OPEN ENROLLMENT | NOVEMBER 2 – 12, 2020

My Health and Well-Being Benefits: 2021

for HealthFitness Corporation
Regular, Full-Time Associates

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

Trustmark®
benefits beyond benefits

An Employee Benefits Message from CEO Kevin Slawin

Welcome to our annual benefits open enrollment. This booklet provides detailed information about your benefits selections for 2021 – and there's good news this year. Please set aside time to review your choices and discuss them with your family before you make your open enrollment elections in Workday starting Nov. 2.

This year we are continuing our efforts to help lower associates' expenses associated with the medical plan. **It's my pleasure to tell you for the second year in a row that we are reducing premium rates for the employee medical plan – annual rates for next year are reduced 10 percent across the board.** Between this reduction and the premium reduction implemented in 2020, Trustmark has reduced annual premium rates 30 percent at a time when healthcare costs are increasing.

We're committed to making this investment to demonstrate how much we value our associates and to continue to attract top talent to Trustmark. As always, it's important for us to keep working together to achieve our profitable growth objectives, which in turn will help fuel additional investments in our benefits.

We know that 2020 has been a challenging year for associates, and our benefits are more important than ever. So we've also introduced several new benefits this year, including Vitality's wellness programs, Support Solutions EAP, and Wellthy's caregiver support and childcare resources, to help associates manage the complexities of their lives today. More benefit enhancements are on the way, so watch for further information soon.

On behalf of the entire leadership team, I want to thank you for your hard work day in and out in these challenging times. Together, we're fulfilling our mission by providing caring service and valuable benefit solutions to our clients.

Be well,
Kevin Slawin

TABLE OF CONTENTS

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Tips for a Successful Open Enrollment

Start early: Review the materials in advance so you are ready to enroll starting on Monday, Nov. 2. Your enrollment event is located in the announcement on the home page and in your Workday inbox. The last day to make your elections on Workday is Thursday, Nov. 12.

Take your time to avoid mistakes: Before you make your elections, visit Live Your Beyond to watch informative videos about your benefits and read the benefits booklet to fully understand your options prior to enrolling.

All current elections carry over to the new plan year, except for HSA and FSA which require a new enrollment each year. Remember to add dependents on the second page of healthcare enrollment cards in Workday. Dependent verification is required if enrolling new dependents in medical, dental or vision plans and your covered dependents' Social Security Numbers (SSN) must be entered in order to avoid delay in claim payment.

Carefully review and print your elections on the summary page in Workday. After Open Enrollment ends, changes may only be made due to a qualifying life event.

Put important deadlines on your calendar: Don't miss out! Open Enrollment in Workday ends on Nov. 12. Evidence of insurability for life plans must be completed online with The Standard by Nov. 30.

What's New in 2021

Lower Medical Plan Premiums
In response to feedback from associates, medical plan premiums are being reduced for the second year in a row. Annual rates for next year are 10 percent lower than this year's rates. Please review the new premiums on page 18.

Vision Plan Enhancements
The VSP Enhanced vision plan is introducing new enhancements for 2021. The retail frame allowance for featured frame brands only has been increased to $250. In addition, the Enhanced vision plan will now offer scratch-resistant lenses, covered at no charge every calendar year.

26 Pay Periods in 2021
Benefits deductions will be taken over 26 pay periods in 2021, starting with the Jan. 15, 2021 paycheck.

MedCost PPO Network
The MedCost PPO network for North Carolina associates will be discontinued on Dec. 31, 2020 as the Aetna Signature Administrators (Aetna ASA) PPO network now includes those providers.

Dependent Life Insurance Premiums
For the first time in many years, premiums have increased for Dependent Life Insurance to reflect experience in the group. Please review the new premiums on page 27.

Health and Well-Being Program Eligibility

Associates working 30 or more hours

Medical
Health Savings Account (HSA)
Telemedicine and Telebehavioral Health
24/7 Nurseline
Health Management
Diabetes Management
Dental
Vision
Flexible Spending Account (FSA)
Life Insurance
Short-Term and Long-Term Disability
Caregiver Support
Employee Assistance Program
Wellness Program
Voluntary Benefits

All Associates

Commuter Benefits
401(k) - See page 25 for eligibility

Waiting Periods

If you are newly eligible for benefits, you'll have a waiting period prior to the coverage start date. All benefits begin on the first day of the month following your date of hire or rehire.

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 and life insurance benefits to your qualified partner and his or her eligible children. Qualified partners are domestic partners as defined by Trustmark or common law marriage or domestic partnerships as defined by the state in which you live.

Children of your qualified partner 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 pay slip.

Please contact Hillary Kravitz at **hkravitz@trustmarkbenefits.com** for the Attestation QP form. Return the completed form and dependent verification documentation by the enrollment deadline or within 10 days of entering a status change on **Workday**.

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 in Workday within 30 days of the status change (60 days for CHIP event). Additionally, please 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 Hillary Kravitz at **hkravitz@trustmarkbenefits.com**.

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 Hillary Kravitz at **hkravitz@trustmarkbenefits.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.

Trustmark Wellness Program

Trustmark's wellness program offers you the opportunity to participate in Vitality – a fun and innovative program that can help you improve your overall health and wellness. Choose from and be rewarded for a wide variety of healthy activities on your own personal pathway to better health.

In these uncertain times, staying as healthy as possible is important for all of us. Vitality can help you create healthy routines, so perhaps a new habit or behavior you start now will become permanent. With its holistic approach, Vitality offers a variety of tools, online courses and challenges to improve your physical, social and emotional well-being.

Incentive rewards

Vitality points earned during the 2020 Wellness Program count toward a premium discount in 2021. Associates newly eligible or hired on or after June 1, 2020 will automatically receive the full per-paycheck premium discount if enrolled in the medical plan in 2021.

Our new wellness program year launched Oct. 1. Take advantage of the myriad opportunities to enhance your health and wellness while earning rewards toward your 2022 incentive.

Start now for success

Here's what you need to do to take your first step toward your healthiest life:

- **Visit www.powerofvitality.com to register.** You'll need your employee ID number (available in **Workday** by clicking View Profile under your photo or cloud icon in the upper right corner) and your date of birth to register.
- **Take the Vitality Health Review:** a brief, confidential assessment of your current health status.
- Plan the healthy activities you want to accomplish with the Points Planner.
- **Download the Vitality mobile app, *Vitality Today*, from the Apple App Store or Google Play.**
- Learn more by visiting the Guide to Vitality page on the Vitality site and by viewing the Getting Started video.

2021 Medical Plans at a Glance

Premier 1500	Essential 2500	Balanced 4500
HDHP Premier	HDHP Essential	HDHP Balanced

Provider Networks: Call or login to Grand Rounds to find a quality in-network doctor.
You may also see a list of in-network providers at www.aetna.com/asa.

HSA Contributions

Trustmark contributes $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. The total of company and employee contributions cannot exceed $3,600 for Employee Only coverage or $7,200 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.

2021 Medical Plans at a Glance

Call Trustmark Health Benefits at (877) 367-5690 if you have questions.

Premier 1500 HDHP Premier		Essential 2500 HDHP Essential		Balanced 4500 HDHP Balanced	
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.
Telemedicine and Telebahavioral Health					
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 Trustmark Health Benefits. The fee to use telebehavioral health is $160 for a psychiatry initial consultation, $90 for a subsequent psychiatry visit, and $80 for licensed clinical social worker, psychologist, counselor or therapist visit.					
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 CVS 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 CVS 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. Please check the CVS Caremark website at www.caremark.com for the most accurate up-to-date coverage and cost information.

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 Trustmark's medical plan provides 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.

Trustmark
benefits beyond benefits

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.

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. Specific brands of the colonoscopy prep kit from the pharmacy are covered at 100 percent. Please see the CVS Caremark website for the brands.

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 Trustmark Health Benefits if you have questions about preventive care benefits.

Call Trustmark Health Benefits at (877) 367-5690 if you have questions.

Prescription Drug Coverage

Your medical 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 cost share.

   Categories include:
   Aspirin therapy
   Tobacco cessation
   Prescription contraception
   Cardiovascular conditions
   Diabetes
   Hypertension
   Mental health

Go to www.caremark.com or use CVS 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. Drugs that are subject to generic step therapy, brand penalty and prior authorization may be not covered at 100 percent by the plan.

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.

Mail Order

Visit the CVS Caremark website at www.caremark.com to print the form for use with a paper prescription, or use the site to request that CVS 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.

Health Plan Portal

myTrustmarkBenefits.com is your online portal to personal information about your healthcare benefits, flexible spending accounts, including commuter, and links to access your health plan programs.

First-time users should register as a Participant online at myTrustmarkBenefits.com creating a **unique, personal user ID**, to start accessing your data. Do **not** use your Trustmark/Health Benefits three character ID when creating your personal myTrustmarkBenefits.com account.

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.
- Get answers to your important questions and request additional ID cards.

Please contact Trustmark Health Benefits Customer Service at (877) 367-5690 for login issues.

Finding a Quality Doctor

Whether you are looking for a doctor, in need of a second opinion or have questions about a current treatment plan, Grand Rounds is your first stop. Grand Rounds provides expert medical guidance and support to help ensure you always receive the best care possible. Whether you need help finding the best physician in your area, information about a new diagnosis or treatment, or support deciding if surgery is right for you, Grand Rounds will take care of it all.

Grand Rounds works with top doctors and specialists across the country and identifies the highest quality physicians for your unique needs.

Grand Rounds is with you when:

- You need a doctor/specialist. They'll find the best physician in your area.
- You need a hand. Once a new physician is recommended, they'll book the appointment with that physician and gather your medical records.
- You need an expert. They'll get you a second opinion or personalized care plan from a world-leading expert.
- You need support. They'll help you make tough decisions or help you decide if surgery is right for you.

Use Grands Rounds any time, but especially if:

- You need a second opinion on a new or long-term health issue or treatment plan
- You were recently diagnosed and need to see an expert about your condition
- You are considering surgery and want to make sure it's right for you
- You need personalized advice about recommendations your doctor has made
- You are in pain and having a hard time getting to the root of the problem
- You want peace of mind that you are on the right medications
- You've recently moved and need to find a new doctor

Grand Rounds delivers expert opinions from world-leading doctors on any condition: neck or back pain, joint-related issues, chronic headaches/migraines, IBD/IBS/ Crohn's, fibromyalgia, sports injuries, cancer, endocrinology, pediatric care, pregnancy complications and others.

Grand Rounds will connect you to world-leading in-network doctors including: primary care physicians, orthopedists, OB/GYNs, neurologists, dermatologists, gastroenterologists, otolaryngologists, endocrinologists, psychiatrists, pediatricians and more.

To learn more, visit grandrounds.com/trustmark or call (800) 929-0926 from 8 a.m. to 9 p.m. ET.

Healthcare Cost Transparency

You know you have a choice about where you go for healthcare tests and procedures — but how can you get the information you need to help you save money? Healthcare Bluebook offers a number of resources to enable you to become an informed consumer by learning how to understand your medical needs and treatment options. Healthcare Bluebook is a tool that makes healthcare shopping simple and fast. Using a cost and transparency tool like Healthcare Bluebook could potentially save you thousands of dollars on procedures like sleep studies, MRIs and CTs.

You can compare cost and quality information on the Healthcare Bluebook website or mobile app:

Search - Easily search any procedure to find out how much you should be paying in your area.

Compare - Use Fair Price information to compare procedure costs and make decisions about your healthcare.

Save - Save hundreds to thousands of dollars in out-of-pocket costs every time you receive medical care.

Associates who use Healthcare Bluebook can receive a reward check in the mail for using select green facilities and services. These include: colonoscopy, $100; sleep study, $50, knee arthroscopy, $100; CT scan, $25; MRI, $25 and more. Use the site to find a green provider, make your appointment and you'll receive the check after your procedure. Rewards are taxable and will be processed as earnings through payroll upon notification from Healthcare Bluebook.

You may access Healthcare Bluebook on the Trustmark Health Benefits portal at myTrustmarkBenefits.com.

Health Savings Accounts

Trustmark has selected HealthEquity as its preferred trustee of HSA accounts. An account will be opened on your behalf when you enroll in an employee medical plan. The company will pay for your HealthEquity account maintenance fees while you are enrolled in the high deductible health plan as an active employee.

HealthEquity is the largest, independent provider of HSAs, managing 3.7 million HSAs with $6.7 billion in custodial assets. While it is not owned by a bank or health plan, HealthEquity partners with FDIC-insured banks so your savings account is protected. Their U.S.-based customer service is available 24/7/365, and you'll have access via phone, email or chat to HSA mentors who will help you better understand your HSA, empowering you to build your health savings account balance.

HealthEquity's robust and user friendly platform integrates claims information, so you can pay providers from your HSA account with the click of a mouse. The portal serves as a document library to store all your receipts for tracking and auditing. You can also use the HealthEquity mobile app for all services including investing.

Understanding Your HSA

An HSA is an account you can use for your own and your 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.

You own the account and manage it. You choose whether to use funds or let them build up. The account is not "use it or lose it" like an FSA. 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.

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 team 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.

For more about HealthEquity, call (866) 346-5800 or visit www.healthequity.com/trustmark if you have questions or to learn more. Download the mobile app for account access anytime.

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 prorated 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 from Federal and Most States

You can also contribute money to your HealthEquity 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 $3,600 for individual and $7,200 for family coverage. Employees over age 55 may contribute an additional $1,000 catchup contribution. **You can start, change or stop your HSA contribution throughout the year by creating a change benefit event on Workday.**

It is estimated that $265,000 will be needed for healthcare expenses after retirement. Your 401(k) is intended for your living expenses and use of these funds is not tax-free if used for healthcare expenses. Plan ahead by growing your HSA balance for payment of healthcare expenses in the future, including after retirement.

Visit www.healthequity.com/trustmark to learn more.

Telemedicine/Telebehavioral Health

Associates and their covered dependents can talk to a doctor anytime through Teladoc via phone or computer video. 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, including behavioral health.

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 telemedicine is $45. Associates pay the fee upfront and Teladoc will submit the claim to Trustmark Health Benefits.

If you have concerns such as stress, anxiety, depression, grief or family difficulties, Teladoc Behavioral Health Services provide convenient and cost-effective care via phone or computer. You can work with a provider who can prescribe medication and medication management, if necessary. The fee to use telebehavioral health is $160 for a psychiatry initial consultation, $90 for a subsequent psychiatry visit, and $80 for licensed clinical social worker, psychologist, counselor or therapist visit.

Whether for medical or behavioral health services, associates pay the fee upfront and Teladoc will submit the claim to Trustmark Health Benefits.

Call Teladoc at 800-Teladoc or (800) 835-2362, visit www.teladoc.com or download the mobile app.

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.

MyNurse 24/7

Diabetes Management Program

Livongo

Livongo is a new approach to diabetes management that combines the latest technology and coaching to support you or your covered dependents in managing diabetes. This company-paid, cutting-edge program includes a smart touchscreen glucose meter and unlimited lancets and test strips – all at no cost to you. The key benefits of Livongo include:

Support when you need it - Livongo coaches are diabetes educators who are available anytime to discuss your blood glucose readings, nutrition or lifestyle changes.

Smart glucose meter - A company-paid meter that gives you personalized tips after each check to help you stay or get in range;

Unlimited strips at no cost - Get as many strips and lancets as you need shipped right to your door.

Visit join.livongo.com/TRUSTMARK/register or call (800) 945-4355.

Maternity Special Services

It's important to know all you can about your health when you become pregnant. That's why Trustmark offers Special Delivery, a comprehensive program that promotes the health and well-being of soon-to-be moms and babies to help prevent health issues during pregnancy. Best of all, this program is available at no additional cost to you.

When you discover that you're expecting, just call **(888) 785-2229** to enroll in Special Delivery and take part in a voluntary assessment for pregnancy risks and information to help you have a healthy pregnancy. Based on your initial assessment results, you'll receive personalized health information and a prenatal education book. Registered nurses are available to answer your questions about pregnancy, labor and delivery, preparing the nursery, infant safety, feeding and newborn care.

You can earn up to $100 in gift cards for enrollment and participation in Special Delivery. When you enroll, you'll receive a $25 gift card. If you participate in the program and complete the assessment after delivery, you'll receive a $75 gift card.

Financial Healthcare

SIMPLICITY®
Simplifying Healthcare Payments

As part of your benefits, you have access to Simplicity, a unique financial healthcare benefit. Simplicity revolutionizes how you pay your medical expenses. Instead of getting bills from multiple doctors, you get one monthly statement from Simplicity that includes all of your obligations for the month – just like 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 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

For more information, visit myTrustmarkBenefits.com.

Biweekly Medical Premiums

Premiums are withdrawn before taxes from each of your 26 paychecks in 2021. Associates earn points toward a premium discount by participating in wellness programs. Vitality points earned during the 2020 Wellness Program count toward a premium discount in 2021.

Associates newly eligible or hired on or after June 1, 2020 will automatically receive the full per-paycheck premium discount if enrolled in the medical plan in 2021.

Premium discounts are displayed as *Benefit Credit* on the enrollment submission page on Workday and on your pay slip.

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

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

HDHP Premier 1500	
Employee Only	$46.62
Employee + Spouse/QP	$127.85
Employee + Child(ren)	$117.69
Employee + Family	$148.62
HDHP Essential 2500	
Employee Only	$42.46
Employee + Spouse/QP	$113.54
Employee + Child(ren)	$103.85
Employee + Family	$131.54
HDHP Balanced 4500	
Employee Only	$36.00
Employee + Spouse/QP	$97.38
Employee + Child(ren)	$89.08
Employee + Family	$112.15

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 their 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/Qualified Partner	$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

As a member, you'll receive access to care from great eye doctors, quality eyewear, and the affordability you deserve, all at low out-of-pocket costs. You'll get great care from a VSP network doctor, including a WellVision Exam — a comprehensive exam designed to detect eye and health conditions. With the largest national network of private-practice doctors, plus participating retail chains, it's easy to find the in-network doctor who's right for you.

Visiting the Doctor

VSP uses a network of professionally certified optometrists and ophthalmologists and retail stores including Costco, Pearl Vision, Walmart, Sam's Club, Rosin Eyecare and Visionworks. To find an eye doctor, visit vsp.com or call **(800) 877-7195**. At your appointment, tell them you have VSP. There's no ID card necessary. After 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.

Eyeconic® seamlessly connects your eyewear, your insurance coverage, and the VSP® doctor network. Plus, you get the convenience of online shopping along with the personal touch from a VSP doctor.

ONLINE SHOPPING WITH BENEFITS

Online shoppers will love:

- A huge selection of contact lenses and designer frames 24/7—and the Virtual Try-On tool.
- Free shipping and returns. Plus, if you find the same merchandise at a lower price, we'll refund the difference.*
- Free frame adjustment or contact lens consultation.
- Verification of your prescription and the 25-point inspection process to ensure your eyewear is just right.

IT'S EASY TO USE YOUR VSP BENEFIT

Create an account at vsp.com. Review your vision benefit and access your eligibility and coverage information, including how to apply your benefits at Eyeconic.

Find superior eye care near you. The decision is yours—choose a conveniently located VSP doctor or any out-of-network provider. Visit **vsp.com** or call **(800) 877-7195** to find the best provider for you.

Check out Eyeconic and browse the frame brands you love. You can connect to your VSP benefits, upload your prescription and order your glasses following your WellVision Exam®.

Hearing Aid Discounts

VSP members in either plan can save up to 60 percent on the latest brand-name hearing aids through its TruHearing discount program. Dependents and even extended family members are eligible for exclusive savings, too. TruHearing provides access to a national network of more than 6,000 hearing healthcare providers, nationally fixed pricing on a wide selection of hearing aids and deep discounts on batteries shipped directly to your door. Call **(877) 396-7194** and mention VSP to schedule an exam.

TruHearing also provides you with:

- Three provider visits for fitting and adjustments
- A 45-day trial
- Three-year manufacturer warranty for repairs and one-time loss and damage replacement
- 48 free batteries per hearing aid

Biweekly Vision Plan Premiums

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

	Basic	Enhanced
Employee Only	Company Paid	$5.44
Employee & Spouse/Qualified Partner	Company Paid	$8.68
Employee & Children	Company Paid	$8.87
Employee & Family	Company Paid	$14.08

Call VSP at (800) 877-7195 or visit VSP.com with questions or to find an in-network provider.

Basic Plan

VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10 Every calendar year
Extra Savings	**Glasses and Sunglasses** • 20% savings on complete pair of prescription glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months from your last WellVision Exam	
	Contacts • 15% savings on a contact lens exam (fittng and evaluation)	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	

Enhanced Plan

VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10 Every calendar year
Prescription Glasses		$25
Frame	• $200 allowance for a wide selection of frames • $250 allowance for featured frame brands • 20% savings on the amount over your allowance • $110 Costco, Walmart and Sam's Club frame allowance	Included in Prescription Glasses Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children	Included in Prescription Glasses Every calendar year
Lens Enhancements	• Scratch-resistant lenses • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $0 $95 - $105 $150 - $175 Every calendar year
Contacts (instead of glasses)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60 Every calendar year
Extra Savings	**Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
	Retinal Screening • No more than a $30 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.	
	Diabetic Eyecare Plus Program • Retinal screening for members with diabetes - $0 • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. - $20 per exam Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	

Your Coverage with Out-of-Network Providers

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Flexible Spending Plans

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. FSAs 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.

Trustmark
benefits beyond benefits

Call Trustmark Health Benefits at (877) 367-5690 if you have questions.

Healthcare FSA
An employee may contribute an annual maximum of $2,750 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.

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 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 is not tied to your health plan.

Steps to Start Saving with an FSA

1. Determine Your Expenses. Estimate the amount of healthcare expenses you think you will experience through Dec. 31. 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 via Workday. The annual amount you elect is deducted in equal amounts based on 26 deductions in 2021.
3. Reimbursement. 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 myTrustmarkBenefits.com. As an active employee, you'll have 90 days after the last day of the plan year to submit your claims for reimbursement.

Use the Trustmark Health Benefits portal and mobile app to help you manage your FSA. Use the portal, accessible through myTrustmarkBenefits.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 myTrustmarkBenefits FSA/HRA, allows you to submit claims and receipts using your device's camera, receive text message alerts, check claims and more.

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.)

Eligible Dependents

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

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

Eligible Expenses
Expenses may be reimbursed for services provided:

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

Ineligible Expenses
Expenses will not be reimbursed for:

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

Commuter Benefits

Use tax-free money to pay the costs of commuting to work via mass transit and to pay parking fees at work. With Commuter Benefits through Trustmark Health Benefits 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 Trustmark. 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.

Contact Julie Pierce at jpierce@trustmarkbenefits.com for additional plan and enrollment information.

401(k) 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 Live Your Beyond site.

The plan offers two contribution types: **pre-tax contributions** that are deducted from your pay before income taxes and may lower the amount of current income taxes you pay each pay period and **Roth after-tax contributions** that means your contributions may not be taxed when funds are distributed in retirement. Another program 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 75 percent of your gross wages (subject to IRS limits)
- The company will match $0.20 on every $1.00 you contribute up to the first 10 percent you defer
- 5-year graduated vesting schedule on company match
- 401(k) contribution maximum is $19,500; plus $6,500 for catch-up contributions for those age 50 and over
- Contributions to the plan are withheld through the convenience of payroll deductions
- You choose how to invest your contributions from more than 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 once you have met the following eligibility criteria. You are eligible to participate in the plan if you are:

- At least 18 years of age; and
- Regular associates (not on-call) who work 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 at www.401k.com or call their toll-free number (800) 835-5091.

Life Insurance

The company's benefit plan offers Basic and Supplemental Life Insurance plans to provide personalized life coverage for employees and their families.

Company-Paid Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Benefit

Full-time employees 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 your annual base salary with a minimum of $50,000. Salespeople receive a life benefit of two times base salary. The company pays the entire cost of the Basic Plan benefit for all full-time employees.

Supplemental Life Insurance Plan and Accidental Death and Dismemberment (AD&D) Benefit

For those desiring additional life and AD&D insurance protection, the company offers a Supplemental Group Term Life Insurance and AD&D insurance in increments of $5,000 up to $500,000. Premiums vary according to age and benefit amount. To determine your biweekly premium cost, find your age on the chart below. Take your benefit election amount, divide it by 1,000 and multiply by the selected premium rate. Supplemental coverage is subject to underwriting guidelines.

Newly eligible associates may enroll up to $200,000 without evidence of insurability. Any increase to coverage after this enrollment will require evidence of insurability (EOI). To meet this requirement, complete the medical history statement online. This link is also available on Workday on the Enrollment submission page, and on the intranet.

Biweekly Premium

Based on age throughout the year.

Age	Cost per $1,000 of coverage	Age	Cost per $1,000 of coverage
29 under	0.030	55-59	0.225
30-34	0.033	60-64	0.283
35-39	0.040	65-69	0.499
40-44	0.054	70-74	0.820
45-49	0.084	75-79	1.508
50-54	0.134	80+	3.004

Dependent Life Insurance

You may choose life insurance coverage for your spouse/qualified partner and dependent children, provided the amount of your dependent coverage does not exceed 100 percent of your own life insurance benefit. Life insurance benefits for your spouse are available in $5,000 increments ranging from $5,000 to $50,000 and coverage for children is half the spouse amount in $2,500 increments from $2,500 to $25,000. Choose from one of the coverage pairings below; one premium covers your spouse and/or all eligible children. To determine the biweekly premium amount, locate the premium amount that corresponds to the benefit amount you wish to purchase.

Please refer to the Eligibility section for the definition of dependent children. Any increase to coverage after initial eligibility enrollment requires evidence of insurability. To meet this requirement, complete the **medical history statement online**. This link is also available on Workday on the Enrollment submission page, and on the intranet.

Spouse/Qualified Partner Benefit	Dependent Children	Biweekly Premium
$5,000	$2,500	$0.49
$10,000	$5,000	$0.98
$15,000	$7,500	$1.47
$20,000	$10,000	$1.96
$25,000	$12,500	$2.45
$30,000	$15,000	$2.94
$35,000	$17,500	$3.43
$40,000	$20,000	$3.92
$45,000	$22,500	$4.41
$50,000	$25,000	$4.90

Disability Benefits

Short-Term Disability
Short-Term Disability benefits are provided by the company to regular, full-time associates 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. This plan coordinates coverage with all applicable state temporary disability benefits.

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.

Begins Where Short-Term Plan Leaves Off

Coverage for this benefit begins after 120 days of continuous disability. Usually, benefits for an eligible disability would be paid by the Short-Term Disability Plan during this waiting period.

Continuing Benefits
Once eligible, you will receive LTD benefits equal to 60 percent of your base salary (up to a maximum benefit of $18,000 per month) for the duration of the disability period or until you reach the plan's maximum benefit. Disability benefits for salespeople are based on the average of the last 24 months' incentive compensation and base salary. Your benefit is subject to integration guidelines with other sources of income.

Choice to Pay Tax on Premium
When you enroll, you must select whether or not you want to pay income tax on the company-paid Long-Term Disability premiums (labeled as post-tax option in Workday.) If you do not choose to pay the income tax now, you will pay tax on any subsequent disability benefits you receive (labeled as pre-tax option in Workday.) If you opt to treat the premiums as income, they will produce tax-free disability benefits. This is a one-time decision at the time of initial eligibility and cannot be changed.

Support Solution (EAP)

To help you manage life's daily challenges, Trustmark offers Support Solution, a service provided through Trustmark Health Benefits. Support Solution offers confidential, expert content and comprehensive tools at no cost to you or your eligible dependents. When feelings of anxiety and stress are heightened and can be overwhelming, Support Solution will help you find the care that is appropriate for what you are going through. Services included with our new EAP are:

Short-Term Counseling

All Trustmark benefits-eligible associates and your eligible dependents will receive up to five counseling sessions with a licensed clinician to address issues such as:

- Anxiety
- Depression
- Marriage and relationship problems
- Grief and loss
- Substance Abuse
- Anger management
- Work-related pressures
- Stress

Referrals

In addition to short-term counseling, you can count on Support Solution for referrals and consultations for legal, financial or family issues.

Website Access

Support Solution is available at no charge and is completely confidential. You can contact Support Solution anytime, around-the-clock, 365 days a year. Getting started is easy.

1. Visit Support Solution at https://trustmark.mysupportportal.com/
   Enter **tmk** in lowercase in the login field.

2. For support by phone, call **(800) 845-3240**.

Integrated Support Solution with Your Medical Plan

For associates and their dependents covered under the medical plan, Support Solution offers additional support by integrating the EAP with the medical plan. When you contact Support Solution to find a provider, Support Solution will ensure that the provider is also in your medical network. Then, should you need to continue services with your provider beyond the five visits provided by the EAP, you will be able to continue services with the same provider under your medical plan.

Deductible and coinsurance will apply for continued services under the medical plan. Support Solution also coordinates with the medical plan's utilization management and case management services for an enhanced, integrated approach that delivers support through the continuum of behavioral health care services as you need them.

Please contact Trustmark Health Benefits with any questions at (877) 367-5690.

Caregiver and Childcare Support Program

Associates who are taking care of loved ones with complex, chronic or ongoing care needs can save time, money and stress with Wellthy. Wellthy is a company-paid service for caregivers that provides comprehensive care support for families. Wellthy connects caregivers with their own private Care Coordinator – that means best-in-class knowledge and support, simplified communication, and everything in one place on their online care dashboard.

Guidance from experts who know the care industry

Your Wellthy Care Coordinator knows your story beginning to end. They'll guide your whole family through a care plan, advocate for your loved one, and tackle those tricky tasks. Wellthy Care Coordinators know their way around the system – from healthcare to insurance and beyond. Your Care Coordinator can:

- Schedule appointments
- Refill prescriptions
- Handle prior authorizations
- Source and vet in-home aides
- Handle a move into a care facility
- Help resolve insurance bill discrepancies

Family communication, simplified

Keep siblings, friends, even neighbors in the loop and on board with care with streamlined communication – one email thread, one moderator, one voice of reason.

Everything you need, all in one place

Your dashboard keeps everything safe and accessible, for whenever you need it. Keep track of appointments, save your contacts, organize tasks by type, store important documents, and revisit past conversations.

Childcare support

In these complicated times, even the simplest family care decisions are more complex. Parents will do everything they can to keep their kids engaged, challenged, social, physically active, and supported. Navigating the maze of childcare is nerve-racking, time consuming, and frankly just a lot to take on. We know that time is precious, especially when balancing work and other family responsibilities.

Wellthy extends their service experience beyond aging care, special needs, and complex care support to help families find the right options for their children. Whether it is finding a babysitter/nanny, local program, virtual programs, or something more specific. Get personalized support for your family needs for tasks like:

- Sourcing and vet in-home childcare like a nanny or babysitter
- Evaluating available education-focused options
- Exploring virtual and/or local recreational activities to keep children entertained

To access the program, visit wellthy.com/trustmark.

Home and Auto Discounts

Liberty Mutual has partnered with Trustmark 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, 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.

Pet Insurance

Through its partnership with Liberty Mutual, Trustmark offers discounted pet insurance for associates' dogs and cats from ASPCA Pet Health Insurance. Any elected coverage is maintained directly between the employee and ASPCA and premium payment is made to ASPCA. ASPCA's Complete Coverage offers protection for your pet when they're hurt or sick. You can set your annual coverage limit with choices from $5,000 to unlimited.

The plan covers:

- Accidents
- Illnesses
- Dental disease
- Behavioral issues
- Hereditary conditions and more.

What's not covered:

- Pre-existing conditions
- Breeding costs
- Cosmetic procedures

To get a quote, visit https://www.aspcapetinsurance.com/trustmark.

Voluntary Benefits at Discounted Rates for Associates

Trustmark associates can get these valuable benefits for themselves and their family, at special discounted rates, during the annual Voluntary Benefits special enrollment. ** NOTE ** The 2020 annual Voluntary Benefit enrollment has ended and will not happen again until 2021.

Trustmark Universal Life & Universal LifeEvents® Insurance with Long-Term Care Benefit

- **Two-in-one security** that combines **permanent life insurance** with benefits that can help with the high costs of **long-term care services**.
- Select a benefit amount that works for you, and **"lock in" a rate** that is designed to last a lifetime and doesn't increase due to age.
- For the same rate, the Universal LifeEvents option provides a **higher death benefit** during your working years. The death benefit then reduces after age 70.[1] You also get a higher benefit for long-term care that never reduces.

Trustmark Critical HealthEvents® Insurance

- Pays **cash straight to you** when you are diagnosed with **cancer, heart attack or stroke**, and may pay benefits for **earlier identification** of illness.
- Full benefits no matter what your health insurance covers; use the benefit any way you wish.
- Your **maximum benefit amount is restored every year**, so your plan can keep you protected for your whole life.
- Healthy living rider **pays you $50 annually** for getting a covered test for early detection and prevention.

Trustmark Accident Insurance

- Pays you to help with the cost of covered **accidental injuries**, at work or outside of work, and the **services** you use to help treat them.
- Can help with things like **medical co-pays and deductibles**, getting to and from the hospital, and your everyday expenses.
- Benefits are **paid in cash**, and you can use them for whatever you need most.

Trustmark Hospital StayPay® Insurance

- Helps you keep a **hospital trip affordable** with cash benefits for admission and each day spent in the hospital due to a covered sickness or accident, normal childbirth or mental wellness/addiction recovery.
- Designed to **pair with your medical plan** so you can be more confident in your protection.
- Flexibility to **adjust your benefit** amount as your needs change.
- Get **paid $100 back automatically** every two years you don't file a claim.

With all Voluntary Benefits plans:

- Benefits paid in cash, **in addition** to any other insurance you have, with no restrictions on how you use them.
- **Apply for family members** as well as for yourself.
- Fully **portable** – keep your coverage, at the same rate and benefits, if you change jobs or retire.
- Pay for coverage via **convenient payroll deduction**, as long as you stay employed with Trustmark.
- **File a claim** or manage your Trustmark Voluntary Benefits policy online at TrustmarkVB.com.

Plan forms GUL.205/IUL.205, CII 214, A-607, HII 119 and applicable riders are underwritten by Trustmark Insurance Company, Lake Forest, Illinois. In New York, plan form IUL.205 NY and applicable riders are underwritten by Trustmark Life Insurance Company of New York, Albany, New York. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Pre-existing condition limitations may apply. Benefits, availability, exclusions and limitations may vary by state and may be named differently. Your policy will contain complete information. In FL, the long-term care benefit is an Accelerated Death Benefit. In NY the long-term care benefit is a Convalescent Care Benefit. In MA, the long-term care benefit is an Accelerated Death Benefit for Chronic Illness. Trustmark®, LifeEvents®, Trustmark Critical HealthEvents®, Trustmark Paycheck Protect® and Trustmark Hospital StayPay® are registered trademarks of Trustmark Insurance Company. [1]Universal LifeEvents death benefit reduces to one-third at the latter of age 70 or the 15th policy anniversary; issue age is 18-64.

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
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
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 VERIFICATION DOCUMENTATION REQUIREMENTS

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 TRUSTMARK SERVICES COMPANY, TRUSTMARK HEALTH BENEFITS and HEALTH FITNESS CORPORATION**

NOTICE OF PRIVACY PRACTICES

Covered Person Information. Covered Person Rights. Plan Administrator Responsibilities.

Effective Date of this Notice: September 23, 2013

This notice describes how medical information about the *covered person* may be used and disclosed and how he can get access to this information. Please review it carefully.

COVERED PERSON RIGHTS

The ***covered person*** has the right to:

- Get a copy of his health and claims records
- Correct his health and claims records
- Request confidential communication
- Ask the ***plan administrator*** to limit the information it shares
- Get a list of those with whom the ***plan administrator*** has shared information
- Get a copy of this privacy notice
- Choose someone to act for the ***covered person***
- File a complaint if the ***covered person*** believes his privacy rights have been violated

COVERED PERSON CHOICES

The ***covered person*** has some choices in the way that the ***plan administrator*** uses and shares information as it:

- Answers coverage questions from the ***covered person's*** family and friends
- Provides disaster relief
- Markets its services and sells the ***covered person's*** information

PLAN ADMINISTRATOR'S USES AND DISCLOSURES

The ***plan administrator*** may use and share the ***covered person's*** information as it:

- Helps manage the health care treatment the ***covered person*** receives
- Run the ***plan administrator's*** organization
- Pay for the ***covered person's*** health services
- Administer the ***covered person's*** health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

THE COVERED PERSON'S RIGHTS

When it comes to the ***covered person's*** **health information, he has certain rights.** This section explains the ***covered person's*** rights and some of the ***plan administrator's*** responsibilities to help the ***covered person***.

Get a copy of health and claims records

- The ***covered person*** can ask to see or get a copy of his health and claims records and other health information the ***plan administrator*** has about him. The ***covered person*** may ask the ***plan administrator*** how to do this.
- The ***plan administrator*** will provide a copy or a summary of the ***covered person's*** health and claims records, usually within 30 days of his request. The ***plan administrator*** may charge a reasonable, cost-based fee.

Ask the plan administrator to correct health and claims records

- The ***covered person*** can ask the ***plan administrator*** to correct the ***covered person's*** health and claims records if he thinks they are incorrect or incomplete. The ***covered person*** may ask the ***plan administrator*** how to do this.
- The ***plan administrator*** may say "no" to the ***covered person's*** request, but the ***plan administrator*** will tell him why in writing within 60 days.

Request confidential communications

- The ***covered person*** can ask the ***plan administrator*** to contact the ***covered person*** in a specific way (for example, home or office phone) or to send mail to a different address.
- The ***plan administrator*** will consider all reasonable requests, and must say "yes" if the ***covered person*** tells the ***plan administrators*** he would be in danger if the ***plan administrator*** does not.

Ask the plan administrator to limit what it uses or shares

- The ***covered person*** can ask the ***plan administrator*** not to use or share certain health information for treatment, payment, or ***Plan*** operations.
- The ***plan administer*** is not required to agree to the ***covered person's*** request, and the ***plan administrator*** may say "no" if it would affect the ***covered person's*** care.

Get a list of those with whom the plan administrator has shared information

- The ***covered person*** can ask for a list (accounting) of the times when the ***plan administrator*** shared the ***covered person's*** health information for six years prior to the date the ***covered person*** asks, who it was shared with, and why.
- The ***plan administrator*** will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any the ***covered person*** asked the ***plan administrator*** to make). The ***plan administrator*** will provide one accounting a year for free but will charge a reasonable, cost-based fee if the ***covered person*** asks for another one within 12 months.

Get a copy of this privacy notice

The ***covered person*** can ask for a paper copy of this notice at any time, even if the ***covered person*** has agreed to receive the notice electronically. The ***plan administrator*** will provide the ***covered person*** with a paper copy promptly.

Choose someone to act for the *covered person*

- If the ***covered person*** has given someone medical power of attorney or if someone is the ***covered person's*** legal guardian, that person can exercise the ***covered person's*** rights and make choices about the ***covered person's*** health information.
- The ***plan administrator*** will make sure the person has this authority and can act for the ***covered person*** before taking any action.

Covered Person may file a complaint if he feels his rights are violated

- The ***covered person*** can complain if he feels the ***plan administrator*** has violated his rights by contacting the ***plan administrator*** at Privacy Officer, Privacy Request, Trustmark Companies, P.O. Box 7961, Lake Forest, Il 60045-7961.
- The ***covered person*** can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- The ***plan administrator*** will not retaliate against the ***covered person*** for filing a complaint.

THE COVERED PERSON'S CHOICES

For certain health information, the *covered person* can tell the plan administrator his choices about what information is shared. If the ***covered person*** has a clear preference for how the ***plan administrator*** shares his information in the situations described below, the ***covered person*** should tell the ***plan administrator*** what he wants it to do, and the ***plan administrator*** will follow the instructions.

In these cases, the ***covered person*** has both the right and choice to tell the ***plan administrator*** to:

- Share information with the ***covered person's*** family, close friends, or others involved in payment for his care
- Share information in a disaster relief situation

*If the **covered person** is not able to tell the **plan administrator** his preference, for example if he is unconscious, the **plan administrator** may go ahead and share the **covered person**'s information if it believes it is in the **covered person**'s best interest. The **plan administrator** may also share the **covered person**'s information when needed to lessen a serious and imminent threat to health or safety.*

In these cases the ***plan administrator*** will *never* share the ***covered person's*** information unless he gives written permission:

- Marketing purposes
- Sale of the ***covered person's*** information

USES AND DISCLOSURES

How does the plan administrator typically use or share the covered person's health information?

The ***plan administrator*** typically uses or shares the ***covered person's*** health information in the following ways.

- **Help manage the health care treatment the covered person receives**
  The ***plan administrator*** can use the ***covered person's*** health information and share it with professionals who are treating him.
  *Example: A doctor sends information about the **covered person's** diagnosis and treatment plan so the plan administrator can arrange additional services.*

- **Run the organization**
  - The ***plan administrator*** can use and disclose the ***covered person's*** information to run its organization and contact him when necessary.
  - The ***plan administrator*** is not allowed to use genetic information to decide whether it will give the ***covered person*** coverage and the price of that coverage. This does not apply to long term care plans.

  Example: The plan administrator uses health information about the covered person to develop better services for him.

- **Pay for the covered person's health services**
  The ***plan administrator*** can use and disclose the ***covered person's*** health information as it pays for his health services.
  Example: The plan administrator shares information about the covered person with the dental plan to coordinate payment for his dental work.

- **Administer the Plan**
  The ***plan administrator*** may disclose the ***covered person's*** health information to his health plan sponsor for ***Plan*** administration.
  Example: The covered person's company contracts with the plan administrator to provide a health plan, and it provides the company with certain statistics to explain the premiums charged.

How else can the plan administrator use or share the covered person's health information?

The *plan administrator* is allowed or required to share the *covered person's* information in other ways – usually in ways that contribute to the public good, such as public health and research. The *plan administrator* has to meet many conditions in the law before it can share the *covered person's* information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- **Help with public health and safety issues**
  The *plan administrator* can share health information about **the *covered person*** for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

- **Do research**
  The *plan administrator* can use or share **the *covered person's*** information for health research.

- **Comply with the law**
  The *plan administrator* will share information about **the *covered person*** if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that the ***plan administrator*** is complying with federal privacy law.

- **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**
  - **The *plan administrator*** can share health information about the ***covered person*** with organ procurement organizations.

- **The *plan administrator*** can share health information with a coroner, medical examiner, or funeral director when an individual dies.

- **Address workers' compensation, law enforcement, and other government requests**
  The *plan administrator* can use or share health information about the ***covered person***:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

- **Respond to lawsuits and legal actions**
  The *plan administrator* can share health information about the ***covered person*** in response to a court or administrative order, or in response to a subpoena.

THE PLAN ADMINISTRATOR'S RESPONSIBILITIES

- **The *plan administrator* is required by law to maintain the privacy and security of the *covered person's* protected health information.**
- **The *plan administrator* will let the *covered person* know promptly if a breach occurs that may have compromised the privacy or security of his information.**
- **The *plan administrator* must follow the duties and privacy practices described in this notice and give the *covered person* a copy of it.**
- **The *plan administrator* will not use or share the *covered person's* information other than as described here unless he tells the *plan administrator* it can in writing. If the *covered person* tells the *plan administrator* it can, the *covered person* may change his mind at any time. The *covered person* should let the *plan administrator* know in writing if he changes his mind.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

CHANGES TO THE TERMS OF THIS NOTICE

The *plan administrator* can change the terms of this notice, and the changes will apply to all information the *plan administrator* has about the *covered person*. The new notice will be available upon request, on the *plan administrator's* web site, and the *plan administrator* will mail a copy to the *covered person*.

OTHER INSTRUCTIONS FOR NOTICE

- A ***covered person*** may contact the Trustmark Services Company, Trustmark Health Benefits, Inc. or Health Fitness Corp. representative at the following address:

  Privacy Officer
  Privacy Request
  Trustmark Companies
  P.O. Box 7961
  Lake Forest, Il 60045-7961

  Email – PrivacyOffice@trustmarkbenefits.com

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

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

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

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

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

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

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

[If the Plan provides retiree health coverage, add the following paragraph:]

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- *[add if Plan provides retiree health coverage:* Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

[*Enter name of the Plan and name (or position), address and phone number of party or parties from whom information about the Plan and COBRA continuation coverage can be obtained on request.*]

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 coinsurances that apply to mastectomies under the terms of the Plan.

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

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 Tracy Rhomberg, Human Resources trhomberg@trustmarkbenefits.com or 847-283-2093.

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 Trustmark Services Company/Trustmark Health Benefits, Inc./Health Fitness Corp.		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? Tracy Rhomberg		
11. Phone number (if different from above) 847-283-2093	12. Email address trhomberg@trustmarkbenefits.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.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

*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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Important Notice

This booklet provides an overview of your benefits choices and is not intended to be all-inclusive. The items 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.

400 Field Drive, Lake Forest, IL 60045
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