Healthy and Wise

Trustmark Companies Well-being Program

My Health and Wellness Benefits: 2018

for HealthFitness Regular, Full-Time Associates based in the United States

Helping people increase wellbeing through better health and greater financial security.

OPEN ENROLLMENT for 2018

A Message from CEO Joe Pray

Welcome to our 2018 benefits open enrollment. Please set aside ample time to review this benefits booklet as you make these important benefit elections.

Improvements to Benefits Plans

It is important that we offer competitive benefits to all our associates. We routinely review our benefit plans and change them when it makes sense to do so. We balance competitiveness with the impact to associates and the company when making these decisions. As a result of this review, we are changing the Short-Term Disability plan so we will provide the same benefit to eligible associates across the enterprise. For you, it means a shorter waiting period until Short-Term Disability benefits begin.

In addition, Trustmark's contribution to your health savings account (HSA) will be fully funded in January rather than deposited in installments throughout the year. Trustmark contributes $500 to your HSA if you have Employee Only coverage or $1,000 if you have Spouse, Children or Family coverage.

No Increase in Medical Plan Contributions for 2018

I'm also pleased to share that you will not see an increase in medical plan premiums next year.

Tools to Help You Make Cost-Effective Benefits Choices

Please continue to do all you can to make wise healthcare choices and take advantage of tools we've introduced to help in that effort. The transition to consumer-directed health plans helps us better understand the real cost of healthcare. We've introduced transparency tools, like the healthcare shopping tool Castlight, so you can compare the cost of services from different providers. We've also launched Teladoc so you can visit a doctor by phone or the web for a $45 fee. And we've offered webinars and online courses, which many of you have participated in and learned from.

Clearly, we're already doing many of the right things, and there's always more we can do. We will continue offering ways to expand your knowledge. Our three interactive courses, *Making Good Healthcare Choices, Understanding Your Prescription Benefits* and *The Ins and Outs of HSAs,* are available to take any time on the **Healthy and Wise** site.

We're also offering webinars during open enrollment that can help you consider whether this is a good time to revisit your benefit choices. Just because something worked for you in the past does not mean it's necessarily still the best solution. Webinar dates and times are listed on the following page.

I encourage you to use all the resources we provide to learn and make informed healthcare choices during open enrollment and throughout the year.

Be well,

Joe Pray
CEO, Trustmark Companies

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Take Action to Make Informed Choices

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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 and 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 **Healthy and Wise** and eCentral at: **http://eCentral.hfit.com**

Starting on Wednesday, Nov. 1, you can enroll on Workday to select your benefits. Your enrollment event is in your Workday inbox. **https://www.myworkday.com/trustmark/**

Important Dates

Make Your Enrollment Elections on Workday

Nov. 1-16

Remember, deadlines are firm and cannot be extended.

WEBINARS **Further your understanding and ask questions**

Attend an informational webinar to learn about changes for 2018, how to make informed decisions and how to best maximize the benefits and tools available to you, including HSAs, Castlight and preventive care benefits.

Each one-hour webinar includes a presentation and Q&A session. All webinars are Central time.

Monday, Oct. 23	1 p.m. – 2 p.m.
Thursday, Nov. 2	9 a.m – 10 a.m.
Tuesday, Nov. 7	11 a.m. – 12 p.m.
Friday, Nov. 10	10 a.m. – 11 a.m.

Information to access webinars:

https://trustmarkins.globalmeet.com/MelodyCanak

USA: 1-719-359-9722

Guest Passcode: 750474

Make your elections on Workday no later than 11:59 p.m. Eastern time on Thursday, Nov. 16.

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 eCentral 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 29, and on eCentral. The deadline to complete your health statement is Nov. 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 24 for more information.

What's New in 2018

Premiums Taken in 26 Deductions Instead of 24
Starting in 2018, premium deductions for medical, dental, vision, life and disability coverage, and FSA and HSA contributions will be taken from each of your 26 paychecks, rather than from 24 paychecks. The annual premium you pay has been divided by 26 rather than 24. Commuter benefits will continue to come out of 24 paychecks. Please review the new premium charts in this booklet for additional details.

Short-Term and Long-Term Disability
The Short-Term Disability plan will be changed to provide the same benefit to eligible associates across the enterprise. The STD plan will provide a benefit of 60 percent of weekly base salary for up to 120 days following a one-week waiting period. Long-Term Disability benefits begin after 120 days of continuous disability. The LTD plan you select this open enrollment cannot be changed going forward. Please read the instructions on page 30 before making your selection.

PPO Network Change for Minnesota
Starting in 2018, the Preferred One PPO network which serves Minnesota will be part of Aetna Signature Administrators (ASA) network. Associates and their covered family members will access Preferred One providers through ASA network and no longer utilize the stand-alone Preferred One network. Associates in Minnesota will receive new medical ID cards with the Aetna Signature Administrators logo.

HSA Contributions
Trustmark's contribution to your health savings account (HSA) account will be fully funded in January, rather than deposited in installments throughout the year. Trustmark will contribute $500 to your HSA if you have Employee Only coverage or $1,000 if you have Spouse, Children or Family coverage. The maximum of all contributions (yours and the company's) in 2018 cannot exceed $3,450 for individual coverage and $6,900 for family coverage.

An HSA provides a "triple tax benefit" while allowing account owners to pay for current healthcare expenses and save for those in the future. Its first advantage is that contributions are tax-deductible (or pretax if you use payroll deduction). Second, the interest earned is tax-free. Third, account owners may make tax-free withdrawals for qualified medical expenses.

Healthcare FSA Maximum Contribution
The flexible spending account (FSA) maximum contribution for healthcare expenses will increase to $2,600 in 2018. If you are contributing the maximum to your HSA and are still seeking additional tax savings for qualified healthcare expenses, the FSA may be right for you. If you are eligible to contribute or you are receiving employer contributions to your HSA, you may only enroll in the Limited Healthcare FSA plan, which is described on page 24. If you are covered by an HSA plan, please be certain to select Limited Healthcare FSA when enrolling in Workday.

New FSA Administrator
CoreSource will be the new administrator for healthcare and dependent care flexible spending accounts (FSA), replacing TASC. See details starting on page 24. Healthcare FSA participants will receive a new stored-value card to access monies in their healthcare FSA account.

New CoreSource Customer Service Number
The phone number for CoreSource Customer Service is changing to (877) 367-5690.

Voluntary Benefits Enrollment
Trustmark Voluntary Benefit Solutions will hold its annual employee enrollment for Universal Life, Universal LifeEvents®, Critical LifeEvents® and Accident insurance during open enrollment. See the following page for information.

ONLINE COURSES — Better understand your plan options

Make plans to take these interactive online courses available on the Healthy and Wise site:

The Ins and Outs of HSAs
Helps you understand what an HSA is, what advantages it offers and how it works with a high deductible health plan.

Understanding Your Prescription Benefits
Outlines the prescription drug coverage and how to make the most of your pharmacy benefits.

Making Good Healthcare Choices
Explains how the choices you make are critical to your healthcare.

Learn about your available benefits offered by **Voluntary Benefit Solutions**

The Trustmark Companies is excited to announce the 2018 enrollment for HealthFitness associates. We are pleased to offer you a special opportunity to enroll in our voluntary benefits plans offered by Voluntary Benefit Solutions. These plans can provide you and your family with additional financial protection and help you meet your long-term financial goals.

As a HealthFitness associate you may be able to enroll yourself and your family with limited underwriting questions. **Every associate who speaks with a benefit counselor will have a chance to win a Target gift card.**

Benefit counselor meetings will be conducted over the telephone. Choose a time that is convenient for you; the meetings should take approximately 10-15 minutes. These meetings are not mandatory, however everyone is encouraged to schedule a meeting today!

Product Offerings

The following plans are offered to HealthFitness associates this year.

- **Universal Life (UL) and Universal LifeEvents® (ULE):** life insurance products that offer two benefits in one policy: permanent life insurance and living benefits for long-term care. Read about Life Insurance Myth vs. Fact.
- **Accident:** helps with the cost of unexpected bills related to accidents that occur any day. Benefits for initial care, injuries and follow-up care. Read about how Accident Insurance is your financial cushion.
- **Critical LifeEvents® (CLE):** provides tiered cash benefits for both early identification and late-stage diagnosis of critical illnesses like cancer, heart attack and stroke. Benefit replenishes each year.

Click here to learn more about these plans and how they can work for you.

Attend a webinar to learn about the Voluntary Benefit Solutions plans and ask questions.

There will also be two half-hour webinars to give associates an opportunity to learn about the plans and ask questions. They will be held Oct. 25 and Oct. 31. You can use the links below to attend a webinar.

Wednesday, Oct. 25 – 12:30 to 1:00 p.m. CT

Tuesday, Oct. 31 – 12:30 to 1:00 p.m. CT

Top 4 Reasons to Schedule a Telephonic Meeting

1. As a HealthFitness associate, you're eligible for financial protection for you and your family at special discount rates.
2. Premiums are based on your initial issue age and do not increase as you age. The younger you are when you purchase UL, ULE and/or CLE coverage, the more benefit you will receive for the same premium. Take advantage of your buying power!
3. Associates can schedule one-on-one phone calls with a benefits counselor at a time that is convenient for you.
4. Learn more about the products Trustmark offers its customers and be entered in the raffle to win a Target gift card!

Schedule your benefits call TODAY!
Click on this link or call:
1-866-998-2915

You care. We listen.

Trustmark
Voluntary Benefit Solutions®
PERSONAL. FLEXIBLE. TRUSTED.®
Underwritten by Trustmark Insurance Company

Health and Well-Being Program Eligibility

Associates working 30 or more hours

Medical	Disability
Dental	Employee Assistance Program
Vision	Be Your Best Self Health Improvement Program
Health Savings Account (HSA)	*My*Nurse 24/7
Flexible Spending Account (FSA)	401(k) - including part-time associates. See page 11 for eligibility.
Life Insurance	

Associates who are newly eligible for benefits have a waiting period prior to the coverage start date. All benefits, with the exception of the Short-Term Disability and Long-Term Disability plans, begin on the first day of the month following date of hire or rehire. The Short-Term Disability and Long-Term Disability plans have a 3-month waiting period.

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, 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 eCentral.

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 31.

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 31 and send to Julie Pierce, Benefits HR.

Contact Julie at **julie.pierce@trustmarkins.com** if you have questions.

FORMS

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

- Attestation of Qualified Partnership
- FSA Direct Deposit Form
- FSA Reimbursement Claim Form
- FSA Annualized Dependent Care Reimbursement Form

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 Julie Pierce at **julie.pierce@trustmarkins.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 Julie Pierce, Benefits HR.

Contact Julie at julie.pierce@trustmarkins.com if you have questions.

Health and Well-Being Programs

myCoreSource.com

myCoreSource.com is your online portal to personal information about your medical and dental benefits and flexible spending accounts. First-time users should register online at **myCoreSource.com** to start accessing your data. Visit the site 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 information 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) 367-5690 for login issues.

SIMPLICITY® Simplifying Healthcare Payments

As part of your benefits, you have access to Simplicity, a unique financial healthcare benefit. Simplicity pays your portion of your medical expenses on your behalf. This means that instead of getting bills from multiple providers, you'll get one consolidated monthly statement, similar to a credit card statement. And to make it even simpler for you to manage your medical expenses, you may pay your statement in full or spread out the payments over 12 months.

Activate Simplicity during open enrollment as part of your annual enrollment choices to get:

- One consolidated monthly healthcare bill
- Flexible payment options, with a manageable minimum payment due and 0 percent interest
- The ability to earn up to 5 percent in rewards to be used on future payments
- Confidence in accurate billing and a designated advocate if needed.

MyNurse 24/7

MyNurse 24/7 is a free, confidential service that provides access to a registered nurse any time of the day or night. Call **(866) 366-6877** toll-free 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; and education on health conditions diagnosed by a physician.

TELADOC. Associates and their covered dependents 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 is $45. Associates pay the fee upfront and Teladoc will submit the claim to CoreSource.

castlight HEALTH

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.

Qualified searches on Castlight earn you rewards points toward a medical premium discount.

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.

Health Improvement Program

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 open to all benefits-eligible employees. Through the Be Your Best Self program, you can learn how to minimize your personal health risks.

Participation in wellness programs in 2017 earned points toward your wellness incentive in 2018. Program information for 2018 will be available in the first quarter.

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.

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.

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.

MoneySteps℠ Financial Wellbeing Program

MoneySteps℠ is a program available to you at no cost that can support you in taking control of your personal finances to achieve financial wellbeing. Associates can gain both knowledge and support for personal finance issues ranging from basic topics like budgeting and saving through more complex areas like investing and preparing for retirement.

MoneySteps includes:

- Access to educational materials and financial tools/calculators at a secure website, **www.financialwellbeing.com**
- Financial coaches who will support you in setting and achieving financial goals that are relevant to you, and
- Monthly newsletters, webinars, and other program events.

Associates can engage with their financial coach via the website or by calling **1.877.230.0899**.

For general questions or help in getting started with the program, call **1.877.230.0899** or email **help@financialwellbeing.com**.

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 Morneau Shepell whenever you experience personal problems of any kind, whether or not they are affecting your job performance.

A master's level Member Advocate 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 **(888) 293-6948**.

Online access is available at **workhealthlife.com/Standard6**. 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.

Life Services Toolkit
Your EAP plan provides online services that can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

Services to help you now:

- Estate planning assistance
- Financial planning
- Health and wellness
- Identity theft prevention
- Funeral arrangements

Services for your beneficiary:

- Grief support
- Legal services
- Financial assistance
- Support services
- Online resources

Learn more by viewing the Life Services Toolkit flyer on the Virtual Water Cooler under My Benefits.

Liberty Mutual Home and Auto Discounts

Liberty Mutual has partnered with Trustmark Companies to offer employees special savings on quality auto and home insurance.[1] And with benefits such as Multi-Policy Discount, Personal Property Replacement[2], and 24-Hour Claims Assistance, you'll worry less and save more. You can also sign up for payroll deduction, and your Liberty Mutual Insurance monthly premium will be automatically deducted from your paycheck.[3] Employees can call Liberty Mutual at **800-699-5298** for a no-obligation rate quote year-round.

For online quotes, HealthFitness associates can visit **www.libertymutual.com/healthfitness**.

[1] Discounts and savings are available where state laws and regulations allow, and may vary by state. Certain discounts apply to specific coverages only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify.
[2] Optional coverage.
[3] Payroll deduction available only through employer affinity groups.

Commuter Benefits: Use Tax-Free Money to Pay for Mass Transit and Parking

Do you know you can use pretax money to pay the costs of commuting to work via mass transit and to pay parking fees at work? With Commuter Benefits through HSA Bank, you can make tax-free payroll deductions, up to the IRS limits, to cover various modes of mass transit and parking expenses. Contributions are deducted from your pay before taxes, which can mean substantial tax savings. This program is open to all regular full-time and part-time associates in any location (as well as on-call workers in San Francisco, New York and DC) who commute to work for the Trustmark Companies. Enrollees must also receive a regular paycheck allowing for this deduction.

Use Commuter Benefits to pay for:

Mass Transit - Mass Transit accounts cover eligible workplace mass transit expenses such as tickets, vouchers and passes to ride a subway, train, bus, vanpool or ferry.

Parking - Parking accounts enable you to pay for eligible workspace parking expenses, parking costs at or near your primary work site, as well as parking costs at the place where you access transportation to work, such as a train station or vanpool stop.

How Commuter Benefits Work

The IRS sets the maximum monthly pre-tax deductions. These limits reflect the maximum allowed pre-tax contribution and reimbursement amounts per calendar month in 2017:

Mass Transit maximum: $255 per month

Parking maximum: $255 per month

Deductions will occur two times per month. Your election amount will be divided by 2 to get the per pay deduction.

How to Enroll

Determine how much you want to contribute to your Commuter Benefits accounts and then follow these steps to enroll through Workday.

- **You must enter enrollment in Workday by the 10th of the month for coverage in the following month.** This allows time for processing and, if necessary, distribution of an HSA Bank card to use for mass transit purchases.
- Click on the **Benefits** icon and then **Change Benefits**. **Select the Change Commuter Benefits event reason and enter the 1st of the following month so deductions begin on the 1st check of the following month for all months except January.** For example, if you enroll by Nov. 10 using an effective date of Dec. 1, your election would be available for use on Dec. 1 via your HSA Bank card. For January enrollment use Jan. 2 as the effective date.
- Once your event is created, click on Open box to enter your election. Select **Elect to enroll in Mass Transit and/or Parking**. Divide your monthly election in half and enter this amount in the Amount box. Your election must be between $0 and $127.50.
- You can change your monthly election as needed as long as you enter your new election by the 10th of the month for coverage in the following month. The effective date will always be the 1st of the month. Contact Benefits if you have questions about entering your enrollment in Workday.

Paying for your Commuter Expenses

Mass Transit – You must use your HSA Bank card to pay for your transit pass. Reimbursement from your Commuter Benefits account is not available if you use another form of payment. You may not use your pre-tax benefit for expenses incurred prior to enrollment in the plan. It is recommended that you contribute only what is needed to pay for transit expenses each month but unused balances will carry over to the following year.

Parking – You can use your HSA Bank card for eligible parking expenses, or you can use another form of payment to pay for parking and seek reimbursement within 180 days with a paper claim form.

If you already have an HSA Bank card, you can use the card you already have. If you do not, you will be issued an HSA Bank card after your enrollment in Workday.

View your account information online at **https://myaccounts.hsabank.com** or download the HSA Bank Mobile App. Contact Melody Canak at **melody.canak@trustmarkins.com** or Julie Pierce at **julie.pierce@trustmarkins.com** if you have questions.

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! Learn more about your retirement plan on the **Healthy & Wise site**.

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
- 5-year graduated vesting schedule on company match.
- 401(k) contribution maximum is $18,000, $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 a day, 7 days a 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 two consecutive pay periods

How to Enroll

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

Fidelity Website: www.401k.com

Fidelity Retirement Benefits Line: (800) 835-5091

2018 Medical Plans at a Glance

Premier 1500 HDHP Premier		Essential 2500 HDHP Essential		Balanced 4500 HDHP Balanced	
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 **$3,450** for Employee Only coverage or **$6,900** for family coverage.					
Deductible*: the amount of expenses that must be incurred by the participant before the plan pays at the coinsurance level.					
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
• **$1,500** deductible if you have Employee Only coverage • **$3,000** aggregate deductible if you have Spouse, Children or Family coverage	• **$3,000** deductible if you have Employee Only coverage • **$6,000** aggregate deductible if you have Spouse, Children or Family coverage	• **$2,500** deductible if you have Employee Only coverage • **$5,000** aggregate deductible if you have Spouse, Children or Family coverage	• **$5,000** deductible if you have Employee Only coverage • **$10,000** aggregate deductible if you have Spouse, Children or Family coverage	• **$4,500** deductible if you have Employee Only coverage • **$9,000** aggregate deductible if you have Spouse, Children or Family coverage	• **$6,350** deductible if you have Employee Only coverage • **$12,700** 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 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	• **$5,500** if you have Employee Only coverage • **$11,000** aggregate if you have Spouse, Children or Family coverage	• **$3,000** if you have Employee Only coverage • **$6,000** 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.					
• **$4,250** if you have Employee Only coverage • **$8,500** aggregate if you have Spouse, Children or Family coverage	• **$8,500** if you have Employee Only coverage • **$17,000** aggregate if you have Spouse, Children or Family coverage	• **$5,500** if you have Employee Only coverage • **$11,000** aggregate if you have Spouse, Children or Family coverage	• **$11,000** if you have Employee Only coverage • **$22,000** aggregate if you have Spouse, Children or Family coverage	• **$6,350** if you have Employee Only coverage • **$12,700** aggregate if you have Spouse, Children or Family coverage	• **Unlimited**
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.

2018 Medical Plans at a Glance

HDHP Premier 1500		HDHP Essential 2500		HDHP Balanced 4500	
Annual Preventive Care Including Well Child Care					
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
100% coverage of preventive care.	60% after deductible.	100% coverage of preventive care.	60% after deductible.	100% coverage of preventive care.	Not covered.
Office Visits/ Therapies/ Lab Services (excluding lab services for preventive care)					
Plan pays 80% after your deductible is met.	Plan pays 60% after your deductible is met.	Plan pays 80% after your deductible is met.	Plan pays 60% after your deductible is met.	Plan pays 70% after your deductible is met.	Plan pays 50% after your deductible is met.
Inpatient and Outpatient Care					
Plan pays 80% after your deductible is met.	Plan pays 60% after your deductible is met.	Plan pays 80% after your deductible is met.	Plan pays 60% after your deductible is met.	Plan pays 70% after your deductible is met.	Plan pays 50% after your deductible is met.
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 $45 fee upfront and Teladoc will submit the claim to CoreSource.					
Emergency Room Visits					
Plan pays 80% for emergency visits and 50% for non-emergency visits after your deductible is met.				Plan pays 70% for emergency visits and 50% for non-emergency visits after your deductible is met.	
Mental Health/Substance Abuse Services					
Plan pays 80% after your deductible is met.	Plan pays 60% after your deductible is met.	Plan pays 80% after your deductible is met.	Plan pays 60% after your deductible is met.	Plan pays 70% after your deductible is met.	Plan pays 50% after your deductible is met.
Prescription Drugs					
Preventive Drugs[1] (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 Drugs[1] (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	

[1] Drugs 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 eCentral 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.

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 18 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 Signature Administrators ASA preferred provider network, **www.aetna.com/asa**. 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.

***Your*Care**
*Your*Care maximizes your health potential by reminding you about preventive health screenings, and for those with chronic conditions, by reinforcing evidence-based standards of care. *Your*Care will send reminders for medically recommended preventive tests, such as a mammogram or colonoscopy. If you have one of nine chronic conditions, *Your*Care 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 **(866) 454-5376.**

Employee Claims and Customer Service Number
(877) 367-5690

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.

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 (HSA), better understand the true cost of care, and carry HSA account balances with them into retirement.

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 14 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.

- **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 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 **https://myaccounts.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.

- **Health Savings Account (HSA) Eligibility and Dual Coverage**
  To enjoy the benefits of the health savings account, participants may only be enrolled in another health plan if that coverage is also another qualified high deductible health plan. Non-qualifying health coverage for an HSA includes coverage under Medicare, coverage by the military, copay plans offered through a spouse, as well as others. Please notify the Benefits Specialist if you have dual coverage through another health plan that makes you ineligible for the health savings account.

  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.

- **Company Contribution to Your HSA Account**
  The company will contribute $500 to your HSA if you select Employee Only coverage or $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 $3,450 for individual and $6,900 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 22.

* *Tax-free from federal and most, but not all, state taxes. For more information, go to https://myaccounts.hsabank.com*

Deductibles

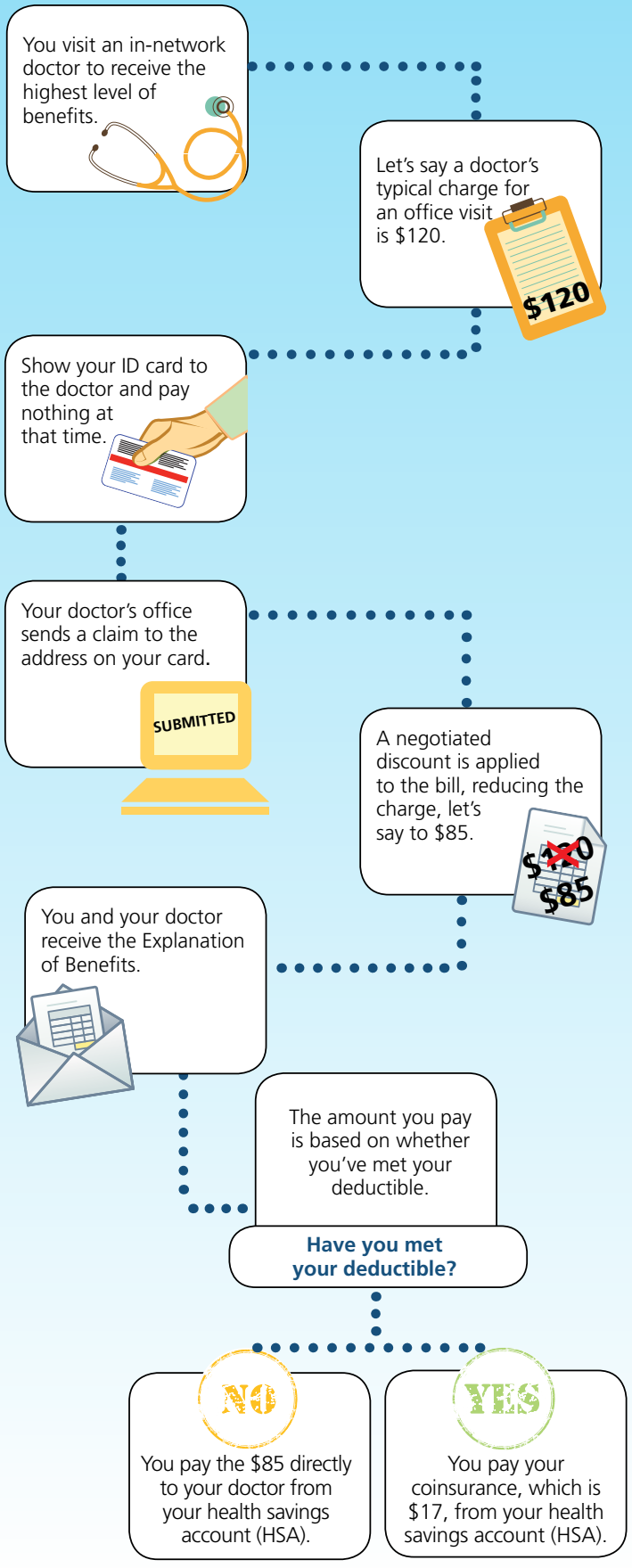
The plans have a deductible for Employee Only coverage, and an aggregate deductible for Spouse, Children or Family coverage. That means if you select coverage other than Employee Only, the aggregate deductible must be met in full before coinsurance benefits kick in for any member of your family. Medical 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 12.

What Happens at the Doctor When You Have a High Deductible Health Plan?



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
- Women's health

A Preventive Therapy Drug category list is located on the **Healthy and Wise site**. Go to **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 covered under the Preventive Therapy Drug benefit?

- 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** 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** 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.

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 (which can also be a routine gynecological exam), by a network provider are covered each year. 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. The plan covers 3D mammograms at the age recommended by your provider.

"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.

- **Breast screening MRI** – The plan covers a breast screening MRI when medically necessary.
- **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 Category List on eCentral or visit the Caremark website at 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 Caremark website for the brands.

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 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 7.

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, reimburse yourself with an online transfer or take the deduction at tax time.

"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.***

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.

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.

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.

Healthy and Wise

Take Action to Make Informed Choices

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 Plan Document 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?

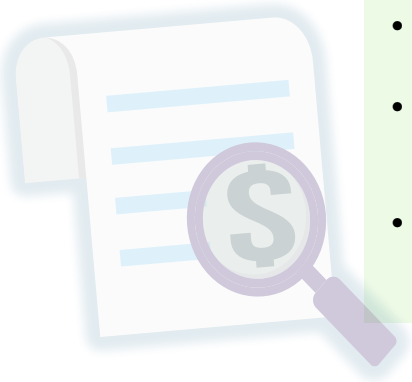
Consider a lower cost option:

- 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-patient surgery are covered in-network.
- 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 DO 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.

Biweekly Medical Premiums

Premiums are withdrawn before taxes from each of your 26 paychecks. If you earned a wellness credit in 2017, this amount will display on the enrollment submissions page on Workday and on your payslip.

Associates hired on or after June 1, 2017 will receive the maximum wellness discount of $23.08 per pay period if enrolled in the medical plan in 2018.

To determine your actual premium paid, subtract the wellness discount you will receive from the per paycheck premium amount.

$600 wellness discount = **$23.08** per paycheck
$500 wellness discount = **$19.23** per paycheck
$400 wellness discount = **$15.38** per paycheck

		Biweekly Medical Premium
HDHP Premier 1500	Employee Only	$67.85
	Employee + Spouse/QP	$197.54
	Employee + Child(ren)	$192.00
	Family	$229.85
HDHP Essential 2500	Employee Only	$61.85
	Employee + Spouse/QP	$174.92
	Employee + Child(ren)	$169.85
	Family	$203.08
HDHP Balanced 4500	Employee Only	$41.08
	Employee + Spouse/QP	$150.00
	Employee + Child(ren)	$145.85
	Family	$173.54

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

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
Antiparisitic & 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.

CoreSource administers employees' FSAs. Call CoreSource at (877) 367-5690 if you have questions.

Healthcare FSA

An employee may contribute an annual maximum of **$2,600** to a healthcare FSA. Your spouse may elect to contribute to an FSA through his or her employer.

Employees will receive a stored-value FSA card with a MasterCard logo that can be used to pay some healthcare FSA-reimbursable expenses. Use of the FSA 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 and you are eligible for health savings account (HSA) contributions, your use of the healthcare flexible spending account (FSA) will be limited. When you are eligible for the HSA, your FSA funds cannot be used to pay for expenses that go toward meeting your plan deductible. You can use FSA funds to pay coinsurance expenses after your deductible is met. For non-deductible expenses, dental and vison 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 you are eligible for an HSA, you must choose the **Healthcare FSA Limited (Allowed with HSA)** on Workday if you choose to enroll in the FSA. Associates enrolled in the Healthcare FSA Limited may not use the stored-value card for FSA-reimbursable medical expenses; you will be reimbursed for these expenses by submitting an FSA claim form.

If you choose to enroll in the FSA, select the correct plan based on whether you are eligible to receive contributions to an HSA in this plan year:

- If you are enrolled in a high deductible health plan and you are eligible to receive contributions to your HSA, select the **Healthcare FSA Limited (Allowed with HSA)** in Workday
- If you are not eligible to receive HSA contributions due to your participation in Medicare or military benefits, select the **Healthcare FSA Standard (Not allowed with HSA)** in Workday

Enrollment in the Dependent Care FSA (day care, adult care) is not tied to your health plan.

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 26. If you are not sure how to estimate your healthcare expenses, review your checking 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 26 deductions per year.

3. Reimbursement

See the charts on pages 22-23 for a list of IRS-eligible healthcare expenses. As you have eligible expenses throughout the year, you have three options for reimbursement: submit a claim form and receive a check, submit a claim form and receive reimbursement through direct deposit (you must sign up for this service) or depending on the type of service, you can use the FSA card to access monies in your healthcare FSA. Download FSA reimbursement forms from eCentral. Eligible claims must be incurred during the plan year.

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.

CoreSource offers an easy-to-use consumer portal and mobile app to help you manage your FSA. Use the portal, accessible through **mycoresource.com** to check balances, claims and payments; file claims and submit receipts, order new debit cards and sign up for direct deposit. The mobile app, called **myCoreSource FSA/HRA**, allows you to submit claims and receipts using your device's camera, receive alerts via text message, check claims requiring receipts and more. The mobile app is available for Apple and Android-powered devices.

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 26. If you are not sure how to estimate your dependent care expenses, review your checking 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 26 deductions per year. 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

As you have eligible expenses throughout the year, you have two options for reimbursement: submit a claim form and receive a check or submit a claim form and receive reimbursement through direct deposit (you must sign up for this service.) Download FSA reimbursement forms from eCentral.

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.

"It took a couple of years for me to take advantage of the convenience and tax savings of the dependent care FSA, and I don't know why I didn't do it sooner. I use the FSA to cover daycare expenses for my two younger sons. I set up an annualized reimbursement claim, so every two weeks the reimbursement amount is deposited directly into my bank account. There's definitely a monetary savings, but for me the convenience is what's so valuable." ~ Virginia D.

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.

Annual Healthcare Expenses

Deductibles $_____
(not reimbursable from FSA if enrolled in a high deductible plan)

Medical, dental, vision

Coinsurance $_____

The amount not paid by your health plan coverage

Amounts not covered by insurance $_____

Vision care not covered by insurance $_____

Dental care not covered by insurance $_____

Other anticipated healthcare expenses

_____ $_____

_____ $_____

_____ $_____

Total Annual Healthcare Contribution **$**_____

Annual Dependent Care Expenses

Annual Child Care Services

Day care center $_____

In-home care $_____

Nursery and pre-school $_____

After-school care $_____

Au pair services $_____

Summer day camp $_____

Annual Elder Care Services

Day care center $_____

In-home care $_____

Total Dependent Care Contribution **$**_____

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 by 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.

Service & Description	In Network	Out of Network
Diagnostic & Preventive Services Exams & cleanings, x-rays, fluoride treatments, sealants	100%	100% of maximum allowable fee**
Basic Services 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	80% after deductible is met	80% of maximum allowable fee** (after deductible is met)
Endodontics Pulpotomies on primary teeth for dependent children, root canal therapy on permanent teeth		
Periodontics Surgical/Nonsurgical periodontics		
Oral Surgery Surgical/Nonsurgical extractions, all other oral surgery		
Major Restorative* Crowns	50% after deductible is met	50% of maximum allowable fee** (after deductible is met)
Prosthetic Repairs and Adjustments* Denture adjustments and repairs, bridge repair		
Prosthetics* Dentures (full and partial), bridges		
Deductible Per Person/Per Family (calendar year) No deductible for diagnostic and preventive services	$100/$300	$100/$300
Calendar Year Plan Maximum Per Person	$2,000	$2,000

* 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.

Biweekly Dental Premiums

Premiums are withdrawn before taxes from each of your 26 paychecks.

Employee Only	$8.10
Employee + Spouse/QP	$25.90
Employee + Child(ren)	$24.30
Family	$41.60

www.deltadentalmn.org

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** 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.

Basic Plan	
Exam	Once per calendar year
Exam copay	$10

Enhanced Plan	
Exam	Once per calendar year
Exam copay	$10
Contact lenses*	Up to a 12-month supply
Frames	Once per 2 calendar years
Lenses	Once per calendar year
Materials copay	$25
Frame allowance	$170
Contact lenses allowance	$170

*If you choose contact lenses instead of glasses, you will not be eligible to receive any frames and lenses during the same service period.

Options That May Require Additional Expenses

- Scratch-resistant coating
- Anti-reflective coating
- Ultraviolet (UV) protection
- Progressive lenses
- Blended bifocal lenses
- Most tinted and photochromic lenses
- Any frame valued at more than your plan's allowance

"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.

Biweekly Vision Plan Premiums

Premiums are withdrawn before taxes from each of your 26 paychecks.

Vision

	Basic	Enhanced
Employee Only	Company Paid	$5.15
Employee & Spouse/ Qualified Partner	Company Paid	$8.22
Employee & Children	Company Paid	$8.40
Employee & Family	Company Paid	$13.33

Life Insurance

The company's benefit plan offers Basic and Supplemental 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 two times your annual base salary. The company pays the entire cost of the Basic Plan benefit for all regular full-time associates.

Supplemental Life Insurance Plan and Accidental Death and Dismemberment Benefit

For those desiring additional life and AD&D insurance protection, the company offers an Supplemental 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 biweekly premium cost, find your age on the chart at right to establish the rate. Take your benefit election amount, divide it by 1000 and multiply by the selected premium rate. Supplemental coverage is subject to underwriting guidelines.

Biweekly Premium Calculation

Employee Age (as of January 1)	Cost per $1,000 of coverage
Under 30	$0.051
30-34	$0.055
35-39	$0.065
40-44	$0.088
45-49	$0.129
50-54	$0.208
55-59	$0.374
60-64	$0.503
65-69	$0.854
70-74	$1.302
75+	$2.372

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

Dependent Life Insurance

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

Spouse Coverage Amount
If you are enrolled in Supplemental 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 Supplemental 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

Employee Age (as of January 1)	Biweekly Rate (per $1,000 of total coverage)
Under 30	$0.037
30-34	$0.042
35-39	$0.051
40-44	$0.074
45-49	$0.115
50-54	$0.194
55-59	$0.406
60-64	$0.489
65-69	$0.840
70-74	$1.288
75+	$2.358

Spouse Rates
If you elect Dependent Life Insurance for your spouse, your monthly premium rate for this coverage is indicated in the "Spouse Rates" table at right. This is for Life Insurance only and doesn't include an AD&D benefit. Premiums for this coverage will be deducted directly from your biweekly paycheck. To determine premium cost, find your age on the chart above to establish the rate. Take your benefit election amount, divide it by 1000 and multiply by the selected premium rate. This will give you the biweekly amount. 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 Dependent Life insurance for your eligible children, your monthly premium rate for $10,000 of coverage is $0.78 per pay period, regardless of the number of eligible children covered.

When applicable, please complete the medical history statement online at:
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) or other state leave laws, 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

Disability benefits are provided by the company to regular, full-time associates once they reach three months of service. The Short-Term Disability Plan protects full-time employees against loss of income if they are unable to work because of a non-occupational illness or accidental injury. The plan provides a benefit of 60 percent of weekly base salary for up to 120 days after a one-week elimination period. Disability benefits for salespeople are based on the average of the last 24 months' incentive compensation and base salary.

"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 with 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 full-time employees with at least three months of service are eligible for LTD coverage.

- **Begins Where Short-Term Plan Leaves Off –** Coverage for this benefit begins after 120 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 $13,000 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 –** Important note regarding your Long-Term Disability enrollment: The LTD plan you select this open enrollment cannot be changed going forward. Please read the following instructions carefully and make your selection below:
  - **If you choose pre-tax**, you will not pay tax on the company paid premium and if you were to become disabled, you will pay taxes on the benefit which is paid to you. This election cannot be changed for the remainder of your employment.
  - **If you choose post-tax**, you will pay taxes on the company paid premium and if you were to become disabled, the benefit that is paid to you will be non-taxable. This election cannot be changed for the remainder of your employment.

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. Please retain a copy of all documents for your records.

STATUS	REQUIRED DOCUMENTATION
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. **or** • 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 Qualifed 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. **or** • 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 Qualifed 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 Qualifed 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; www.birthcertificate.com; 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

GROUP BENEFIT PLAN FOR EMPLOYEES (AND THEIR DEPENDENTS)
OF
HEALTH FITNESS CORPORATION
NOTICE OF PRIVACY PRACTICES
Effective date of this notice: September 23, 2013

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 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 of the 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.

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of an employee, enrollment of the employee in Medicare (Part A, Part B, or both), the employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, then COBRA continuation lasts for up to 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. Disability Extension of 18-month Period of Continuation Coverage

If an employee or anyone in his or her family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and the employee notifies the Plan Administrator in a timely fashion, the employee and his or her entire family can receive up to an additional 11 months of COBRA continuation coverage for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. **The employee must make sure that the Plan Administrator is notified of the SSA's determination within 60 days of the determination** and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to Health Fitness Corporation, Attn: Human Resources, 1700 West 82nd Street, Suite 200, Minneapolis, MN 55431 with the supporting documentation from the Social Security Administration.

2. Second Qualifying Event - Extension of 18-month Period of Continuation Coverage

If the employee's family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in the employee's family can get additional months of COBRA continuation coverage up to a maximum of 36 months total. This extension is available to the spouse and dependent children if the former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, **but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred**. In all these cases, **the employee must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event.** The supporting documentation must be sent to Health Fitness Corporation, Attn: Human Resources, 1700 West 82nd Street, Suite 200, Minneapolis, MN 55431.

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/ebsa**.

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.

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/med/medindex.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
Medicaid 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

PENNSYLVANIA – Medicaid
Website:
http://www.dpw.state.pa.us/partnersproviders/medicalassistance/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/premiumpymt/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

Form Approved
OMB No. 1210-0149
(expires 1-31-2017)

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 not 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 Melody Canak, Human Resources mcanak@trustmarkins.com or 847-283-2339.

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.

3. Employer name CoreSource, Inc. / Trustmark Services Company / Health Fitness Corporation		4. Employer Identification Number (EIN) 35-1846036/27-0056662/ 41-1580506
5. Employer address 400 Field Drive		6. Employer phone number 847-283-1500
7. City Lake Forest	8. State IL	9. ZIP code 60045
10. Who can we contact about employee health coverage at this job? Melody Canak		
11. Phone number (if different from above) 847-283-2339	12. Email address mcanak@trustmarkins.com	

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

- As your employer, we offer a health plan to:

  ☐ All employees.

  ☑ Some employees. Eligible employees are:

  Regular employees working full-time 30 hours or more per week

  Associates who qualify under ACA, averaging 30 hours per week over a 12-month measurement period.

- With respect to dependents:

  ☑ We do offer coverage. Eligible dependents are:

  Legally married spouse, qualified partner, children up to age 26

  The term “qualified partner” means domestic partner or other qualified relationship type as defined by the employer and/or state in which they live.

  The term “child” means the employee’s natural child, stepchild, legally adopted child, child placed for adoption, a natural child of the employee’s qualified partner, a child for whom the employee, covered spouse or the employee’s qualified partner has been appointed legal guardian, provided the child is less than twenty-six (26) years of age, and dependent, disabled children age 26 and older.

  ☐ 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.