insurance program (CHIP)**

- **A COBRA qualifying event**

Please see the Summary Plan Description for additional information regarding qualified plan changes.

If you experience one of the qualified status changes and wish to change your plan elections, you must enter your plan changes on Workday within 30 days of the status change (60 days for CHIP events). Benefit changes will not display in Workday until approved by the benefits team. Do not create an additional event if your change is not shown immediately. Contact Kristine Kuter at Kristine.Kuter@hfit.com if you have questions.

Your benefits will begin or end on the event date or the day of the start or loss of other coverage. Premium will be deducted or refunded retroactive to the date of the qualified status change.

An employee who loses coverage during the plan year and subsequently re-enrolls in coverage during the same plan year must enroll in the same plan option in which he or she was enrolled at the time he or she terminated the original election.

**You must provide supporting documentation of the status change and verification of newly added dependents within 10 days of entering your change in Workday. You may attach documents to the event in Workday or send to Kristine Kuter, Benefits HR.**

Contact Kristine at Kristine.Kuter@hfit.com if you have questions.
Benefits and Wellness Eligibility

Associates working 30 or more hours

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<td>Vision</td>
<td>Be Your Best Self Health Improvement Program</td>
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<td>Health Savings Account (HSA)</td>
<td>MyNurse 24/7</td>
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<td>Flexible Spending Account (FSA)</td>
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Dependent Coverage
Dependent coverage is available for your spouse or qualified partner; your child up to age 26 (including a stepchild or child of a qualified partner); your child who, because of a handicap condition that occurred before the attainment of the limiting age, is incapable of self-sustaining employment and is dependent on his parents or other care providers for lifetime care and supervision.

Qualified Partner Information
The company extends medical, dental and vision insurance benefits to employees’ qualified partners and their children. Qualified partners are domestic partners as defined by Trustmark or common law marriage, civil union relationships or domestic partnerships as defined by the state in which you live.

Children of your qualified partners can also be covered by the medical plan up to age 26. The portion of premium you pay for your qualified partner’s coverage and the amount the company contributes for their premium may be considered taxable income. You will see a separate deduction for pre- and post-tax premium on your payslip.

Additional eligibility information is located on page 30.

To add your qualified partner and his or her eligible children to your coverage, indicate your election during enrollment on Workday.

You must also complete the Attestation of Qualified Partnership form and provide dependent verification documentation by the enrollment deadline. A list of dependent verification documents is listed on page 28.

Verification of Dependents
Verification of newly added dependents to your healthcare benefits is required by the enrollment deadline or within 10 days of entering a status change on Workday. Please review the list of acceptable verification documents starting on page 28 and send to Kristine Kuter, Benefits HR.

Contact Kristine at Kristine.Kuter@hfitt.com if you have questions.

Forms
Forms you may need are located on eCentral under Your Benefits:

- Attestation of Qualified Partnership
- FSA Reimbursement Claim Form
- Dependent Verification Form
Be Your Best Self
The Be Your Best Self health improvement program can help you take charge of your health so you’re more likely to reach your personal health goals. The program is voluntary and available to all employees. Through the Be Your Best Self program, you can learn how to minimize your personal health risks. Participation in wellness programs in 2016 earned points toward your wellness incentive in 2017.

Log in to the Be Your Best Self portal at https://trustmark.biovia.healthfitness.com for health information and guidance to keep your personal plan on track and for more information about discounts. These tools, and many others, are available to support you as you choose to make lifestyle changes that improve your health and quality of life.

“Extrinsic motivators, especially work-related team challenges, have become more important to me in my ‘later years.’ Knowing that others are having fun competing with me and my team helps me to take care of myself better, and to appreciate the value of prevention unlike ever before! Plus, our Be Your Best Self programs help serve as a periodic reminder of ALL the good that exercising and eating well does for us.”
— Ron I.

Log on to the Be Your Best Self portal at: https://trustmark.biovia.healthfitness.com. Based on your responses, you’ll receive a personalized report suggesting ways to incorporate healthier lifestyle choices.

Online Health Assessment
Learn how to identify your personal risks for diabetes, cardiovascular disease and other conditions with a confidential health assessment. It’s quick (about 15 minutes) and easy to complete.

Health Coaching
The health coaching program provides information to help you make positive changes in your health, such as quitting smoking, eating better or beginning a fitness program. Health coaching combines the convenience of the Internet with the support of a professional health coach. Learn to make changes that energize you today and lower your risk of chronic diseases down the road.

Health and Fitness Trackers
Use the Be Your Best Self portal to keep track of measurements such as lab test results, cholesterol, weight and blood glucose levels. You can even graph your information over time. The My Workouts section of the portal allows you to keep track of your daily exercise routines. One of the best motivators to stick to a regular workout program is to keep a detailed record of your exercise sessions.

myCoreSource.com
myCoreSource.com is your online portal to personal information about your medical and dental benefits and flexible spending accounts. Visit myCoreSource.com or download the mobile app to:
- View an Explanation of Benefits (EOB).
- Get more detail on your benefits, including deductibles and out-of-pocket limits for you and your dependents.
- Use an online Message Center to get speedy answers to your important questions; and request additional ID cards.

How to Register on myCoreSource.com
Register for the portal after your benefit effective date by going to myCoreSource.com. Users must have Internet Explorer 8.0 or higher or Firefox 3.5 or higher.

To register:
1. Select Create an account under Not Registered?
2. Key in the letters, numbers, spaces and/or punctuation from the distorted image and click Submit to continue.
3. Enter a username (do not use your three-digit Novell ID), password, e-mail address and answers to the security questions.
4. Print out the Successful Account Creation page for your records and select Proceed to Registration.
5. Register as a member (or delegated authority). Follow the on-screen directions to enter your first and last name, date of birth, ZIP code and your unique member number (from your medical or dental ID card) or your Social Security Number using numbers only, do not use dashes.

Please contact CoreSource Customer Service at (877) 588-0617 for login issues.

My Nurse 24/7 is Your Line to a Registered Nurse
My Nurse 24/7 is a free, confidential service, available to all associates enrolled in our company medical plan, that provides access to a registered nurse any time of the day or night. Call toll-free (866) 366-6877 to talk to a nurse to address health concerns, including:
- Symptoms
- Self-care tips
- Treatment options, including when to go to the emergency room
- Decision support regarding procedures, services and tests
- Education on health conditions diagnosed by a physician
Associates and their covered dependents who are enrolled in the company medical plan, can talk to a doctor anytime through Teladoc. Teladoc is a national network of U.S. board-certified doctors available on demand 24 hours a day, 365 days a year to diagnose, treat and prescribe medication for many medical issues.

You can call Teladoc at 800-Teladoc (835-2362), visit www.teladoc.com or download the mobile app:

- When you need care now
- If you’re considering the ER or urgent care center for a non-emergency visit
- On vacation, on a business trip or away from home
- For short-term prescription refills

Board-certified physicians can resolve many medical issues, including: cold and flu symptoms; bronchitis; respiratory infections; sinus problems; allergies; urinary tract infections; ear infections and pink eye.

The fee to use Teladoc will increase from $40 to $45 on July 1, 2017. Associates pay the fee upfront and Teladoc will submit the claim to CoreSource.

The Castlight healthcare shopping tool helps associates and their adult dependents who are covered by the medical plan find the best doctors and facilities at the best price. Castlight allows users to search for any medical service, from routine doctor visits to urgent care to MRIs, and view prices instantly. This eliminates guessing and surprise medical bills.

Castlight allows you to:

- Understand your options for in-network doctors and medical services in your area.
- See estimated prices to understand what you might pay.
- View information on quality and patient experience to understand how your different options compare.
- Review your past medical spending so you know how much you paid and why.
- Receive recommendations for ways to find high-quality care and be an informed healthcare consumer.

Visit Castlight at www.mycastlight.com/trustmark or download the mobile app.

Employee Assistance Program (EAP)

We all experience times when we need a little help with life’s challenges. You can take advantage of the EAP services offered by The Standard through Bensinger, DuPont & Associates, whenever you experience personal problems of any kind, whether or not they are affecting your job performance.

A master’s level Member Advocate from The Standard EAP services will confidentially consult with you over the phone and help you find resources and solutions. The Member Advocate will provide you with consultation, resources, an action plan and information to help you address your issue. You may also receive referrals to support groups, community resources, a network counselor or your health plan. If you or a family member are referred to a counselor, up to six sessions will be covered at absolutely no cost to you. Telephone consultation is available at (877) 851-1631.

Online access is available at www.eapbda.com. Enter “standard6” in lowercase letters as the login ID. Enter “eap4u6” in lowercase letters as the password. Your calls and all counseling services are completely confidential. Information will be released only with your permission or as required by law.

You can contact the EAP with any kind of personal problem: child care and elder care, alcohol and drug abuse, difficulties in relationships, stress and anxiety with work or family, identity theft and fraud resolution, life improvement, depression, personal achievement, emotional well-being, financial and legal concerns, and grief and loss.
401(k) Savings Plan

The 401(k) plan is a convenient way to invest in your future by allowing you to make contributions into a retirement account. You’re never too old or too young to start!

Click the following link to learn more about the HealthFitness 401(k) Plan and how it can help get you on the right track for retirement, including helpful information on fund selections: https://www.brainshark.com/fidelityemg/

Trustmark26023

Your tax-deferred contributions are deducted from your pay before income taxes. This means that you may actually lower the amount of current income taxes you pay each pay period. Another program that is offered by your 401(k) plan is the Automatic Annual Increase program. You can set your deferral percentage to increase automatically every year. To make changes to your deferral percentage or to update your 401(k) plan beneficiaries, log onto the Fidelity website at www.401k.com.

401(k) Plan Highlights

- You decide how much to contribute to the plan – up to 60% of your gross wages (subject to IRS limits)
- The company will match $.20 on every $1.00 you contribute - up to the first 10% you defer
- 401(k) Contribution Maximum $18,000 in 2017, $6,000 for Catch Up Contributions
- Contributions to the plan are withheld through the convenience of payroll deductions
- Your payroll deductions are tax-deferred
- You choose how to invest your contributions from over 25 available fund options with varying risk
- You can change your payroll deductions and investment allocations at any time (redemption fees may apply)
- You have access to your account 24 hours/day, 7 days/week via internet and an automated phone system

Eligibility & Participation

You can start participating in the plan on the first day of the month following one month of continuous employment as an eligible associate.

You are eligible to participate in the plan if you are:

- At least 18 years of age; and
- Complete one month of service as a regular full-time or part-time associate working 20 or more hours per week; or
- Regular associates (not on-call) working less than 20 hours per week on a regularly scheduled basis but who work a total of at least 76.9 hours over 2 consecutive pay periods

How to Enroll

The on-line enrollment process is fast and easy (should take approximately 5 to 10 minutes)! Either go to the Fidelity participant website or call their toll-free number.

Fidelity Website: www.401k.com

Fidelity Retirement Benefits Line: (800) 835-5091
Medical Insurance Options

Three PPO Medical Plans to Choose From:
Trustmark offers three medical plans with varying deductibles and coinsurance. All medical plans may be paired with a Health Savings Account (HSA) to give you more control over your healthcare spending. The plan options are:
- HDHP Premier Plan
- HDHP Essential Plan
- HDHP Balanced Plan

The medical plans allow you to match your family’s needs with the appropriate degree of coverage. Those with health insurance through another source may also choose to waive coverage.

100 Percent Preventive Care Benefit
Prevention is the best defense. That’s why all plans offer a robust in-network benefit that covers preventive (age and gender appropriate) tests at 100 percent. See page 4 for more information about services covered.

Provider Networks Based on Your Location
With all three plans, you’ll get the most out of your coverage when you visit a network provider. Most associates will use the Aetna ASA preferred provider network, www.aetna.com/asa. Employees in Minnesota will use the Preferred One network, www.preferredone.com and associates in North Carolina will use the MedCost network, www.medcost.com.

Prescription Drug Coverage
All three plans offer prescription drug coverage with cost savings on quality medications. Caremark is the pharmacy benefits manager for all medical plans. Be sure to show your ID card with the Caremark logo to receive the plan benefit.

YourCare
YourCare maximizes your health potential by reminding you about preventive health screenings, and for those with chronic conditions, by reinforcing evidence-based standards of care. YourCare will send reminders for medically recommended preventive tests, such as a mammogram or colonoscopy. If you have one of nine chronic conditions, YourCare will review whether or not you are receiving treatment consistent with evidence-based standards of care. People with chronic conditions do better physically and spend less on treatment when they follow evidence-based standards of care for their condition. For more information, call (800) 480-6658.

Medical Pre-certification
To help control medical costs while allowing for the most appropriate care, all inpatient procedures require pre-certification prior to the procedure. Call the number on the back of your medical ID card. Outpatient procedures do not require pre-certification.

Employee Claims and Customer Service Number
(877) 588-0617

Premier
1500
Essential
2500
Balanced
4500
**2017 Medical Plans at a Glance**

### Company Contribution to HSA

- **$500** if you have Employee Only coverage or **$1,000** if you have Spouse, Children or Family coverage.
- Contributions are prorated for a partial year.

### Total Contributions to HSA

The total of company and employee contributions cannot exceed **$3,400** for Employee Only coverage or **$6,750** for family coverage.

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<td><strong>$1,500</strong> deductible if you have Employee Only coverage</td>
<td><strong>$3,000</strong> deductible if you have Employee Only coverage</td>
<td><strong>$2,500</strong> deductible if you have Employee Only coverage</td>
<td><strong>$5,000</strong> deductible if you have Employee Only coverage</td>
<td><strong>$4,500</strong> deductible if you have Employee Only coverage</td>
<td><strong>$6,350</strong> deductible if you have Employee Only coverage</td>
</tr>
<tr>
<td><strong>$3,000</strong> aggregate deductible if you have Spouse, Children or Family coverage</td>
<td><strong>$6,000</strong> aggregate deductible if you have Spouse, Children or Family coverage</td>
<td><strong>$5,000</strong> aggregate deductible if you have Spouse, Children or Family coverage</td>
<td><strong>$10,000</strong> aggregate deductible if you have Spouse, Children or Family coverage</td>
<td><strong>$9,000</strong> aggregate deductible if you have Spouse, Children or Family coverage</td>
<td><strong>$12,700</strong> aggregate deductible if you have Spouse, Children or Family coverage</td>
</tr>
</tbody>
</table>

### Deductible*: the amount of expenses that must be incurred by the participant before the plan pays at the coinsurance level.

- **$1,500** deductible if you have Employee Only coverage
- **$3,000** aggregate deductible if you have Spouse, Children or Family coverage

### Coinsurance*: the percentage of covered expenses shared by the plan and participant after the deductible has been met.

- **Plan pays 80%**
- **Participant pays 20%**
- **Plan pays 60%**
- **Participant pays 40%**
- **Plan pays 70%**
- **Participant pays 30%**
- **Plan pays 50%**
- **Participant pays 50%**

### Participant’s Coinsurance Maximum*: does not include deductible.

- **$2,750** if you have Employee Only coverage
- **$5,500** aggregate if you have Spouse, Children or Family coverage
- **$3,000** if you have Employee Only coverage
- **$5,000** aggregate if you have Spouse, Children or Family coverage
- **$6,000** if you have Employee Only coverage
- **$12,000** aggregate if you have Spouse, Children or Family coverage
- **$1,850** if you have Employee Only coverage
- **$3,700** aggregate if you have Spouse, Children or Family coverage
- **Unlimited**

### Out-of-Pocket Maximum: The combined amount of deductible and coinsurance that must be met before the plan pays at 100%.

- No individual will have an in-network out-of-pocket maximum that exceeds **$6,850**.

### Plan Pays* (after out-of-pocket maximum is met)

- **100%**
- **100%**
- **100%**
- **100%**
- **100%**
- **N/A**

* Subject to the usual and customary charges, exclusions and limitations.
### 2017 Medical Plans at a Glance

#### Annual Preventive Care Including Well Child Care

<table>
<thead>
<tr>
<th></th>
<th>HDHP Premier</th>
<th>HDHP Essential</th>
<th>HDHP Balanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>100% coverage of preventive care.</td>
<td>100% coverage of preventive care.</td>
<td>100% coverage of preventive care.</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>60% after deductible.</td>
<td>60% after deductible.</td>
<td>Not covered.</td>
</tr>
</tbody>
</table>

#### Office Visits/ Therapies/ Lab Services (excluding lab services for preventive care)

<table>
<thead>
<tr>
<th></th>
<th>HDHP Premier</th>
<th>HDHP Essential</th>
<th>HDHP Balanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after your deductible is met.</td>
<td>Plan pays 60% after your deductible is met.</td>
<td>Plan pays 70% after your deductible is met.</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after your deductible is met.</td>
<td>Plan pays 60% after your deductible is met.</td>
<td>Plan pays 50% after your deductible is met.</td>
<td></td>
</tr>
</tbody>
</table>

#### Inpatient and Outpatient Care

<table>
<thead>
<tr>
<th></th>
<th>HDHP Premier</th>
<th>HDHP Essential</th>
<th>HDHP Balanced</th>
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<td>Plan pays 70% after your deductible is met.</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after your deductible is met.</td>
<td>Plan pays 60% after your deductible is met.</td>
<td>Plan pays 50% after your deductible is met.</td>
<td></td>
</tr>
</tbody>
</table>

#### Teladoc

Talk to a doctor anytime through Teladoc, a national network of U.S. board-certified doctors available on demand 24 hours a day, 365 days a year to diagnose, treat and prescribe medication for many medical issues. Pay a $40 fee ($45 beginning on July 1, 2017) upfront and Teledoc will submit the claim to CoreSource.

#### Emergency Room Visits

<table>
<thead>
<tr>
<th></th>
<th>HDHP Premier</th>
<th>HDHP Essential</th>
<th>HDHP Balanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% for emergency visits and 50% for non-emergency visits after your deductible is met.</td>
<td>Plan pays 70% for emergency visits and 50% for non-emergency visits after your deductible is met.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Mental Health/Substance Abuse Services

<table>
<thead>
<tr>
<th></th>
<th>HDHP Premier</th>
<th>HDHP Essential</th>
<th>HDHP Balanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after your deductible is met.</td>
<td>Plan pays 60% after your deductible is met.</td>
<td>Plan pays 70% after your deductible is met.</td>
<td></td>
</tr>
<tr>
<td>Out-of-Network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan pays 80% after your deductible is met.</td>
<td>Plan pays 60% after your deductible is met.</td>
<td>Plan pays 50% after your deductible is met.</td>
<td></td>
</tr>
</tbody>
</table>

#### Prescription Drugs

**Preventive Drugs¹**  
(Routine/Women's/Preventive Therapy)  
-- Covered at 100%

**All Other Drugs**  
-- Subject to deductible and coinsurance. You pay 100% of the discounted cost until the deductible is met and then you pay 20%.

* Specialty Drugs must be obtained through Caremark's Specialty Pharmacy
** Mail order optional; 90-day supply at CVS pharmacy is available

**Preventive Drugs¹**  
(Routine/Women's/Preventive Therapy)  
-- Covered at 100%

**All Other Drugs**  
-- Subject to deductible and coinsurance. You pay 100% of the discounted cost until the deductible is met and then you pay 30%.

* Specialty Drugs must be obtained through Caremark's Specialty Pharmacy
** Mail order optional; 90-day supply at CVS pharmacy is available

¹Drugs that are subject to generic step therapy, brand penalty and prior authorization may be not covered at 100% by the plan.

See the Prescription Drug section on page 17 for more detailed information about this program.

Please check the Caremark website at www.caremark.com for the most accurate up-to-date coverage and cost information. These copays apply to the employee's out-of-pocket maximum, but do not apply to the deductible.
High Deductible Health Plan
Partnered with an HSA

High deductible health plans (HDHP) are designed to give you choice and flexibility in your healthcare coverage. These plans allow participants to make pre-tax contributions to a health savings account, better understand the true cost of care, and carry HSA account balances with them into retirement. The plans combine a qualified high deductible health plan (HDHP), with a health savings account (HSA). The HSA is a bank account you can make withdrawals from for healthcare expenses. You can also use your HSA to save for future healthcare expenses. You own the HSA and can fund it using pre-tax dollars; your employer also contributes to your account.

The high deductible health plans feature a PPO network of carefully selected doctors, hospitals and other healthcare providers who have agreed to provide medical care at special negotiated rates. The plans offer you the freedom to seek care from any provider you choose; however, you will receive the most favorable benefits at the lowest out-of-pocket cost if you use a network provider. See page 12 for provider networks.

High Deductible Health Plans Highlights

- **Lower Premiums**
  High deductible health plans offer premiums that are lower in exchange for more out-of-pocket expenses when you use the plan. Many associates use the premium savings to help fund their HSA.

- **Health Savings Account (HSA) Eligibility and Dual Coverage**
  To enjoy the benefits of an HSA, participants who enroll in a high deductible health plan may only be enrolled in another health plan if that coverage is also another qualified high deductible health plan. Medicare and Tricare are not qualified plans for dual coverage for HSA purposes.
  Employees enrolled in Medicare may choose to enroll in the high deductible health plan but will not qualify for contributions to the pre-tax health savings account. Please contact the Benefits Team for alternative options.
  Since HSA eligibility is based on coverage under a qualified health plan, your enrolled adult dependents may also open their own HSA account through their own bank if they do not have other coverage unless that coverage is another qualified HDHP.

- **The HSA Bank Account**
  Trustmark has selected HSA Bank, an FDIC-insured financial institution that administers HSAs, as its preferred trustee based on the bank’s history of excellent service. You may access the funds in your health savings account account by using a debit card that is provided at no cost or by ordering checks.
  The HSA is a bank account and funds must be in the account in order to use them. If funds are not available, you may use your personal funds to pay for your healthcare expense and pay yourself back later when HSA funds become available. Human Resources will contact you with information regarding your account upon enrollment in the plan.
  The company will pay for your account maintenance fees while you are enrolled in the high deductible health plan as an active employee. Visit www.HSAbank.com for a complete list of account fees and answers to other common health savings account questions. You can also download the mobile app.

- **Company Contribution to Your HSA Account**
  The company will contribute $500 to your HSA if you select employee only coverage and $1,000 if you choose spouse, children or family coverage. Amounts are pro-rated for mid-year enrollment. The money in your HSA is yours and you may continue to draw on the funds until they are used, even if you are no longer enrolled in a qualified high deductible health plan.

- **Your HSA Contributions are Tax-Free**
  You can also contribute money to your HSA with pretax dollars through payroll deduction, but the sum of all contributions to your HSA (yours and the company's) cannot exceed the annual maximum of $3,400 for individual and $6,750 for family coverage. Employees over age 55 may contribute an additional $1,000 catch-up contribution. You can start, change or stop your HSA contribution throughout the year by creating a change benefit event on Workday.

- **Use Your HSA Funds to Cover Qualified Expenses**
  You can use your HSA funds for you and your qualified IRS dependents’ qualified healthcare expenses. These may include expenses that apply to your deductible and coinsurance, prescription drugs, expenses not covered by the medical plan, prescription eyeglasses and contacts not covered by a vision plan, and expenses not covered by your dental plan. See the list of IRS-eligible healthcare expenses on page 19.

* Tax-free from federal and most, but not all, state taxes. For more information, go to www.HSAbank.com
Deductibles
The plans have a deductible for employee only coverage, and an aggregate deductible for spouse, children or family coverage. That means if you select coverage other than employee only, the aggregate deductible must be met in full before coinsurance benefits kick in for any member of your family. Medical expenses for all covered family members are added together to reach the aggregate deductible, but if only one member has claims during the year, the aggregate deductible still applies.

Coinsurance and Out-of-Pocket Maximum
After meeting your deductible, the plans pay in-network covered charges at the coinsurance level shown on page 12 until you reach your out-of-pocket maximum for the year. Medical expenses for all covered family members are added together to reach the aggregate out-of-pocket maximum. After meeting the in-network out-of-pocket maximum, the high deductible health plans provide 100 percent coverage for the remainder of the year for in-network covered charges.

For a breakdown of out-of-network deductibles and out-of-pocket maximums for the plans, refer to the Medical Plans at a Glance chart on page 13.
Prescription Drug Coverage

The high deductible health plans offer coverage of quality medications in two ways:

1. **Preventive Drugs** – Covered by the plan at 100 percent. These include over-the-counter and prescription drugs mandated by the Affordable Care Act, as well as preventive therapy drugs the company has chosen to offer with no copay. Drugs that are subject to generic step therapy, brand penalty and prior authorization may be not covered at 100 percent by the plan.

   **Categories include:**
   - Anticoagulant / Antiplatelets
   - Anticonvulsants
   - Bowel preparations
   - Cardiovascular conditions
   - Coronary artery disease
   - Diabetes
   - Hematologic agents
   - Hypertension
   - Immunizing agents
   - Mental health
   - Osteoporosis
   - Preventive care services
   - Respiratory disorders
   - Various conditions
   - Women’s health
   - Aspirin therapy with a prescription
   - Breast cancer prevention

   A Preventive Therapy Drug List with covered drug names is located on eCentral, but keep in mind that new drugs are added and others deleted throughout the year so this list may not provide you with the most complete coverage information. Go to [www.caremark.com](http://www.caremark.com) or use Caremark’s mobile app to get the most up-to-date coverage and cost information. Enrollment in the plan and registration to the site is required in order to gain access.

2. **All Other Prescription Drugs** – Subject to deductible and coinsurance. You’ll pay 100 percent of the discounted cost until the deductible is met and then you’ll pay at the applicable coinsurance level.

Making Informed Choices

Talk to your doctor for help finding the lowest-cost prescription drugs that best meet your needs. The Caremark mobile app can help provide drug information when speaking with your doctor. To help you make the most informed choices, please consider the following:

**Is this drug a generic that is on the Preventive Therapy Drug List?**
- If yes, it’s covered by the plan at 100 percent.
- If no, it may not be covered at 100 percent. If you fill a brand name when there is an available generic equivalent, then be prepared to have a penalty added to your out-of-pocket cost equal to the cost difference between brand and generic equivalent. If you fill a brand name drug that falls under step therapy or prior authorization, the drug will not be covered by the plan until approval is obtained by Caremark.

**Is this drug a Specialty drug?**
- If yes, make sure you go through the Caremark Specialty Drug Program, or it won’t be covered.
- If your Specialty drug is on the Preventive Therapy Drug List, it will be covered by the plan at 100 percent.
- If your Specialty drug is not on the Preventive Therapy Drug List, you will pay the full cost until your deductible is met. Once your deductible is met, you’ll pay at the applicable coinsurance level until your out-of-pocket annual maximum has been met.

**What if my drug is subject to generic step therapy, brand penalty or prior authorization?**
Call Caremark to better understand your alternatives or what is required for approval.

**Will the cost of my drug be the same every month?**
No. Drug costs can change so it may not be the same amount each time you fill.

**Mail Order**
Visit the Caremark website at [www.caremark.com](http://www.caremark.com) to print the form for use with a paper prescription, or use the site to request that Caremark contact your doctor for authorization. You can also get a 3-month supply by using the Maintenance Choice program at a local CVS Pharmacy.

**When You Visit the Pharmacy**
Check the Caremark website at [www.caremark.com](http://www.caremark.com) to see if your pharmacy is in-network. If it is not, you will want to find a network pharmacy or your prescription won’t be covered by the plan. Only prescriptions filled at a network pharmacy are covered by the plan.

Show your medical ID card with the Caremark logo when you visit the pharmacy, that way you will receive the discounted price. CoreSource, which administers the medical plan, shares deductible information with the pharmacy benefits provider Caremark, so you pay only your portion at the time of service.
**Twice-Monthly Medical Premiums**

Premiums are withdrawn before taxes from your first and second paychecks of the month, beginning with the first paycheck of the month in which coverage is effective. If you earned a wellness credit for 2017, this amount will display on the enrollment submissions page on Workday and on your payslip.

Associates hired on or after May 1, 2016 will automatically receive the maximum wellness discount if enrolled in the medical plan in 2017. Please refer to the chart below.

**Note:** If you earned a wellness reward, you will see the full medical premium on one line on your paycheck, and a wellness credit on another line. Those amounts will net to the premiums shown below.

<table>
<thead>
<tr>
<th></th>
<th>FULL PREMIUM</th>
<th>ANNUAL WELLNESS REWARD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(No Wellness Rewards Earned in 2016)</td>
<td>$600 Earned</td>
</tr>
<tr>
<td><strong>HDHP Premier 1500</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$73.50</td>
<td>$48.50</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$208.00</td>
<td>$183.00</td>
</tr>
<tr>
<td>Employee + Spouse/QP</td>
<td>$214.00</td>
<td>$189.00</td>
</tr>
<tr>
<td>Family</td>
<td>$249.00</td>
<td>$224.00</td>
</tr>
<tr>
<td><strong>HDHP Essential 2500</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$67.00</td>
<td>$42.00</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$184.00</td>
<td>$159.00</td>
</tr>
<tr>
<td>Employee + Spouse/QP</td>
<td>$189.50</td>
<td>$164.50</td>
</tr>
<tr>
<td>Family</td>
<td>$220.00</td>
<td>$195.00</td>
</tr>
<tr>
<td><strong>HDHP Balanced 4500</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Only</td>
<td>$44.50</td>
<td>$19.50</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$158.00</td>
<td>$133.00</td>
</tr>
<tr>
<td>Employee + Spouse/QP</td>
<td>$162.50</td>
<td>$137.50</td>
</tr>
<tr>
<td>Family</td>
<td>$188.00</td>
<td>$163.00</td>
</tr>
</tbody>
</table>
IRS-Eligible Healthcare Expenses
See IRS Publication 502 for a complete listing and additional information about what healthcare expenses are eligible to be paid from your HSA or FSA. Retain receipts for your medical expenditures in case you ever need to validate your HSA or FSA expenditures.

Equipment

**Eligible:**
- Diabetic supplies including monitoring system, insulin pump, glucose kit, test strips, lancets
- Blood pressure monitor kits
- Condoms
- Denture supplies
- Female contraceptives and spermicidal products
- Incontinence supplies
- Ovulation and pregnancy tests
- Crutches
- Oxygen equipment and oxygen used to relieve breathing problems that result from a medical condition

**Ineligible:**
- Maternity clothing
- Toilet paper and tissues
- Diapers
- Feminine products including sanitary napkins, tampons, pads

Drugs

**Eligible:**
- Prescription drugs
- Over-the-counter medications with a prescription
- Diabetic treatment (insulin)

**Ineligible:**
- Drugs for cosmetic purposes
- Toiletries including shampoo, soap, shaving cream, deodorant, toothpaste
- Drugs that are merely beneficial for general health (e.g., multi-vitamins)
- Over-the-counter medications without a prescription

Procedures/Treatments

**Eligible:**
- Anesthesiologist
- Surgery
- Hospital services
- Weight loss programs prescribed to treat a medical condition (e.g., obesity)
- Smoking cessation programs
- Treatment for alcoholism or drug dependency
- Acupuncture
- Infertility treatment
- Speech therapy
- Physical therapy
- Occupational therapy
- Obstetrical and gynecological procedures
- Dermatological procedures
- Chiropractors and osteopaths
- Sterilization and reversed sterilization
- Nursing services for care of a specific medical ailment
- Cosmetic surgery/procedure that treats a deformity, caused by an accident or trauma, disease, or an abnormality at birth

**Ineligible:**
- Physical treatments unrelated to specific health problem (e.g., massage for general well-being)
- Any illegal treatment
- Cosmetic surgery/procedures that improve patient’s appearance but do not meaningfully promote the proper function of the body or prevent/treat an illness/disease

Vision/Hearing

**Eligible:**
- Hearing aids, batteries for operation of hearing aids, hearing aid repairs
- Optometrist or ophthalmologist fees
- Eyeglasses
- Contact lenses and cleaning solutions
- Corrective eye surgery including radial keratotomy

**Ineligible:**
- Lens replacement insurance
- Warranties
- Protection plans
- Coating/tints that do not treat a medical condition

Dental

**Eligible:**
- Dental care
- Artificial teeth/dentures
- Braces, orthodontic services

**Ineligible:**
- Teeth bleaching
- Tooth bonding that is not medically necessary

Psychiatric Care

**Eligible:**
- Services of psychotherapists, psychiatrists, and psychologists
- Legal fees directly related to commitment of mentally ill person

**Ineligible:**
- Psychoanalysis undertaken to satisfy curriculum requirements of a student
- Marriage counseling

Insurance

**Eligible:**
- Deductibles and copayments for healthcare plans (e.g., medical, dental, vision) (limited for HDHP plans)
- Coinsurance (only the percentage of charges not paid by your healthcare plan)
- Amounts over usual and customary limits

**Ineligible:**
- All premiums/contributions for insurance coverage (including health insurance, long-term care, loss of income and loss of life)
- Expenses paid by your healthcare plan

Miscellaneous Charges

**Eligible:**
- Shipping, handling, delivery charges, and sales tax for eligible expenses
- Expenses connected with donating an organ
- Lodging expenses (not provided in a hospital or similar institution) not to exceed $50 per night per individual while away from home if the lodging is primarily for and essential to medical care provided by a doctor
- Transportation expenses primarily for and essential to, medical care including mileage, bus, taxi, train/plane fares, ambulance services, parking fees and tolls
- Social Security tax paid with respect to wages of a qualified nurse’s service

See IRS Publication 502 for a complete listing and additional information about what healthcare expenses are eligible to be paid from your HSA or FSA. Retain receipts for your medical expenditures in case you ever need to validate your HSA or FSA expenditures.
IRS-Eligible Healthcare Expenses (continued)

See IRS Publication 502 for a complete listing and additional information about what healthcare expenses are eligible to be paid from your HSA or FSA. Retain receipts for your medical expenditures in case you ever need to validate your HSA or FSA expenditures.

### IRS-Eligible Medical Items

**that DO NOT require a doctor's prescription**

- Athletic Braces & Supports
- Bandages
- Baby Sunscreen
- Baby Thermometers
- Breast Pumps & Accessories
- Blood Glucose Monitors & Test Strips
- Blood Pressure Monitors
- Children’s First Aid
- Children’s Sunscreen
- Condoms
- Contact Lens Solution
- Denture Cream & Cleansers
- Diabetes Care Accessories
- Eye Glass & Lens Accessories
- First Aid Kits
- First Aid Treatments & Supplies
- Glucosamine Supplements
- Glucose Tablets
- Hearing Aid Batteries
- Home Medical Equipment
- Heating Pads & Wraps
- Hot & Cold Packs
- Incontinence Products
- Lip Balm
- Medical Monitoring & Testing Devices
- Motion Sickness Aids
- Orthopedic & Surgical Supports
- Pregnancy & Fertility Tests
- Prenatal Vitamins
- Reading Glasses & Magnifiers
- Shoe Insoles & Inserts
- Sunscreen
- Thermometers
- Vaporizers & Inhalers
- Walking Aids
- Wheelchairs & Accessories

### IRS-Eligible Medical Items

**that DO require a doctor's prescription**

- Acne Treatments
- Allergy Medicine
- Antacids & Acid Controllers
- Anti-Fungal Treatments
- Anti-Itch Treatments
- Antiparasitic & Lice Treatments
- Aspirin & Baby Aspirin
- Chest Rubs
- Children’s Cold & Allergy Medicine
- Children’s Fever & Pain Relievers
- Children’s Stomach & Digestive Aids
- Cold Sore Treatments
- Corn & Callus Removers
- Cough Drops & Spray
- Cough, Cold & Flu Medicine
- Diaper Rash Cream
- Ear Drops & Wax Removers
- External Pain Relievers
- Eye Drops
- Feminine Personal Care Treatments
- Hemorrhoidal Treatments
- Laxatives
- Nicotine Gum & Patches
- Oral Pain Remedies
- Pain Relieving Creams & Pads
- Pain Relievers
- Skin Treatments
- Sleep Aids
- Stomach & Digestive Aids
- Topical Skin Treatments
- Wart Removers
Healthcare and Dependent Care Flexible Spending Accounts (FSA)

A flexible spending account is an employer-sponsored plan that lets you deduct dollars from your paycheck and put them into a special account that's protected from taxes. The money in an FSA account can be used for eligible healthcare and dependent care expenses incurred by you, your spouse and your IRS dependents. FSA accounts are exempt from federal taxes, Social Security (FICA) taxes and, in most cases, state income taxes.

You can change your FSA election only if it corresponds to the IRS rules for a qualified change in status. Do not overestimate your expenses because you cannot stop deductions once they have begun. For more information on qualified change in status, please see the plan document or contact the Benefits Specialist in Human Resources.

Healthcare FSA

An employee may contribute an annual maximum of $2,500 to a healthcare FSA. Your spouse may elect to contribute to an FSA through his or her employer.

Employees will receive a debit card, a stored-value card with a MasterCard logo that can be used to pay some healthcare FSA-reimbursable expenses. Use of the debit card may be limited based on the type of provider.

How the FSA Works with the High Deductible Health Plan

If you are enrolled in a high deductible health plan, your use of the healthcare flexible spending account will be limited because FSA funds cannot be used to pay for expenses that go toward meeting your plan deductible. For non-deductible expenses, it does not matter whether you seek reimbursement from your HSA or FSA, but keep in mind that FSA funds do not roll over to the following year. If enrolled in the company medical plan, you must choose Limited FSA on Workday.

In addition, the debit card may not be used for medical expenses. You will reimburse for these expenses by submitting an FSA claim form.

Steps to Start Saving

1. Determine Your Expenses
First you must estimate the amount of healthcare expenses you think you will experience from your eligibility date through Dec. 31. To estimate your expenses, you can use the FSA worksheet on page 23. If you are not sure how to estimate your healthcare expenses, review your checkbook and credit card statements. Be sure to calculate your annual FSA contribution wisely because any money in your FSA that you do not use for eligible expenses incurred during the calendar year will be forfeited.

2. Enroll
You must enroll in your FSA each calendar year.
Make your FSA elections when you select your benefits via Workday. The annual amount you elect is deducted in equal amounts based on 24 deductions per year.

3. Reimbursement
See the chart on page 19 for eligible FSA healthcare expenses. Eligible claims must be incurred during the time you were enrolled during the plan year (plan years run from Jan. 1 to Dec. 31). You’ll have 90 days after the last day of the plan year to submit your claims for reimbursement. As you have eligible expenses throughout the year, there are three ways to submit for reimbursement.

   1. Once enrolled in the Healthcare FSA, TASC will mail a TASC Debit Mastercard to you. This card can be used to pay for your eligible healthcare expenses.
   2. MyTASC Mobile App
   3. Online Request for Reimbursement Wizard in BeneCenter/MyTASC (www.tasconline.com).

Requests through the mobile app or online are processed daily with approved reimbursements deposited directly into your MyCash account (unless otherwise indicated). Log on to eCentral to learn more details.

www.tasconline.com
This is your online portal to review details with your flexible spending accounts. Register after your benefits effective date by going to the website, clicking login and then following the prompts to create a New Profile.

As an active employee, you’ll have 90 days after the last day of the plan year to submit your claims for reimbursement. It is recommended that you submit claims for reimbursement as they occur to avoid missed deadlines.

How the FSA Works with the HSA

If you choose an HSA plan, your use of the healthcare flexible spending account will be limited because FSA funds cannot be used to pay for expenses that go toward meeting your HSA plan deductible. For non-deductible expenses, it does not matter whether you seek reimbursement from the HSA or FSA, but keep in mind that FSA funds do not roll over to the following year.
Dependent Care FSA

The dependent care flexible spending account helps you pay for childcare services which make it possible for you and your spouse (if applicable) to work. Under certain circumstances it also may be used to help pay for the care of elderly parents, or a disabled spouse or dependent. To be eligible, you must be at work during the time your eligible dependent receives care.

You must also meet one of the following eligibility criteria:

- You are a single parent or guardian
- You have a working spouse or a spouse looking for work
- Your spouse is a full-time student at least five months during the year while you are working
- Your spouse is physically or mentally unable to provide for his or her own care
- You are divorced or legally separated and have custody of your child even though your former spouse may claim the child for income tax purposes. (Your FSA can be used to pay for childcare services provided during the period the child resides with you.)

Steps to Start Saving

1. Determine Your Expenses
First you must estimate the amount of dependent care expenses you think you will experience from your eligibility date through Dec. 31. To estimate your expenses, you can use the FSA worksheet on page 23. If you are not sure how to estimate your dependent care expenses, review your checkbook and credit card statements. Be sure to calculate your annual FSA contribution wisely because any money in your FSA that you do not use for eligible expenses incurred during the calendar year will be forfeited.

2. Enroll
You must enroll in your FSA each calendar year. Make your FSA election when you select your benefits on Workday.

The annual amount you elect is deducted in equal amounts based on 24 deductions per year. For 2017, you may contribute an annual maximum of $5,000 to a dependent care FSA if you are married filing jointly, or $2,500 to a dependent care FSA if you are married filing individually.

3. Reimbursement
Eligible claims must be incurred during the time you were enrolled during the plan year (plan years run from Jan. 1 to Dec. 31). You’ll have 90 days after the last day of the plan year to submit your claims for reimbursement. There are three ways to submit for reimbursement. In all three situations you are allowed to use amounts that do not exceed the current balance of your Dependent Care FSA account.

1. Once enrolled in the Dependent Care FSA, TASC will mail a TASC Debit Mastercard to you. This card can be used to pay for your eligible daycare expenses.
2. MyTASC Mobile App
3. Online Request for Reimbursement Wizard in BeneCenter/MyTASC (www.tasconline.com).

Requests through the mobile app or online are processed daily with approved reimbursements deposited directly into your MyCash account (unless otherwise indicated). Log on to eCentral to learn more details.

Eligible Dependents
An eligible dependent is a qualifying individual who spends at least eight hours a day in your home and is one of the following:

- Your dependent under age 13 for whom you can claim an exemption
- A child under the age of 13 for whom you have custody if you are divorced or legally separated
- Your spouse who is physically or mentally incapable of self-care
- Your dependent who is physically or mentally incapable of self-care, even if you cannot claim an exemption for the person for income tax purposes.

Eligible Expenses
Expenses may be reimbursed for services provided:

- Inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under the age of 19
- In a dependent care center or a childcare center. (If the center cares for more than six children, it must comply with all applicable state and local regulations.)
- By a housekeeper whose services include, in part, providing care for a qualifying individual
- Through child or adult day care; through nursery, preschool, after-school or summer day camp programs. Taxes you pay on wages for eligible dependent care can also be reimbursed.
- By a home day care provider. The provider’s Social Security or Tax ID number and payment/services details must be included with your federal income tax return on Form 2441. (As a result, your provider will have to pay taxes on that income.)

Ineligible Expenses
Expenses will not be reimbursed for:

- Dependent care for a child 13 or over, overnight camp, babysitting that is not work-related, schooling in kindergarten and higher grades, long-term care services. All submitted expenses are reviewed for eligibility according to Internal Revenue Code Sections 125 and 129.
FSA Health and Dependent Care Worksheet

Use this worksheet to help you determine your healthcare and dependent care annual contribution.

<table>
<thead>
<tr>
<th>Annual Healthcare Expenses</th>
<th>Annual Dependent Care Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>Annual Child Care Services</td>
</tr>
<tr>
<td>$_________</td>
<td>Day care center</td>
</tr>
<tr>
<td>(not reimbursable from FSA if enrolled in a high deductible plan)</td>
<td>$_________</td>
</tr>
<tr>
<td>Medical, dental, vision</td>
<td>In-home care</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Nursery and pre-school</td>
</tr>
<tr>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>The amount not paid by your health plan coverage</td>
<td>After-school care</td>
</tr>
<tr>
<td>Amounts not covered by insurance</td>
<td>Au pair services</td>
</tr>
<tr>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>Vision care not covered by insurance</td>
<td>Summer day camp</td>
</tr>
<tr>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>Dental care not covered by insurance</td>
<td></td>
</tr>
<tr>
<td>$_________</td>
<td>Annual Elder Care Services</td>
</tr>
<tr>
<td>Other anticipated healthcare expenses</td>
<td>Day care center</td>
</tr>
<tr>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>$_________</td>
<td>In-home care</td>
</tr>
<tr>
<td>$_________</td>
<td>$_________</td>
</tr>
<tr>
<td>Total Annual Healthcare Contribution</td>
<td></td>
</tr>
<tr>
<td>$_________</td>
<td>Total Dependent Care Contribution</td>
</tr>
<tr>
<td></td>
<td>$_________</td>
</tr>
</tbody>
</table>
Dental Plans

The dental plan, administered by Delta Dental of Minnesota, is available to all regular, full-time associates of HealthFitness. It is designed so it is easy to use and gives you and your family maximum flexibility, network savings, and a strong commitment to service and peace of mind. The dental plan covers an assortment of preventive and standard dental services. Diagnostic and Preventive services are covered at 100%, while other services are paid at a coinsurance level once you meet the plan’s annual deductible. This plan does not cover orthodontic services.

Through a unique contractual agreement, Delta Dental maintains a network of participating dentists. Nationally, Delta Dental Premier is the largest dental network in the country with about 117,000 participating dentists. Finding a participating dentist is easy.

Simply visit www.deltadentalmn.org and use our interactive national Dentist Search tool or call Customer Service at (651) 406-5916 or toll-free at (800) 553-9536. If dental services are received from a non-participating dentist, you will be responsible for paying the difference between the maximum allowable amount (up to the reasonable and customary limits for the geographic area) and what the dentist charges. You may be responsible for submitting your own claim when services are rendered with a non-participating dentist.

A Snapshot of Your Dental Coverage

This is a summary of benefits only and does not guarantee coverage.

For a complete list of covered services and limitations/exclusions, please refer to the Dental Summary Plan Document.

<table>
<thead>
<tr>
<th>Service &amp; Description</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic &amp; Preventive Services</td>
<td>100%</td>
<td>100% of maximum allowable fee**</td>
</tr>
<tr>
<td>Exams &amp; cleanings, x-rays, fluoride treatments, sealants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic Services</td>
<td></td>
<td>80% of maximum allowable fee** (after deductible is met)</td>
</tr>
<tr>
<td>Emergency treatment for relief of pain, space maintainers, amalgam restorations (silver fillings) and composite resin restorations (white fillings) on anterior (front) teeth and posterior (back) teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endodontics</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>Pulpotomies on primary teeth for dependent children, root canal therapy on permanent teeth</td>
<td>after deductible is met</td>
<td></td>
</tr>
<tr>
<td>Periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical/Nonsurgical periodontics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical/Nonsurgical extractions, all other oral surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Restorative*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns</td>
<td>50%</td>
<td>50% of maximum allowable fee** (after deductible is met)</td>
</tr>
<tr>
<td>Prosthetic Repairs and Adjustments*</td>
<td>50%</td>
<td>50% of maximum allowable fee** (after deductible is met)</td>
</tr>
<tr>
<td>Denture adjustments and repairs, bridge repair</td>
<td>after deductible is met</td>
<td></td>
</tr>
<tr>
<td>Prosthetics*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dentures (full and partial), bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductible Per person/per family (calendar year)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No deductible for diagnostic and preventive services</td>
<td>$100/$300</td>
<td>$100/$300</td>
</tr>
<tr>
<td>Calendar Year Plan Maximum Per Person</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

* 12 Month Waiting Period Applies
**Dentists who have signed a participating network agreement with Delta Dental have agreed to accept the maximum allowable fee as payment in full. Non-participating dentists have not signed an agreement and are not obligated to limit the amount they charge; the member is responsible for paying any difference to the non-participating dentists.

Dental Premiums – Twice Monthly

Premiums are withdrawn before taxes beginning with the first paycheck of the month in which coverage is effective.

<table>
<thead>
<tr>
<th></th>
<th>Employee Only</th>
<th>$8.78</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee + Child(ren)</td>
<td>$26.33</td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse/QP</td>
<td>$28.06</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$45.07</td>
<td></td>
</tr>
</tbody>
</table>

This is your online portal to review coverage and claims information for your dental plan. Register after your benefits effective date by going to the website and following the prompts to create a new User ID and Password.
Vision Plans

**Basic Plan**
The company offers a company-paid Basic Vision Plan. All full-time associates and their dependents are eligible. You must add your dependents to the basic vision plan on Workday in order to receive this benefit. The plan offers an annual eye exam from a VSP provider for each employee and dependent for just the cost of a $10 copay for each exam. The plan also provides a discount on materials and frames.

**Enhanced Plan**
Associates who want coverage of eyeglasses and contacts can opt for the Enhanced Vision Plan, which also includes a company-paid annual exam for just the cost of the copay. If you choose the enhanced plan, only those dependents enrolled in the enhanced plan will receive benefits.

### How the Vision Plan Works
VSP uses a network of professionally certified optometrists and ophthalmologists. You can visit the VSP Network Doctor Directory at [www.vsp.com](http://www.vsp.com) or call (800) 877-7195. Simply call a VSP network doctor and tell them you are a VSP member when making your appointment. No VSP ID card is necessary. The VSP network doctor will contact VSP to verify your eligibility, plan coverage and to obtain authorization for services. Upon completion of the appointment, the doctor will submit the claim to VSP for processing and VSP will pay the doctor directly. You won’t have to complete any paperwork, including claim forms; however, you will be responsible for paying any applicable copays, and for additional services or materials not covered.

If you wear glasses, the Enhanced Plan allows you an eye exam and new lenses once every calendar year, but new frames are limited to once every two calendar years. You have the freedom to choose a frame that complements your lifestyle, but if you choose a frame exceeding your plan allowance of $170, you’ll be responsible for paying the additional amount at a discounted rate, in addition to any applicable copays. If you choose contact lenses instead of glasses, you will not be eligible to receive any frames and lenses during the same service period. Your $170 contact lens allowance covers contacts and fitting. The exception is new contact wearers and those with complex prescriptions.

### Twice-Monthly Vision Plan Premiums
Premiums are withdrawn before taxes from your first and second paychecks of the month.

<table>
<thead>
<tr>
<th>Vision</th>
<th>Basic</th>
<th>Enhanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>Company Paid</td>
<td>$5.58</td>
</tr>
<tr>
<td>Employee &amp; Spouse/Qualified Partner</td>
<td>Company Paid</td>
<td>$8.90</td>
</tr>
<tr>
<td>Employee &amp; Children</td>
<td>Company Paid</td>
<td>$9.09</td>
</tr>
<tr>
<td>Employee &amp; Family</td>
<td>Company Paid</td>
<td>$14.44</td>
</tr>
</tbody>
</table>

“"I have an eye condition that causes my vision to change frequently, but with the high cost of glasses, I didn’t replace them as often as I should. Now that I have the Enhanced vision plan, I can get new lenses every year for a reasonable price. I visited a VSP provider and was very impressed by how professional and friendly the doctor and staff were. Even better - my exam only cost $10, and my glasses were about half of what I used to pay.” ~ Jeanette G.
Life Insurance

The company's benefit plan offers Basic and Additional Life Insurance plans to provide personalized life coverage for associates and their families. **Designate your life insurance beneficiaries in Workday on the life insurance elections page while completing your enrollment.**

**Company-Paid Basic Life Insurance and Accidental Death and Dismemberment**

Full-time associates are automatically enrolled in the Basic Life Insurance Program. This plan pays benefits to your selected beneficiary in the event of your death. The Basic Plan provides a life and AD&D benefit equal to 2x your annual base salary. The company pays the entire cost of the Basic Plan benefit for all regular full-time associates.

**Additional Life Insurance Plan and Accidental Death and Dismemberment Benefit**

For those desiring additional life and AD&D insurance protection, the company offers an Additional Group Term Life Insurance and AD&D insurance. All associates may purchase life insurance in increments of $5,000 to a maximum of $300,000 ($10,000 minimum election). Premiums vary according to age and benefit amount. To determine your bi-weekly premium cost, find your age on the chart at right to establish rate. Take your benefit election amount, divide it by $1,000 and multiply by the selected premium rate. This will give you the monthly amount. To determine bi-weekly amount, multiply your monthly amount by 12, then divide by 24. Additional coverage is subject to underwriting guidelines.

As a new hire, coverage amounts up to $50,000 do not require evidence of insurability. Any increase to coverage after the initial election requires evidence of insurability. To meet this requirement, please complete the medical history statement online at [https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f5245291a2e0ae928](https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f5245291a2e0ae928).

Please select HealthFitness from the drop down menu when prompted to enter your division.

<table>
<thead>
<tr>
<th>Employee Age (as of January 1)</th>
<th>Cost per $1,000 of coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>$0.11</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.12</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.14</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.19</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.28</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.45</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.81</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.09</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.85</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.82</td>
</tr>
<tr>
<td>75+</td>
<td>$5.14</td>
</tr>
</tbody>
</table>

**Dependent Life Insurance**

Dependents Life Insurance from Standard Insurance Company is also available with this plan. However, you must elect Additional Life Insurance for yourself in order to elect Dependents Life Insurance.

**Spouse Coverage Amount**

If you are enrolled in Additional Life, you may elect coverage for your spouse. This coverage is available in units of $5,000 to a maximum of $300,000, but not to exceed the Associate portion of Additional Life coverage. If you elect an amount for spouse greater than $25,000, the excess will be subject to medical underwriting approval. All late applications and requests for coverage increases will also require medical underwriting approval. Some family status change events may qualify for guarantee issue amounts without underwriting.

**Spouse Rates**

If you elect Dependents Life Insurance for your spouse, your monthly premium rate for this coverage is indicated in the table at right, “Spouse Rates.” This is for Life Insurance only and doesn’t include an AD&D benefit. Premiums for this coverage will be deducted directly from your bi-weekly paycheck. To determine premium cost, find your age on the chart to establish rate. Take your benefit election amount, divide it by $1,000 and multiply by the selected premium rate. This will give you the monthly amount. To determine bi-weekly amount, multiply your monthly amount by 12, then divide by 24. Additional coverage is subject to underwriting guidelines. As a new hire, coverage amounts up to $25,000 for spousal coverage do not require evidence of insurability. Any increase to coverage after the initial election requires evidence of insurability.

**Children Rates**

If you elect Dependents Life insurance for your eligible children, your monthly premium rate for this coverage is $1.70 per month, regardless of the number of eligible children covered. Premiums for this coverage will be deducted directly from the first two paychecks of each month.

When applicable, please complete the medical history statement online at: [https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f5245291a2e0ae928](https://www3.standard.com/w/PA_AmuBridgeWeb/MuServlet/?id=eb55d8045567ae8f5245291a2e0ae928).

Please select HealthFitness from the drop down menu when prompted to enter your division.
Leave of Absence

Trustmark provides associates who qualify under the Family and Medical Leave Act (FMLA), time off for their own health condition, to care for a parent, spouse or child with a health condition, for the birth or adoption of a child, or to perform military service. Complete eligibility requirements for FMLA are located in the policy located on eCentral. Time off may also be granted under the personal leave policy for those who do not qualify for FMLA or for personal reasons that would not otherwise be approved under the vacation policy.

Associates should review all leave policies to learn more about which type of leave may apply to their situation. Leave may be requested on a continuous or an intermittent basis. A 30-day notice is required for all types of leave, when practical. If a provider certification form is required, the associate will have 15 days to return the completed form. To apply for leave, complete the Leave of Absence form. You will be notified by HR upon approval or denial of your leave request.

Disability Benefits

Short-Term Disability

The Short-Term Disability Plan protects against loss of income if you are unable to work because of a non-occupational illness or accidental injury. All regular full-time associates become eligible for this benefit on the first of the month following 6 months of continual, regular full-time employment. There is a two-week elimination period before benefits begin. The plan provides a benefit of 60 percent of weekly base salary for up to 76 days (after a 14-day waiting period has been met). Disability benefits are calculated on the base salary at the start of the disability.

“Falling suddenly ill was a frightening occurrence, especially because I was dealing with a lot of unknowns. One of my main worries was the financial impact it would have on my family. Working the Benefits Team and The Standard to file a Short-Term Disability claim quickly put my mind at ease. They were prompt and professional, alleviating a major concern for me.”

~ Joshua M.

Long-Term Disability Plan

Income protection for extended disabilities is provided by the Long-Term Disability (LTD) Plan. This plan allows you to choose whether premiums are paid on a before- or after-tax basis. All regular full-time associates become eligible for this benefit on the first of the month following 1 month of continual, full-time employment.

- Begins Where Short-Term Plan Leaves Off – Coverage for this benefit begins after 90 days of continuous disability.
- Continuing Benefits – Once eligible, you will receive LTD benefits equal to 60 percent of your base salary (up to a maximum benefit of $10,000 per month) for the duration of the disability period or until you reach the plan’s maximum benefit. Your benefit is subject to integration guidelines with other sources of income.
- Choice to Pay Tax on Premium – When you enroll, you must select whether or not you want to pay income tax on the company–paid Long-Term Disability premiums. If you do not choose to pay the income tax now, please select the pre-tax LTD option in Workday when enrolling in benefits. By doing this you will pay tax on any subsequent disability benefits you receive. If you opt to treat the premiums as income, please select the post-tax LTD option in Workday when enrolling, which will produce tax-free disability benefits. This benefit requires re-election every year during Open Enrollment. You can can opt in or out during only that time of the year.

Workplace Accidents or Injuries

Associates who are injured must notify their manager or Human Resources as soon as possible. Since these situations may fall under the company’s Workers Compensation policy, the associate should complete the Occupational Illness and Injury form upon return to work and within 24 hours, if possible. Associates do not need to complete paperwork prior to seeking medical attention, especially if a delay could worsen their condition.
**DEPENDENT VERIFICATION DOCUMENTATION REQUIREMENTS**

Dependent verification is required for all dependents prior to coverage start date.

**IMPORTANT:** Send only photocopies of all official documents. DO NOT send originals, as we will retain the documents. Please be sure to write the employee’s name on all documents, and submit them along with the Dependent Verification Form. Please retain a copy of all documents for your records.

<table>
<thead>
<tr>
<th>STATUS</th>
<th>REQUIRED DOCUMENTATION</th>
</tr>
</thead>
</table>
| **Spouse** | - Photocopy of the first page of the employee or spouse’s most recent tax return showing “Married Filing Jointly” or “Married Filing Separately.” The spouse’s name must be entered on the employee’s tax form in the space provided after the “Married Filing Separately” status.  
- Photocopy of a certified marriage certificate issued by county (after date of marriage) with appropriate signatures (Decorative copies or certificates issued by religious institutions will not be accepted)  
  plus one of the following which must be dated within the past 6 months:  
  ✓ Copy of rental agreement/lease/mortgage showing both as tenants/mortgagees  
  ✓ Property tax receipt  
  ✓ Homeowner’s or renters insurance  
  ✓ Church tithing statement  
  ✓ Automobile title or registration listing co-owners  
  ✓ Loan agreement showing both names as co-borrowers  
  ✓ Credit card statements listing both names as cardholders  
  ✓ Two separate current billings, one in each spouse’s name sent to the same address  
  ✓ Current automobile title or registration for each spouse’s car showing the same address  
  or  
- Photocopy of immigration papers that identify employee-spouse relationship plus one of the following which must be dated within the past 6 months:  
  ✓ Copy of rental agreement/lease/mortgage showing both as tenants/mortgagees  
  ✓ Automobile title or registration listing co-owners  
  ✓ Loan agreement showing both names as co-borrowers  
  ✓ Credit card statements listing both names as cardholders  |
| **Civil Union** | - Complete the Attestation of Qualified Partner form and  
- Photocopy of the first page of the employee or spouse’s most recent tax return showing “Married Filing Jointly” or “Married Filing Separately.” The spouse’s name must be entered on the employee’s tax form in the space provided after the “Married Filing Separately” status.  
- Photocopy of a certified marriage/civil union certificate issued by county (after date of marriage) with appropriate signatures  
  plus one of the following which must be dated within the past 6 months:  
  ✓ Copy of rental agreement/lease/mortgage showing both as tenants/mortgagees  
  ✓ Property tax receipt  
  ✓ Homeowner’s or renters insurance  
  ✓ Church tithing statement  
  ✓ Automobile title or registration listing co-owners  
  ✓ Loan agreement showing both names as co-borrowers  
  ✓ Credit card statements listing both names as cardholders  
  ✓ Two separate current billings, one in each spouse’s name sent to the same address  
  ✓ Current automobile title or registration for each spouse’s car showing the same address  |
| **Common Law Marriage, State Domestic Partnership** | - Complete the Attestation of Qualified Partner form and  
- Photocopy of the State certificate or Affidavit, if applicable  
  plus one of the following which must be dated within the past 6 months:  
  ✓ Copy of rental agreement/lease/mortgage showing both as tenants/mortgagees  
  ✓ Property tax receipt  
  ✓ Homeowner’s or renters insurance  
  ✓ Church tithing statement  
  ✓ Automobile title or registration listing co-owners  
  ✓ Loan agreement showing both names as co-borrowers  
  ✓ Credit card statements listing both names as cardholders  
  ✓ Two separate current billings, one in each spouse’s name sent to the same address  
  ✓ Current automobile title or registration for each spouse’s car showing the same address |
## DEPENDENT VERIFICATION DOCUMENTATION REQUIREMENTS

| Trustmark-Defined Domestic Partnership | • Complete the Attestation of Qualified Partner form and  
• Photocopy of rental agreement/lease/mortgage showing both as tenants/mortgagees for at least 12 months prior to enrollment  
plus one of the following which must be dated within the past 6 months:  
- Property tax receipt  
- Homeowner’s or renters insurance  
- Church tithing statement  
- Automobile title or registration listing co-owners  
- Loan agreement showing both names as co-borrowers  
- Credit card statements listing both names as cardholders  
- Two separate current billings, one in each spouse’s name sent to the same address  
- Current automobile title or registration for each spouse’s car showing the same address |
|---|---|
| Dependent child by birth or adoption up to age 26 | Provide one of the following:  
- Photocopy of certified birth certificate that establishes employee / dependent relationship  
- Photocopy of hospital verification of birth (if under 6 months of age)  
- Photocopy of immigration papers that identify parent-child relationship  
- Photocopy of Qualified Medical Child Support Order (QMCSO)  
If the dependent child is disabled, you must also provide one of the following:  
- Photocopy of Social Security disability award letter  
- Copy of signed physician statement  
Provide one of the following:  
- Photocopy of certified court approved adoption  
- Photocopy of placement letter from court/adoption agency  
- Photocopy of birth certificate naming the adoptive parents as the parents  
If the dependent child is disabled, you must also provide one of the following:  
- Photocopy of Social Security disability award letter  
- Copy of signed physician statement |
| Dependent child by custody or guardianship up to age 26 | Provide one of the following:  
- Photocopy of certified court ordered legal guardianship  
- Photocopy of Qualified Medical Child Support Order (QMCSO)  
If the dependent child is disabled, you must also provide one of the following:  
- Photocopy of Social Security disability award letter  
- Copy of signed physician statement |
| Dependent stepchild(ren) and children of qualified partners up to age 26 | • Photocopy of certified birth certificate plus one of the following:  
  ✓ Photocopy of certified marriage certificate issued by county (after date of marriage) with appropriate signatures (Decorative copies or certificates issued by religious institutions will not be accepted)  
  ✓ Photocopy of divorce decree  
  or  
  • Photocopy of immigration papers that identify parent-child relationship plus one of the following:  
  ✓ Photocopy of certified marriage certificate issued by county (after date of marriage) with appropriate signatures (Decorative copies or certificates issued by religious institutions will not be accepted)  
  ✓ Photocopy of divorce decree  
  or  
  • In cases of qualified partnership, photocopy of Attestation of Qualified Partnership plus photocopy of certified birth certificate that identify qualified partner-child relationship:  
  or  
  • Photocopy of Qualified Medical Child Support Order (QMCSO)  
If the dependent child is disabled, you must also provide one of the following:  
- Photocopy of Social Security disability award letter  
- Copy of signed physician statement |

**Resources for obtaining required documentation:** [www.marriagelicense.com](http://www.marriagelicense.com); [www.birthcertificate.com](http://www.birthcertificate.com); [www.vitalchek.com](http://www.vitalchek.com); County office that issued original birth certificate/marriage certificate; US Department of State (for children born outside the United States); Hospital in which child was born; Social Security Administration; Dependent’s physician’s office; State agency that issued final adoption papers or custody/guardianship papers; Adoption agency that issued placement paper
<table>
<thead>
<tr>
<th>State and Taxation of Benefits</th>
<th>Qualified Relationship Type</th>
<th>Must Meet All Requirements Below and Provide Dependent Verification Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>All States and Relationships</td>
<td>Domestic Partnership as</td>
<td>Domestic Partnership 1. Both parties have been living together in the same</td>
</tr>
<tr>
<td>Not Defined Below</td>
<td>defined by Trustmark</td>
<td>household as a couple and have shared the same regular and permanent residence</td>
</tr>
<tr>
<td>Taxed both Federal &amp; State</td>
<td></td>
<td>for at least twelve (12) months; 3. Both parties agreed to be jointly responsible</td>
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<tr>
<td></td>
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<td>for basic living expenses incurred during the qualified partnership; 5. Both</td>
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<td></td>
<td>parties are married to each other; 6. Both parties were mentally competent to</td>
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<td>contract when the qualified partnership began; 7. Neither party is related by</td>
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<td></td>
<td>blood to a degree of closeness that would bar marriage under the laws of the</td>
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<td></td>
<td></td>
<td>state of residence; 9. Neither party is involved in any other partnership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>relationship.</td>
</tr>
<tr>
<td>Alabama</td>
<td>Common Law Marriage</td>
<td>1. Both parties are over eighteen (18) years of age and have the capacity to</td>
</tr>
<tr>
<td>Federal &amp; State Tax-exempt</td>
<td>Cal. Fam. Code §297</td>
<td>consent to marriage; 2. Both parties have a present agreement with each other to</td>
</tr>
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<td></td>
<td>be husband and wife; recognizes that they are married; 3. Both parties have held</td>
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<td>themselves out as married to the public and the public so recognizes that they are</td>
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<td>married; 4. The marriage has been consummated; 5. The parties are not related by</td>
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<td></td>
<td>blood to a degree that would prevent ceremonial marriage under Alabama law; and</td>
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<tr>
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<td></td>
<td>6. Both parties are married only to each other and are not in any other similar</td>
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<tr>
<td></td>
<td></td>
<td>relationship such as a ceremonial marriage, civil union, or domestic partnership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with any other person.</td>
</tr>
<tr>
<td>California</td>
<td>Domestic Partnership</td>
<td>Domestic Partnership 1. Both parties are in a domestic partnership only with each</td>
</tr>
<tr>
<td>State Tax-exempt</td>
<td></td>
<td>other and are not in any other similar relationship such as a marriage or civil</td>
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<td></td>
<td>union with any other person; 3. Both parties are of the same sex or at least one</td>
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<td></td>
<td>of the parties is at least sixty-two (62) years of age; 4. Both parties are</td>
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<td></td>
<td></td>
<td>capable of consenting to the domestic partnership; 5. Both parties are not</td>
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<tr>
<td></td>
<td></td>
<td>related to each other by blood to a degree that would prohibit marriage in California.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Civil Union</td>
<td>Civil Union 1. Both parties must be eighteen (18) years of age, or if under eighteen</td>
</tr>
<tr>
<td></td>
<td>C.S.R.C. §14-2-303.5</td>
<td>(18), written consent from the legal guardian. 2. Both parties must not be</td>
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<td></td>
<td>married or in a civil union with someone other than the person with whom they are</td>
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<td></td>
<td>applying. 3. Neither party may be related to each other by blood to a degree that</td>
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<tr>
<td></td>
<td></td>
<td>would prohibit marriage in Colorado.</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Common Law Marriage</td>
<td>Common Law Marriage 1. Both parties have the capacity to consent to marriage; 2.</td>
</tr>
<tr>
<td>Federal &amp; State Tax-exempt</td>
<td>National Union Fire Ins.</td>
<td>Both parties live together as husband and wife; 3. Both parties have an express</td>
</tr>
<tr>
<td></td>
<td>Co vs. Britton, D.D.D.,</td>
<td>mutual agreement to be married; 4. The parties are not related by blood to a</td>
</tr>
<tr>
<td></td>
<td>187 F. Supp 359 (1960)</td>
<td>degree that would prevent ceremonial marriage under District of Columbia law; and</td>
</tr>
<tr>
<td></td>
<td>Domestic Partnership</td>
<td>5. Both parties are married only to each other and are not in any other similar</td>
</tr>
<tr>
<td></td>
<td>DC ST §32-702</td>
<td>relationship such as a ceremonial marriage, civil union, or domestic partnership</td>
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<tr>
<td></td>
<td></td>
<td>with any other person.</td>
</tr>
<tr>
<td>Delaware</td>
<td>Civil Union</td>
<td>Civil Union 1. Both parties are in a civil union only with each other and are not</td>
</tr>
<tr>
<td>State Tax-exempt</td>
<td>13 Del. C §201, 202</td>
<td>in any other similar relationship such as a marriage or domestic partnership with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>any other person; 2. Both parties are at least eighteen (18) years of age; 3.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Both parties are of the same sex; and 4. Both parties are not related to each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>other by blood to a degree that would prohibit marriage in Delaware.</td>
</tr>
</tbody>
</table>

*As of July 1, 2013, civil unions are no longer offered to any couple and existing civil unions will be converted into marriages by July 1, 2014.
## QUALIFIED PARTNERSHIPS BY STATE FOR BENEFITS ELIGIBILITY AND TAXATION

<table>
<thead>
<tr>
<th>State and Taxation of Benefits</th>
<th>Qualified Relationship Type</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Georgia</strong>&lt;br&gt;Federal &amp; State-tax exempt</td>
<td>Common Law Marriage&lt;br&gt;G.A. Code Ann. §19-3-1.1</td>
<td>1. Both parties have the capacity to consent to marriage; 2. Both parties must have agreed to live together as man and wife; 3. The parties have consummated the marriage; 4. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person; 5. The parties are not related by blood to a degree that would prevent ceremonial marriage under Georgia law; and 6. All of the above requirements were met prior to January 1, 1997.</td>
</tr>
<tr>
<td><strong>Hawaii</strong>&lt;br&gt;State tax-exempt</td>
<td>Civil Union&lt;br&gt;HRS §572 B-2</td>
<td>1. Both parties are in a civil union only with each other and are not in any other similar relationship such as a marriage or domestic partnership with any other person; 2. Both parties are at least eighteen (18) years of age; and 3. Both parties are not related to each other by blood to a degree that would prohibit marriage in Hawaii.</td>
</tr>
<tr>
<td><strong>Idaho</strong>&lt;br&gt;Federal &amp; State-tax exempt</td>
<td>Common Law Marriage&lt;br&gt;I.C. §32-201</td>
<td>Common Law Marriage 1. Both parties have the capacity to consent to marriage and have a present intent and agreement to be married; 2. Both parties must have continuously cohabited since the time of that agreement; 3. The parties have made a general and substantial declaration that they were married; 4. The parties are not related by blood to a degree that would prevent ceremonial marriage under Idaho law; and 5. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person.</td>
</tr>
<tr>
<td><strong>Illinois</strong>&lt;br&gt;Taxed both Federal &amp; State</td>
<td>Civil Union&lt;br&gt;750 ILCS 75/25</td>
<td>1. Both parties have the capacity to consent to marriage and have a present intent and agreement to be married; 2. Both parties must have continuously cohabited since the time of that agreement; 3. The parties have made a general and substantial declaration that they were married; 4. The parties are not related by blood to a degree that would prevent ceremonial marriage under Illinois law; and 5. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person.</td>
</tr>
<tr>
<td><strong>Kansas</strong>&lt;br&gt;Federal &amp; State-tax exempt</td>
<td>Common Law Marriage&lt;br&gt;K.S.A. 23-2502</td>
<td>Common Law Marriage 1. Both parties have the capacity to consent to marriage; 2. Both parties have a present agreement to marry; 3. The parties have held out as husband and wife to the public; 4. The parties are not related by blood to a degree that would prevent ceremonial marriage under Kansas law; and 5. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person.</td>
</tr>
<tr>
<td><strong>Maine</strong>&lt;br&gt;Taxed both Federal &amp; State</td>
<td>Domestic Partnership&lt;br&gt;22 M.S.R.A. §2710</td>
<td>Domestic Partnership 1. Both parties have filed a Declaration of Domestic Partnership with the Maine Office of Date, Research, and Vital Statistics; 2. Both parties are in and expect to remain in a domestic partnership only with each other and are not in any other similar relationship such as a marriage or civil union with any other person; 3. Both parties are over eighteen (18) years of age; 4. Neither party is related by blood to the other party to a degree that would prohibit marriage under Maine law; and 5. Both parties have been legally domiciled with each other in Maine for at least twelve (12) months.</td>
</tr>
<tr>
<td><strong>Montana</strong>&lt;br&gt;Federal &amp; State-tax exempt</td>
<td>Common Law Marriage&lt;br&gt;M.C.A. 40-1-403</td>
<td>Common Law Marriage 1. Both parties have the capacity to consent to marriage; 2. The parties have mutually consented and agreed to enter into a marriage arrangement; 3. The parties have confirmed their relationship by cohabitation and public repute; 4. The parties are not related by blood to a degree that would prevent ceremonial marriage under Montana law; and 5. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person.</td>
</tr>
</tbody>
</table>
| **Nevada**<br>No State Tax, Taxed Federal | Domestic Partnership<br>11 NVST Ch. 1 22A | 1. Both parties have filed a Statement of domestic Partnership with the Nevada Secretary of State; 2. Both parties have chosen to share one another’s lives in an intimate and committed relationship of mutual caring; 3. Both parties are in and expect to remain in a domestic partnership only with each other and are not in any other similar relationship such as a marriage or civil union with any other person; 4. Both parties are over eighteen (18) years of age; 5. Neither party is related by blood to the other party to a degree that would prohibit marriage under Nevada law; and 6. Both parties have a common residence.
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>New Jersey</strong>&lt;br&gt;State Tax-exempt</td>
<td>Civil Union&lt;br&gt;37 NJ ST Ch. 6</td>
<td>Civil Union&lt;br&gt;1. Both parties are in a civil union only with each other and are not in any other similar relationship such as a marriage or domestic partnership with any other person;&lt;br&gt;2. Both parties are at least eighteen (18) years of age; and&lt;br&gt;3. Both parties are the same sex; and&lt;br&gt;4. Both parties are not related to each other by blood to a degree that would prohibit marriage in New Jersey.</td>
</tr>
<tr>
<td><strong>Ohio</strong>&lt;br&gt;Federal &amp; State Tax-exempt</td>
<td>Common Law Marriage&lt;br&gt;R.C. §31.05.12</td>
<td>Common Law Marriage&lt;br&gt;1. Both parties have the capacity to consent to marriage;&lt;br&gt;2. Both parties have agreed to enter into a marriage arrangement;&lt;br&gt;3. The parties have cohabitated as husband and wife;&lt;br&gt;4. The parties have held out to the public that they are husband and wife;&lt;br&gt;5. The parties have a reputation in their community as being husband and wife;&lt;br&gt;6. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person;&lt;br&gt;7. The parties are not related by blood to a degree that would prevent ceremonial marriage under Ohio law; and&lt;br&gt;8. All of the above requirements were met prior to October 10, 1991.</td>
</tr>
<tr>
<td><strong>Oklahoma</strong>&lt;br&gt;Federal &amp; State Tax-exempt</td>
<td>Common Law Marriage&lt;br&gt;In re Sanders Estate, Okla 67, Okla. 3, 168</td>
<td>Common Law Marriage&lt;br&gt;1. Both parties have the capacity to consent to marriage;&lt;br&gt;2. Both parties have mutually agreed to enter into a matrimonial relationship, permanent and exclusive of all others;&lt;br&gt;3. The parties have consummated the relationship by their cohabitation as husband and wife or their mutual assumption of marital duties and obligations;&lt;br&gt;4. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person;&lt;br&gt;5. The parties are not related by blood to a degree that would prevent ceremonial marriage under Oklahoma law; and&lt;br&gt;6. All of the above requirements were met prior to November 1, 1998.</td>
</tr>
<tr>
<td><strong>Oregon</strong>&lt;br&gt;State Tax-exempt</td>
<td>Domestic Partnership&lt;br&gt;O.R.S. §106.310</td>
<td>Domestic Partnership&lt;br&gt;1. Both parties have filed a declaration of Domestic Partnership with the county clerk;&lt;br&gt;2. Both parties are in a domestic partnership only with each other and are not in any other similar relationship such as a marriage or civil union with any other person;&lt;br&gt;3. Both parties are over eighteen (18) years of age; and&lt;br&gt;4. Neither party is related by blood to the other party to a degree that would prohibit marriage under Oregon law.</td>
</tr>
<tr>
<td><strong>Pennsylvania</strong>&lt;br&gt;Federal &amp; State Tax-exempt</td>
<td>Common Law Marriage&lt;br&gt;23 Pa. C.S.A. §11</td>
<td>Common Law Marriage&lt;br&gt;1. Both parties have the capacity to consent to marriage;&lt;br&gt;2. Both parties have exchanged words in the present tense spoken with the specific purpose of creating a legal husband and wife relationship;&lt;br&gt;3. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person;&lt;br&gt;4. The parties are not related by blood to a degree that would prevent ceremonial marriage under Pennsylvania law; and&lt;br&gt;5. All of the above requirements were met prior to January 1, 2005. – 23 Pa. C.S.A. §1103</td>
</tr>
<tr>
<td><strong>Rhode Island</strong>&lt;br&gt;Federal &amp; State Tax-exempt</td>
<td>Common Law Marriage&lt;br&gt;Souza v. O’Hara, 121 R.I. 88, 395 A.2d 1060 (1978)</td>
<td>Common Law Marriage&lt;br&gt;1. Both parties have the capacity to consent to marriage;&lt;br&gt;2. Both parties seriously intend to enter into a husband and wife relationship;&lt;br&gt;3. Both parties have conducted themselves in such a way that would lead the community to believe they were married.&lt;br&gt;4. The parties are not related by blood to a degree that would prevent ceremonial marriage under Rhode Island law; and&lt;br&gt;5. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person.</td>
</tr>
<tr>
<td><strong>Federal &amp; State Tax-exempt</strong></td>
<td>Civil Union*&lt;br&gt;Gen. laws 1936 § 15 (repealed)</td>
<td>Civil Union&lt;br&gt;Provide valid State documentation to Human Resources.&lt;br&gt;*Civil unions are no longer available as of August 1, 2013, when the bill legalizing same-sex marriage took effect, but existing civil unions are still recognized.</td>
</tr>
<tr>
<td><strong>South Carolina</strong>&lt;br&gt;Federal &amp; State Tax-exempt</td>
<td>Common Law Marriage&lt;br&gt;SC ST §20-1-30</td>
<td>Common Law Marriage&lt;br&gt;1. Both parties have the capacity to consent to marriage;&lt;br&gt;2. Both parties must intend to enter into a marriage contract.</td>
</tr>
<tr>
<td><strong>Texas</strong>&lt;br&gt;Federal &amp; State Tax-exempt</td>
<td>Informal Marriage (Common Law Marriage)&lt;br&gt;V.T.C.A. Family Code 2.401</td>
<td>Informal Marriage (Common Law Marriage)&lt;br&gt;1. Both parties have the capacity to consent to marriage;&lt;br&gt;2. Both parties have agreed to be married;&lt;br&gt;3. The parties have lived together in Texas after the agreement;&lt;br&gt;4. Both parties have represented to other that they were married;&lt;br&gt;5. The parties are not related by blood to a degree that would prevent ceremonial marriage under Texas law; and&lt;br&gt;6. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person.</td>
</tr>
<tr>
<td>State and Taxation of Benefits</td>
<td>Qualified Relationship Type</td>
<td>Must Meet All Requirements Below and Provide Dependent Verification Documents</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Utah**  
Taxed both State & Federal | **Common Law Marriage**  
U.C.A. 1953 § 30-1-4.5 | **Common Law Marriage**  
1. Both parties have the capacity to consent to marriage;  
2. Both parties have agreed to be married;  
3. The parties have lived together in Utah after the agreement;  
4. Both parties treat each other as though they were married;  
5. Both parties present each other to the public as if they were married;  
6. Both parties are married only to each other and are not in any other similar relationship such as a ceremonial marriage, civil union, or domestic partnership with any other person;  
7. The parties are not related by blood to a degree that would prevent ceremonial marriage under Utah law; and  
8. The parties have obtained a judicial declaration of marriage from a Utah court. |
| **Washington**  
No State Tax, Taxed Federal | **Domestic Partnership**  
West's RWCA 26.60.020 | **Domestic Partnership**  
1. Both parties are in a domestic partnership only with each other and are not in any other similar relationship such as a marriage or civil union with any other person;  
2. Both parties are over eighteen (18) years of age;  
3. Neither party is related by blood to the other party to a degree that would prohibit marriage under Washington law;  
4. Both parties share a common residence; and  
5. Both parties are of the same sex or at least one of the parties is at least sixty-two (62) years of age.  
*Many domestic partnerships will be converted to or treated as marriages, but Washington will continue to permit some state registered domestic partnerships, such as where one of the domestic partners is age 62 or older. |
| **Wisconsin**  
Taxed both Federal & State | **Domestic Partnership**  
W.S.A. 770.05 | **Domestic Partnership**  
1. Both parties have filed a Declaration of Domestic Partnership with the county clerk;  
2. Both parties are in a domestic partnership only with each other and are not in any other similar relationship such as a marriage or civil union with any other person;  
3. Both parties are over eighteen (18) years of age;  
4. Neither party is related by blood to the other party to a degree that would prohibit marriage under Wisconsin law;  
5. Both parties share a common residence; and  
6. Both parties are of the same sex. |

As of July 1, 2015

Please contact Human Resources if you have any questions pertaining to the taxation of employee benefits.
HEALTH FITNESS CORPORATION’S COMMITMENT TO PROTECTING EMPLOYEE’S PRIVACY

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

Employees do not need to respond to this notice in any way.

HEALTH FITNESS CORPORATION’S RESPONSIBILITIES AND PRIVACY COMMITMENT

Health Fitness Corporation understands the importance of protecting an employee’s private information. Health Fitness Corporation’s highest priority is to maintain an employee’s trust and confidence. Health Fitness Corporation will maintain its commitment to safeguarding employees’ information now and in the future.

Health Fitness Corporation is required by law to:

- Maintain the privacy of employees’ personal information.
- Provide each employee with certain rights with respect to his or her personal information.
- Provide each employee with a copy of this Notice of Health Fitness Corporation’s legal duties and privacy practices with respect to employees’ personal information.
- Follow the terms of the Notice that is currently in effect.

Health Fitness Corporation is guided by their respect for the confidentiality of their employees’ personal information. Health Fitness Corporation is providing the employees with this notice in accordance with privacy laws and because they want their employees to know that they value their employee’s privacy.

INFORMATION HEALTH FITNESS CORPORATION COLLECTS

Personal Information is any information Health Fitness Corporation obtains about their employees in the course of issuing insurance and/or providing services. The information they may obtain includes, but is not limited to, the employees’ past, present, or future physical or mental health or condition, the provision of health care to the employees, payment for the provision of health care to the employees, the employees’ Social Security number, employment history, credit history, income information, and bank or credit card information.

Health Fitness Corporation obtains this information from several sources, including but not limited to applications or other forms the employees complete, the employees’ business dealings with Health Fitness Corporation and other companies, and consumer reporting agencies.

HEALTH FITNESS CORPORATION’S PRIVACY AND SECURITY PROCEDURES

The individuals who have access to this information are those who must have it to provide plan services to the employees. Below are some examples of Health Fitness Corporation’s guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.
- Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to the insureds of Health Fitness Corporation.
- Health Fitness Corporation business associates use information only for the purpose provided. Business associates sign a contract agreeing to follow the privacy procedures of Health Fitness Corporation.
INFORMATION HEALTH FITNESS CORPORATION DISCLOSES

Health Fitness Corporation will not disclose any Personal Information about an employee, except as allowed by law, including the Fair Credit Reporting Act. Health Fitness Corporation may share all of the information they collect with insurance companies, agents, companies that help them conduct their insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times Health Fitness Corporation may share information for business purposes.

- Underwriting;
- Premium rating;
- Submitting claims;
- Reinsuring risk;
- Assessing quality;
- Business management and planning; and
- Sales, transfer, merger or consolidation of the business.

An employee’s information may also be shared:

- For purposes of treatment, payment, and operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.
- With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with an insurance issue.
- In response to an administrative or judicial order, including a search warrant or subpoena.
- With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, discuss drug and disease management approaches, and other purposes permitted or required by law.
- To conduct actuarial or research studies. In this case, individuals are not identified in the research report. Material identifying an individual is destroyed as soon as it is no longer needed.
- With Health Fitness Corporation business associates for use in auditing services or operations, auditing marketing services, performing various functions on the behalf of Health Fitness Corporation, or to provide certain services.
- With a group policyholder for reporting claims experience, or for conducting an audit of Health Fitness Corporation operations or services.
- To consult with outside health care providers, consultants and attorneys, and other health related services.
- As otherwise permitted or required by law.

Health Fitness Corporation requires those with whom they share information to implement appropriate safeguards regarding employees’ Personal Information, as they are also governed by the federal privacy and security law. Health Fitness Corporation shares only that which is minimally necessary to accomplish a task. Information that Health Fitness Corporation gets from a report made by a company that assists Health Fitness Corporation conduct insurance business may be retained by that company and used for other purposes.

An employee’s written authorization is required for uses and disclosures of Personal Information for purposes other than those described above. Health Fitness Corporation will not sell an employee’s Personal Information without obtaining the employee’s written authorization to do so. If an employee provides Health Fitness Corporation authorization to use or disclose Personal Information, an employee may revoke that authorization, in writing, at any time. If an employee revokes authorization, Health Fitness Corporation will no longer use or disclose information for the specific purpose contained in the authorization. Health Fitness Corporation is required to retain any records they may have containing an employee’s Personal Information for the periods specified in document retention laws. If an employee revokes authorization for payment or health care operations, an employee may jeopardize the administration of the benefits under his or her health plan.
CONTINUATION COVERAGE RIGHTS UNDER COBRA
FOR EMPLOYEES AND (THEIR DEPENDENTS)
OF HEALTH FITNESS CORPORATION

Introduction:

Employees receive this notice when they become covered under the Health Fitness Corporation Employee Medical Benefit Plan (the Plan). This notice contains important information about the employee’s rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This Notice generally explains COBRA continuation coverage, when it may become available to an employee and his or her family and what the employee needs to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to the employee and to other members of his or her family who are covered under the Plan when the employee would otherwise lose his or her group health coverage. It can also become available to other members of his or her family who are covered under the Plan when they would otherwise lose their group health coverage. This Notice gives only a summary of the employee’s COBRA continuation coverage rights. For more information about the employee’s rights and obligations under the Plan and under federal law, refer to the Continuation of Coverage section of this Plan Document.

COBRA continuation coverage for the plan is administered by CoreSource. Questions may be directed to the CoreSource COBRA Team at 5200 77 Center Drive, Suite 400, Charlotte, NC 28217-0718, Phone 866-433-0318.

What is COBRA Continuation Coverage?:

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a “qualifying event”. Specific qualifying events are listed later in the notice. After a qualifying event, COBRA must be offered to each person who is a “qualified beneficiary”. The employee, the employee’s spouse, and the employee’s dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. Under the plan, qualified beneficiaries who elect COBRA must pay for COBRA continuation coverage.

A covered employee will become a qualified beneficiary if he or she loses coverage under the Plan because either one of the following qualified events happens:

1. The employee’s hours of employment are reduced, or 
2. The employee’s employment ends for any reason other than his or her gross misconduct.

A covered spouse of an employee will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

1. The employee dies;
2. The employee’s hours of employment are reduced;
3. The employee’s employment ends for any reason other than his or her gross misconduct;
4. The spouse becomes entitled to Medicare (Part A, Part B or both); or
5. The spouse becomes divorced or legally separated from the employee.

A covered dependent child will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee’s hours of employment are reduced;
3. The parent-employee’s employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a “dependent child”.

Sometimes, in the case of retiree health coverage, filing a proceeding in bankruptcy under Title 11 of the US Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Health Fitness Corporation, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries is bankruptcy results in the loss of their coverage under the Plan.

The Employee Must Give Notice of Some Qualifying Events

For the qualifying events of divorce or separation, or a dependent child losing his dependent status under the plan, the employee must notify the Plan Administrator. The Plan requires the employee to notify the Plan Administrator within 60 days after a qualifying event occurs. The employee must send this notice to Health Fitness Corporation, Attn: Human Resources, 1700 West 82nd Street, Suite 200, Minneapolis, MN 55431 and provide documentation to support the qualifying event.
In order to produce a symmetrical appearance, for any participant or beneficiary of the Plan who receives plan benefits for a mastectomy.

The Plan will also provide coverage for any necessary surgery or reconstruction of the breast on which a mastectomy was not performed in order to produce a symmetrical appearance, for any participant or beneficiary of the Plan who receives plan benefits for a mastectomy.

Coverage for such surgery or reconstruction will be subject to the same deductibles and copayments that apply to mastectomies under the terms of the Plan.

Contact the claims processor for medical claims at 877-367-5690 for more information.

Questions Concerning COBRA

If an employee has questions about COBRA continuation coverage, the employee should contact Health Fitness Corporation, Attn: Human Resources, 1700 West 82nd Street, Suite 200, Minneapolis, MN 55431, or the employee may contact the nearest Regional or District Office of the US Department of Labor’s Employee Benefits Security Administration (ESBA).

Addresses and phone numbers or Regional and District ESBA Offices are available through ESBA’s website at www.dol.gov/esa.

Keep The Plan Informed of Address Changes

In order to protect his or her family’s rights, the employee should keep the Plan Administrator informed of any changes in the addresses of the family members. The employee should also keep a copy for his or her records, of any notices the employee sends to the Plan Administrator.

WOMEN’S HEALTH AND CANCER RIGHTS ACT

In compliance with the Women’s Health and Cancer Rights Act of 1998, this Group Health Plan provides coverage for mastectomy-related services, including the procedures necessary to effect reconstruction of the breast on which a mastectomy was performed, the cost of prostheses as well as physical complications of all stages of mastectomy, including lymphedemas, as maybe recommended by an attending physician of any patient on whom a mastectomy has been performed.

The Plan will also provide coverage for any necessary surgery or reconstruction of the breast on which a mastectomy was not performed in order to produce a symmetrical appearance, for any participant or beneficiary of the Plan who receives plan benefits for a mastectomy.

Coverage for such surgery or reconstruction will be subject to the same deductibles and copayments that apply to mastectomies under the terms of the Plan.

Contact the claims processor for medical claims at 877-367-5690 for more information.
MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)
OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If the employee is eligible for health coverage from his employer, but is unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If the employee or his dependents are already enrolled in Medicaid or CHIP and the employee lives in a State listed below, the employee can contact his State Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that the employee or his dependents are eligible for premium assistance under Medicaid or CHIP, the employer’s health plan is required to permit the employee and his dependents to enroll in the plan – as long as the employee and his dependents are eligible, but not already enrolled in the employer’s plan. This is called a “special enrollment” opportunity, and the employee must request coverage within 60 days of being determined eligible for premium assistance.

If the employee lives in one of the following States, the employee may be eligible for assistance paying employer health plan premiums. The following list of States is current as of January 31, 2011. The employee should contact his State for further information on eligibility –

**ALABAMA** – Medicaid  
Website: http://www.medicaid.alabama.gov  
Phone: 1-800-362-1504

**ALASKA** – Medicaid  
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/  
Phone (Outside of Anchorage): 1-888-318-8890  
Phone (Anchorage): 907-269-6529

**ARIZONA** – CHIP  
Website: http://www.azahcccs.gov/applicants/default.aspx  
Phone (Outside of Maricopa County): 1-877-764-5437  
Phone (Maricopa County): 602-417-5437

**ARKANSAS** – CHIP  
Website: http://www.arkidsfirst.com/  
Phone: 1-888-474-8275

**CALIFORNIA** – Medicaid  
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx  
Phone: 1-866-298-8443

**COLORADO** – Medicaid and CHIP  
Medicaid Website: http://www.colorado.gov/  
Medicaid Phone (In state): 1-800-866-3513  
Medicaid Phone (Out of state): 1-800-221-3943  
CHIP Website: http://www.CHPplus.org  
CHIP Phone: 303-866-3243

**FLORIDA** – Medicaid  
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml  
Phone: 1-877-357-3268

**GEORGIA** – Medicaid  
Website: http://dch.georgia.gov/  
Click on Programs, then Medicaid  
Phone: 1-800-869-1150

**IDAHO** – Medicaid and CHIP  
Medicaid Website: www.accesstohealthinsurance.idaho.gov  
Medicaid Phone: 1-800-926-2588  
CHIP Website: www.medicaid.idaho.gov  
CHIP Phone: 1-800-926-2588

**INDIANA** – Medicaid  
Website: http://www.in.gov/fssa  
Phone: 1-800-889-9948

**IOWA** – Medicaid  
Website: www.dhs.state.ia.us/hipp/  
Phone: 1-888-346-9562

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

**KENTUCKY** – Medicaid  
Website: http://chfs.ky.gov/dms/default.htm  
Phone: 1-800-635-2570

**LOUISIANA** – Medicaid  
Website: http://www.lahipp.dhh.louisiana.gov  
Phone: 1-888-342-6207

**MAINE** – Medicaid  
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html  
Phone: 1-800-321-5557

**MASSACHUSETTS** – Medicaid and CHIP  
Medicaid & CHIP Website: http://www.mass.gov/MassHealth  
Medicaid & CHIP Phone: 1-800-462-1120

**MINNESOTA** – Medicaid  
Website: http://www.dhs.state.mn.us/  
Click on Health Care, then Medical Assistance  
Phone (Outside of Twin City area): 800-657-3739  
Phone (Twin City area): 651-431-2670
MISSOURI – Medicaid  
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm  
Phone: 573-751-2005

MONTANA – Medicaid  
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml  
Phone: 1-800-694-3084

NEBRASKA – Medicaid  
Website: http://www.dhhs.ne.gov/medic/index.htm  
Phone: 1-877-255-3092

NEVADA – Medicaid and CHIP  
Medicaid Website: http://dwss.nv.gov/  
Medicaid Phone: 1-800-992-0900  
CHIP Website: http://www.nevadacheckup.nv.org/  
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – Medicaid  
Website: www.dhhs.nh.gov/ombp/index.htm  
Phone: 603-271-4238

NEW JERSEY – Medicaid and CHIP  
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/  
Medicaid Phone: 1-800-356-1561  
CHIP Website: http://www.njfamilycare.org/index.html  
CHIP Phone: 1-800-701-0710

NEW MEXICO – Medicaid and CHIP  
Website: http://www.hsd.state.nm.us/mad/index.html  
Medicaid Phone: 1-888-997-2583  
CHIP Website: http://www.hsd.state.nm.us/mad/index.html  
Click on Insure New Mexico  
CHIP Phone: 1-888-997-2583

NEW YORK – Medicaid  
Website: http://www.nyhealth.gov/health_care/medicaid/  
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid  
Website: http://www.nc.gov  
Phone: 919-855-4100

NORTH DAKOTA – Medicaid  
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/  
Phone: 1-800-755-2604

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

OREGON – Medicaid and CHIP  
Medicaid & CHIP Website: http://www.oregonhealthykids.gov  
Medicaid & CHIP Phone: 1-877-314-5678

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
www.dol.gov/ebsa

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
1-866-444-EBSA (3272) 1-877-267-2323, Ext. 61565

Pennsylvania – Medicaid  
Website: http://www.dpw.state.pa.us/partnersproviders/medicalassistant/doingbusiness/003670053.htm  
Phone: 1-800-644-7730

Rhode Island – Medicaid  
Website: www.dhs.ri.gov  
Phone: 401-462-5300

South Carolina – Medicaid  
Website: http://www.scdhhs.gov  
Phone: 1-888-549-0820

Texas – Medicaid  
Website: https://www.gethipptexas.com/  
Phone: 1-800-440-0493

Utah – Medicaid  
Website: http://health.utah.gov/upp  
Phone: 1-866-435-7414

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

Virginia – Medicaid and CHIP  
Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm  
Medicaid Phone: 1-800-432-5924  
CHIP Website: http://www.famis.org/  
CHIP Phone: 1-866-873-2647

Washington – Medicaid  
Website: http://hrsa.dshs.wa.gov/premiumpyt/Apply.shtm  
Phone: 1-800-562-3022 ext. 15473

West Virginia – Medicaid  
Website: http://www.wvrecovery.com/hipp.htm  
Phone: 304-342-1604

Wisconsin – Medicaid  
Website: http://www.badgercareplus.org/pubs/p-10095.htm  
Phone: 1-800-362-3002

Wyoming – Medicaid  
Website: http://www.health.wyo.gov/healthcarefin/index.html  
Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
Employee Benefits Security Administration  
www.dol.gov/ebsa

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
www.cms.hhs.gov  
1-866-444-EBSA (3272) 1-877-267-2323, Ext. 61565
New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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 and employment-based health coverage offered by your employer.

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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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 any other members of your family) is more than 9.5% 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.¹

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 employee 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 The Health Fitness Benefits Team at 952-897-5246 or benefits@hft.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, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ 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.
PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Fitness Corporation</td>
<td>41-1580506</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1700 West 82nd Street, Suite 200</td>
<td>952-897-5246</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minneapolis</td>
<td>MN</td>
<td>55431</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?
    The Health Fitness Benefit Team

11. Phone number (if different from above) | 12. Email address
   benefits@hfit.com

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  □ All employees. Eligible employees are:

  □ Some employees. Eligible employees are:
    - Regular Full Time Associates working 30 or more hours per week
    - Associates who qualify under PPACA, averaging 30 hours per week over a 12-month measured period.

- With respect to dependents:
  □ We do offer coverage. Eligible dependents are:
    Associate's Legal Spouse, Qualified Partner (with appropriate documentation), children under the age of 26 and dependent children who have reached age limit who are incapacitated, unable to support themselves and living with the associate.
  □ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here’s the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.
Important Notice

This booklet provides an overview of your benefits choices and is not intended to be all-inclusive. The terms and conditions stated in this booklet provide an overview of benefits and are not intended to be contractual. To the extent permitted by law, these benefits may be changed or terminated by the company at any time and for any reason. Premiums, if any, may also be changed at any time.