Compliant with the **Affordable Care Act** as it applies to self-funded plans

Starmark *Healthy*Edge℠

PPO Advantage Plan Designs

Self-Funded Health Plan Designs and Stop-Loss Insurance for Small to Mid-Size Businesses

Trustmark LIFE INSURANCE COMPANY |

PERSONAL. FLEXIBLE. TRUSTED.

Starmark *Healthy*Edge℠

The benefits you want. The protection you need.

Employers like you often struggle to find healthcare benefit options that give you the control, flexibility and value you need – until now. With *Healthy*Edge, you get better control over your health benefits, the flexibility to tailor your self-funded plan to your specific needs, and the opportunity to receive a refund if your group's claims are lower than previously expected and funded. To learn more about self-funding and how your financial risk is minimized with stop-loss insurance, refer to the separate brochure, *Self-Funding: A guide for small to mid-size businesses.*

Why Starmark?

Starmark's expertise in group healthcare benefits has served employers for 30 years.

Control costs and customize benefits through truly flexible mix-and-match plan designs.

Achieve greater network access and in-network discounts with nationwide access to national and regional PPO networks, including Aetna Signature Administrators® (ASA) PPO Network, Cigna® PPO Network and Private Healthcare Systems (PHCS), a MultiPlan network.

Experience cost-effective pharmaceutical care through prescription drug management programs that use a nationwide network of retail pharmacies as well as home delivery and mail order pharmacy services.

Encourage your employees to get and stay healthy with the *Care*Champion 24/7® health advocacy service, and Healthy Foundations® health and wellness management suite.

Make enrollment easy with Express Connect®, Starmark's paperless employee enrollment process.

More than great benefits!

- Experience Starmark's unparalleled personal service.
- Choose from flexible plan designs to create a plan to meet your needs and budget.
- Employers have trusted Starmark® to serve the healthcare benefit needs of their employees since 1985.

Starmark: Personal. Flexible. Trusted.

Starmark is headquartered with the Trustmark Companies in this prairie-style building in Lake Forest, Illinois. ▶

Starmark *Healthy*Edge℠ PPO Advantage

Get the advantage of a familiar benefit offering with the cost-saving feature of separate accruals; one for in-network and another for out-of-network services.

Customize Your Health Plan Design

Starmark® self-funded plan designs are flexible and offer a wide range of choices so you can customize your plan to meet your needs and budget. Refer to the separate insert (MK85) for a comparison of state-mandated benefits for fully insured plans to Starmark self-funded plan designs. Ask your broker for details.

Individual Deductible[1] *(in-network/out-of-network)*

- **Calendar Year –** The 12-month period from January 1 to December 31 during which covered expenses can be applied to satisfy the deductible. The accumulation period resets every January 1.
- **Plan Year –** The 12-month period during which covered expenses can be applied to satisfy the deductible. The plan year begins with the group's effective date and the accumulation period resets 12 months later, on the plan's anniversary.

$ 0/$2,000	$1,000/$2,000	$3,000/$6,000	$5,000/$10,000
$ 250/$750	$1,500/$3,000	$3,500/$7,000	$6,000/$12,000
$ 500/$1,500	$2,000/$4,000	$4,000/$8,000	$6,350/$12,500
$ 750/$1,500	$2,500/$5,000	$4,500/$9,000	$6,600/$13,000

Coinsurance *(in-network/out-of-network)*

100/70[2]	90/70	80/60	70/50	50/50

Individual Out-of-Pocket Limit[1] *(in-network/out-of-network)*

$ 0/$5,000[3]	$1,500/$6,000	$ 3,000/$8,000	$5,000/$12,000
$ 250/$4,000	$1,750/$6,500	$ 3,250/$8,500	$5,500/$12,500
$ 500/$5,000	$2,000/$7,000	$ 3,500/$9,000	$6,000/$12,000
$ 750/$6,000	$2,250/$7,500	$ 3,750/$9,500	$6,350/$12,500
$1,000/$6,500	$2,500/$8,000	$4,000/$10,000	$6,600/$13,000
$1,250/$5,500	$2,750/$7,500	$4,500/$11,000	

The individual out-of-pocket limit is the amount of covered charges the member must pay each year. The out-of-pocket limit includes the plan deductible, coinsurance, copays, access fees, and prescription deductibles, coinsurance and copays.

Family Deductible[1] and Out-of-Pocket Limit[1] Multiplier

A multiple of the individual deductible and out-of-pocket limit.

- One time
- Two times

Lifetime Maximum Benefit

Unlimited for essential health benefits (as defined by federal regulation)

[1]In- and out-of-network deductibles and in- and out-of-network out-of-pocket limits accrue separately. When the in-network deductible is equal to the in-network out-of-pocket limit, only the 100/70 coinsurance can be selected. For plan design purposes, the sum of the in-network deductible, emergency room copay, inpatient admission and outpatient surgery access fees, prescription deductible and non-preferred brand prescription retail copay must be less than the in-network out-of-pocket limit.

[2]When the 100/70 coinsurance is selected and the in-network deductible is equal to the in-network out-of-pocket limit, copays for office visits, urgent care, and emergency room, and inpatient admission and outpatient surgery access fees cannot be selected. Additionally, the Price Assurance Program outpatient prescription drug benefit must be selected.

[3]When the $0/$5,000 individual out-of-pocket limit is selected, the $0/$2,000 individual deductible and 100/70 coinsurance must be selected; however, the inpatient admission and outpatient surgery access fees, and copays for office visits, urgent care, emergency room, therapies and alternative medicine cannot be selected. Additionally, the outpatient diagnostic x-ray and lab benefit must be subject to the deductible and coinsurance, and the Price Assurance Program outpatient prescription drug benefit must be selected.

Benefit Options

Select a physician/specialist office visit copay, urgent care copay and emergency room copay to personalize your self-funded plan design. If desired, a therapy and/or alternative medicine copay can be selected, with the amount dependent on the physician/specialist office visit copay selected. Copays apply toward the out-of-pocket limit, but do not apply toward the plan deductible.

Physician/Specialist Office Visit	Therapies (optional copay)	Alternative Medicine (optional copay)	Urgent Care[1]
■ $20 copay	$20 copay	$20 copay	■ $40 copay
■ $25 copay	$25 copay	$25 copay	■ $45 copay
■ $30 copay	$30 copay	$30 copay	■ $60 copay
■ $35 copay	$35 copay	$35 copay	■ $65 copay
■ $40 copay	$40 copay	$40 copay	■ $75 copay
■ $45 copay	$45 copay	$45 copay	■ $80 copay
■ $50 copay	$50 copay	$50 copay	■ $85 copay
■ $60 copay	$60 copay	$60 copay	■ $100 copay
■ Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	■ Deductible and coinsurance

Physician/Specialist Office Visit

Covered charges are paid in full after the in-network physician/specialist office visit copay. This includes charges for the visit, professional fees for allergy injections and certain non-surgical injections performed at the same office visit, and billed by the attending physician. Additionally, the copay applies to in-network manipulative therapy and includes procedures provided at the office visit. Diagnostic x-rays are subject to the outpatient diagnostic x-ray and lab benefit selected. Refer to the Covered Services section of this brochure for more information.

The physician/specialist office visit copay does not apply to preventive care services, allergy testing and allergy serum, or any surgical procedure. Coverage for preventive care services is described in the Self-Funded Plan Design Features section of this brochure. Surgical procedures, as well as services when a copay is not selected, are subject to the plan deductible and coinsurance.

Therapies

Speech, occupational and physical therapy

The therapy copay applies to in-network speech, occupational and physical therapies. Therapies provided at a physician/specialist office visit may also be subject to the separate physician/specialist office visit copay. Therapies received at a hospital are subject to the plan deductible and coinsurance, and count toward the maximum visit limit. If a copay is not selected, covered services are subject to the plan deductible and coinsurance.

Alternative Medicine

The alternative medicine copay applies to in-network services. If a copay is not selected, covered services are subject to the plan deductible and coinsurance. For a list of covered alternative medicine services, refer to the Covered Services section of this brochure.

Urgent Care

Covered charges are paid in full after the in-network urgent care copay. This includes charges for x-ray, lab, pathology and radiology services performed at the same visit and billed by the urgent care center.

The urgent care copay does not apply to preventive care services or any surgical procedure. Coverage for preventive care services is described in the Self-Funded Plan Design Features section of this brochure. Surgical procedures, as well as services when a copay is not selected, are subject to the plan deductible and coinsurance.

Emergency Room

Copay Choices: ■ $250 ■ $500

Covered charges are paid in full after the copay. The copay is not waived if admitted as inpatient.

Charges for non-emergency treatment received in the emergency room, or services received when a copay is not selected, are subject to the plan deductible and coinsurance. Copays apply toward the out-of-pocket limit, but do not apply toward the plan deductible. For information on emergency admissions, see page 10.

[1] The urgent care copay must be equal to or greater than the physician/specialist office visit copay.

Outpatient Diagnostic X-Ray and Lab

Choices:

- 100% up to $250 per person, per year
- 100% up to $500 per person, per year
- 100% up to $1,000 per person, per year
- 100% unlimited (no dollar limit per person, per year)
- Coinsurance only (deductible waived)[1]
- Deductible and coinsurance

Coverage includes in-network x-ray, lab, pathology and radiology services. This benefit does not apply to diagnostic imaging tests such as CAT, MRI, PET and SPECT scans. Diagnostic imaging tests, covered charges exceeding the maximum or services received out-of-network, are subject to the plan deductible and coinsurance.

Inpatient Admission and Outpatient Surgery Access Fees Option

Choices: ■ $500 ■ $750 ■ $1,000

When the optional inpatient admission and outpatient surgery access fees are selected, an additional access fee applies to facility charges for each hospital admission, and to facility charges for each outpatient surgical visit. After these access fees are paid, covered charges are subject to the plan deductible and coinsurance. These access fees apply toward the out-of-pocket limit, but do not apply toward the plan deductible. For information on emergency admissions, see page 10.

Note: These access fees cannot be selected individually.

Supplemental Accident Option

Choose supplemental accident benefits to help prepare your employees for an unexpected accident or injury by providing first-dollar coverage.

- The first $500 of covered charges per accident is paid at 100 percent under your self-funded plan design.
- Additional covered charges are subject to the plan deductible and coinsurance.
- Coverage includes medical charges resulting from accidental injury incurred within 90 days of the accident.

Maternity Option

Selecting the maternity option provides your employees with peace of mind when planning for pregnancy and delivery. Normal maternity and nursery care covered charges are subject to the plan deductible and coinsurance.

[1]The coinsurance only option is not available when the 100/70 coinsurance is selected.

*Care*Champion 24/7® Option

*Care*Champion 24/7 is an optional health advocacy service that supports members as they navigate through the healthcare system. Advisors are available anytime, day or night, and can help members find a doctor or hospital in-network, understand healthcare benefits and claim payments, identify cost-saving opportunities, handle eldercare issues and more!

*Your*Care Option

Choose the optional *Your*Care health and wellness program to help your employees protect their most important asset – their health. *Your*Care provides members with proactive, timely and personalized information, including:

- Wellness reminders to encourage preventive tests and screenings based on age and gender.
- Personalized, detailed reminders to help members stay current with recommended guidelines for managing a chronic condition.
- Outreach from registered nurses to assist members who have one or more serious health conditions.
- Access to online self-coaching programs to help members create a personalized plan to meet their health goals.

Starmark® Provides Unparalleled Personal Service

- **Starmark calls each new group** to welcome them and follows up to ensure satisfaction continues throughout the year.
- Starmark's **website provides information and resources** to help groups manage their plan and to help members better manage their healthcare.
- Members have **quick access to important documents and benefit information** at www.starmarkinc.com and can quickly access claim status using their telephone keypad.
- Representatives assist to **make transitioning to future contract years easy.**

Outpatient Prescription Drug Benefit Choices Offer Flexibility

Starmark *Healthy*Edge[SM] self-funded plan designs offer 2 prescription drug benefit options to meet your group's needs: a prescription drug card or the Price Assurance Program.

1 | Prescription Drug Card

Prescription Deductible

Must be met in full every year by each member before the copay applies. The prescription deductible does not apply to generics.

- $0 per person
- $100 per person
- $250 per person
- $500 per person

Retail Copay (up to a 30-day supply)			Mail Service Copay (up to a 90-day supply)		
Generic	Preferred Brand	Nonpreferred Brand	Generic	Preferred Brand	Nonpreferred Brand
$ 0	$30	$50	$ 0	$ 75	$150
$ 0	$45	$75	$ 0	$110	$225
$ 7	$25	$45	$14	$ 60	$135
$10	$30	$50	$20	$ 75	$150
$10	$30	$75 or 50%*	$20	$ 75	$200
$15	$30	$60	$30	$ 75	$180
$15	$45	$75	$30	$110	$225
$20	$60	$90	$40	$150	$270

The prescription drug deductible, coinsurance and copays accumulate toward the out-of-pocket limit. The prescription drug deductible does not apply to the medical plan deductibles. Credit from prior plan drug card deductibles and carry-over provisions do not apply to the prescription benefit.

When members or their provider choose a brand-name drug when a generic is available, members must pay the generic copay plus the difference in charges between the generic and brand-name drug.

*$75 or 50%, whichever is greater, up to $200 per prescription

OR

2 | Price Assurance Program

This program provides prescription drug savings at participating pharmacies nationwide. Covered prescription drugs are subject to the in-network plan deductible and coinsurance when the prescription is filled at a participating pharmacy.

When members present their medical ID card at a participating pharmacy, they receive:

- The lowest price available in that store, on that day
- Generic drug savings
- Drug utilization review

The Price Assurance Program includes most drugs that, by federal law, require a prescription. If a prescription drug is excluded from coverage under your self-funded plan design, members may still receive a discount on their prescription through this program.

Prescription Safeguards

To encourage the safe and appropriate use of prescription drugs, Starmark® plan designs utilize quantity limits and prior authorization for certain drug classes covered by the prescription benefit. These limits and prior authorizations are intended to ensure proper prescription utilization and clinically appropriate quantities. Additionally, Specialty Guideline Management, provided by Starmark's contracted pharmacy benefit manager, helps to ensure members receive the most appropriate specialty medication for managing their complex medical conditions. Refer to the separate brochure, *Safety, Savings and Convenience*, for more information.

To learn more about the prescription drug benefit, specialty pharmacy services and ways to save on prescriptions, refer to the separate brochure, *Making the Most of Your Prescription Benefit.*

Visit a Participating Pharmacy to Maximize Benefits

Participating pharmacies have contracted with Starmark's contracted pharmacy benefit manager to charge a fixed amount for prescription drugs. Nonparticipating pharmacies may charge a price significantly above this amount, which may mean higher prescription expenses for members. When a nonparticipating pharmacy is used, the member pays the full price of the prescription drug at the time of purchase.

Self-Funded Plan Design Features

Self-funded plan designs can have many of the same features as a traditional health plan.

Preventive Care Services

Covered preventive care services received in-network will be paid under your self-funded plan design at 100 percent.[1] Out-of-network services are subject to the plan deductible and coinsurance. Covered preventive care services include, but are not limited to:

- Routine physical exam
- Blood and other laboratory tests
- Screening ECG (electrocardiogram)
- Immunizations
- Mammograms: baseline and annual
- PSA (prostate-specific antigen)
- Colorectal cancer screening
- Screening for tobacco use
- Women's preventive services
  - Well-woman visits, including prenatal routine office visits
  - Pap smear
  - HPV (human papillomavirus) testing
  - Contraceptive methods and counseling
  - Breastfeeding support, supplies and counseling

Age and frequency schedules apply. For a complete list of preventive care services, visit **www.hhs.gov/healthcare/prevention/index.html.**

In no event will benefits for preventive care services be less than that which is required by state or federal law, as applicable.

Lab Card® Program

*Healthy*Edge PPO Advantage plan designs include the Lab Card Program. This voluntary program offers 100 percent coverage for covered outpatient laboratory testing when testing is directed to a participating Quest Diagnostics laboratory as part of the Lab Card Program. Provider collection and handling fees may apply and are subject to health benefit plan provisions. For more information, visit **www.labcard.com**.

Note: The Lab Card Program is not available when the Cigna® PPO Network or the SuperMed® Network is selected. Quest Diagnostics Incorporated is a provider of laboratory testing, information and services, and is not an affiliate of Trustmark or Starmark®.

Physician/Hospital PPO Network Selection

Offering employees a choice of PPO networks encourages in-network utilization while maintaining freedom of choice in provider care.

- You may select two networks per business location up to a maximum of five networks.
- By using in-network providers, your employees can take advantage of negotiated discounts. If an out-of-network provider is used, the member is responsible for any amount exceeding the Reasonable and Customary Fee[2].

Note: Some networks have guidelines that may limit availability with other networks.

Receive Network Access While Outside the Primary PPO Service Area

When members and their eligible dependents encounter an unexpected illness or need medical treatment while outside their primary PPO network's coverage area, they can take advantage of in-network benefit levels, subject to the terms of your plan, and PHCS-negotiated discounts by using PHCS Healthy Directions. Members can visit a PHCS Healthy Directions provider when:

- Traveling for business or vacation
- Attending an out-of-area educational institution
- Residing outside their primary PPO network's coverage area

Members who have the Aetna Signature Administrators® (ASA) PPO Network, Cigna PPO Network or Private Healthcare Systems (PHCS) as their network maintain provider access through these networks when outside the primary PPO service area.

For more information about PHCS Healthy Directions, refer to the separate flyer (MK60b).

[1]Preventive care benefits are in accordance with guidelines from the U.S. Preventive Services Task Force, Health Resources and Services Administration, and the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

[2]Reasonable and Customary Fee is the lesser of the provider's actual charge, or 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. Refer to the proposal for details.

Covered Services

When medically necessary, eligible charges for the following services are payable under your self-funded plan design subject to the plan deductible, coinsurance and, for out-of-network providers, Reasonable and Customary Fee[1].

Hospital and Provider Services

- Semiprivate hospital room, board and general inpatient nursing care
- Intensive care unit
- Miscellaneous services and supplies provided by a hospital on an inpatient basis
- Miscellaneous services and supplies provided by a hospital or free-standing surgical center and related to outpatient surgery or outpatient treatment of injury
- Anesthetics and their administration
- Physician's fees, except as otherwise noted
- Preventive care services[2]
- Emergency services

Other Services and Supplies

- Prescription drugs (See page 6 for details on outpatient prescription drug benefits.)
- Blood and blood plasma, oxygen and rental of equipment for its administration
- Local licensed ambulance service to or from a hospital
- X-rays (not dental x-rays) and laboratory tests performed for diagnosis and treatment
- X-ray, radium, cobalt and radioactive isotope therapy
- Artificial limbs and eyes
- Casts, splints, trusses, crutches and nondental braces
- Rental of a wheelchair, hospital-type bed or other durable medical equipment
- Habilitative and rehabilitative devices
- Complications of pregnancy
- Outpatient pre-admissions testing
- Hospice care
  - Maximum of 6 months while covered under this plan
- Home healthcare
  - Maximum of 100 days per year
- Skilled nursing care
  - Maximum of 81 days per year
- RN and LPN fees for private-duty nursing recommended by a physician
- Nondental treatment of temporomandibular joint dysfunction (TMJ)
- Chronic pain treatment programs
  - Maximum of 10 visits per year

Therapies

- Habilitative and rehabilitative services, including speech, occupational and physical therapist's fees, when prescribed by a physician
  - 60-visit limit per therapy per year
- Manipulative therapy
  - 20-visit limit per year

Alternative Medicine

- Acupuncture, massage therapy and naturopathic services
  - 12-visit limit per therapy, per year
- Nutritional counseling[3]
  - 3-visit limit while covered under this plan, except for diabetic counseling

[1]Reasonable and Customary Fee is the lesser of the provider's actual charge, or 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. Refer to the proposal for details.
[2]Coverage for preventive care services is described in the Self-Funded Plan Design Features section of this brochure.
[3]Nutritional counseling may be covered under preventive care services.

Mental Illness, Nervous Disorders, Substance Abuse and Alcohol Abuse

Groups with up to 50 employees[1]

- Outpatient expenses
  - 40-visit limit per year; 120 visits while covered under this plan
  - Covered charges are paid at 60 percent for an in-network provider; 50 percent for an out-of-network provider.
- Inpatient expenses
  - 20 days per year; 40 days while covered under this plan. These limits do not apply to inpatient alcohol abuse treatment.
  - Covered charges are paid according to the in- and out-of-network coinsurance selected.

Groups with 51 or more employees

- Outpatient and inpatient expenses
  - Covered charges are paid the same as any other covered service.

Organ Transplants

- Designated transplant facility
  - Covered charges for approved transplant services, including organ procurement or acquisition, are paid at 100 percent.
  - Coverage is provided for transportation, lodging and meals for a companion, subject to the following limits:
    a. Transportation benefit: maximum of $1,000 per approved transplant procedure
    b. Lodging and meals benefit: maximum of $250 per day; $10,000 while covered under this plan
- Nondesignated transplant facility
  - Covered charges for approved transplant services at an out-of-network facility, including organ procurement or acquisition, are paid at 70 percent.
  - No coverage is provided for transportation, lodging or meals for a companion.

[1]Covered charges may be payable under the Enhanced Health Benefits Package, if selected.

Optional Health Benefits Packages for Your Plan Design

Offer your employees a more complete benefit package by choosing these optional health benefits packages. Since the passage of the Affordable Care Act, employees may expect these benefits in their health plan. Packages may be selected individually.

Enhanced Health Benefits Package

- Mental illness, nervous disorders, substance abuse and alcohol abuse
  - Covered charges are paid the same as any other covered service.
- Routine adult vision screening
  - 100% coverage for one exam per year for adults ages 19 and older
- Routine adult hearing screening
  - 100% coverage for one exam per year for adults ages 19 and older
- Hearing aids
  - Covered charges are paid the same as any other covered service and are limited to a single purchase, including repair and replacement, every 24 months.

Infertility Health Benefits Package

Female members are eligible for benefits up to age 40. Covered charges are paid the same as any other covered service for the following:

- Ovulation induction limited to 6 cycles while covered under this plan
- Intrauterine insemination
- In-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT) or low tubal ovum transfer
- Pre-implantation genetic testing, when medically necessary

Exclusions and limitations apply.

Healthy Foundations® Helps Members Get and Stay Healthy

Healthy Foundations provides a comprehensive suite of health and wellness management tools to help members get and stay healthy, which can help control your plan costs. Healthy Foundations includes: MyNurse 24/7℠, a URAC-accredited nurse line; MaternaLink® maternity wellness program; online support tools and the Healthy Foundations wellness e-newsletter. Plus, you can elect to add the optional *Your*Care health and wellness program with personalized outreach to help employees protect their most important asset – their health.

To learn more, visit www.starmarkinc.com.

Precertification

Precertification is required for all hospital, rehabilitation or skilled nursing admissions, behavioral health residential treatment, hospice, home healthcare or transplant-related services, and outpatient diagnostic imaging tests including, but not limited to, CAT, MRI, PET and SPECT scans.

- To precertify, the member must call the toll-free number listed on the medical identification card.
- Failure to precertify will result in a $300 penalty per occurrence. This penalty will not count toward the plan deductible, or toward the out-of-pocket limit.
- Precertification does not guarantee self-funded plan benefits are payable. The person must be eligible at the time of service.

Emergency Admissions

In the case of an emergency admission, the member must call the toll-free number listed on the medical identification card within 48 hours after the admission or on the next regular business day after the start of treatment, if later.

Failure to call will result in a $300 penalty per occurrence. This penalty will not count toward the plan deductible, or toward the out-of-pocket limit.

Note: If selected, the inpatient admission fee also applies.

Pre-existing Conditions

In accordance with the Affordable Care Act, self-funded plans with an effective date on or after January 1, 2014, are prohibited from excluding or limiting pre-existing conditions from coverage. This means that self-funded plans must cover eligible expenses for pre-existing conditions beginning with the effective date of the self-funded plan.

Deductible Credit for New Groups

A member continuously covered under a prior individual or group health plan with a calendar-year deductible will be credited for any portion of the deductible satisfied under the prior plan during the same calendar year. Deductible credit will not be given if moving to or from a health plan with a plan-year deductible.

Credit is not provided for out-of-pocket amounts, prescription drug card deductibles or for employees added to a self-funded plan after the group's initial effective date.

Limited Occupational/ 24-Hour Coverage

Sickness or injury which occurs while working for wage or profit is not covered, except for a member who is a sole proprietor, partner or executive officer of the company sponsoring a Starmark®-administered plan who is not required by law to have Workers' Compensation or similar coverage and does not have such coverage.

Enrollment

Annual Open Enrollment Period

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year.

Waiting Period

The waiting period is the amount of time the employee must wait before he or she is eligible for coverage under your self-funded plan. The waiting period cannot exceed 90 days.

Timely Enrollees

Timely enrollees are eligible employees who *complete and sign* an Employee Eligibility Statement for themselves and/or their dependents during the employer's waiting period and prior to the end of the initial enrollment period. The initial enrollment period is the 31 days following the waiting period.

Special Enrollees

Special enrollees are employees or dependents who previously waived self-funded coverage, but may now be eligible because they have *involuntarily* lost their other coverage, had a benefit/coverage change or had a life-changing event. The enrollment period for a special enrollee is the 31 days following the special enrollment event (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage).

Special guidelines apply for special enrollees. For more details, refer to the *Important Notice* (UW105 SF) or ask your broker.

Off-Anniversary Terminations

If the stop-loss insurance contract terminates before the end of the contract period, there is no aggregate stop-loss insurance available for the months the contract was in force. As a result, the employer is responsible for reimbursing Trustmark Life Insurance Company and/or Starmark for any aggregate advances and aggregate stop-loss insurance claims paid. The employer is also responsible for paying all covered claims, below the specific deductible, that were incurred and not paid while the plan was in force. Additionally, if the 2/3 Administrative Fee Credit Surplus or the 2/3 Administrative Fee Credit, 2/3 Cash Surplus option was selected, the employer forfeits the surplus.

Hospital Bill Reward Program

If a member detects and resolves an error when reviewing hospital bills, he or she will be rewarded 50 percent of the savings, up to $1,000, under your self-funded plan design.

Exclusions and Limitations

Major Medical

No benefits are payable under your self-funded plan design for the following expenses:

- Services and supplies not prescribed by a physician or required to treat a covered condition, or in excess of the Reasonable and Customary Fee[1], or not medically necessary
- Dental care and treatment, including pediatric dental care and treatment; hearing aids[2], eyeglasses, eyeglass frames and contact lenses; eye or hearing exams[2,3]; all other vision care services; some foot treatment
- Cosmetic surgery; hair prosthesis and transplants; treatment for abnormal male breast enlargement
- Charges the member is not legally required to pay; charges for missed appointments; surcharges for weekend nonemergency office visits and home visits by a physician; treatment rendered by a member of the member's family; occupational sickness and injury, except for members who are not covered by workers' compensation or similar coverage and are not required by law to have such coverage
- Normal pregnancy, elective abortions and routine nursery care, unless maternity benefits are selected; treatment for infertility, except for services related to the diagnosis of infertility, unless the Infertility Health Benefits Package is selected; pregnancy and all associated charges of a person who is not an eligible employee or dependent including, but not limited to, a surrogate; reversal of sterilization
- Weight reduction[3]; smoking deterrent medications[3]; sex transformation or its reversal; restoration or enhancement of sexual activity
- Most treatment for snoring; excessive sweating; phonophoresis; surface electromyogram; therapeutic cold devices; x-rays or tests not related to diagnosis or treatment of sickness or injury, unless otherwise specified
- Most dietary supplements[3]; experimental/investigational drugs or treatment; items for comfort or convenience; expenses at a health spa; family or marriage counseling, aversion therapy, nonmedical self-care or self-help programs; custodial care
- Suicide, attempted suicide or intentional self-inflicted injury, if not the result of a medical condition; injury resulting from one's own illegal use of alcohol, drugs or over-the-counter medications, if not the result of a medical condition
- Acts of war; participation in a riot; commission of or attempt to commit a felony; engaging in an illegal occupation

Optional Infertility Health Benefits Package

No benefits are payable under your self-funded plan design for the following expenses:

- Cryopreservation (freezing) or banking of eggs, embryos or sperm; medications for sexual dysfunction; recruitment, selection and screening, and any other expenses of donors; pregnancy and all associated charges of a person who is not an eligible employee or dependent including, but not limited to, a surrogate; reversal of sterilization

[1]Reasonable and Customary Fee is the lesser of the provider's actual charge, or 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. Refer to the proposal for details.
[2]If the Enhanced Health Benefits Package is selected, hearing aids and routine adult hearing and vision screenings are covered, subject to plan provisions.
[3]No benefits are payable under your self-funded plan design for these expenses, except as required under federal guidelines for preventive care.

Starmark® HRA: Seamless. Innovative. Bottom-line friendly.

Save money and help your employees manage healthcare costs. Pair a higher-deductible health plan with the **Starmark HRA** (health reimbursement arrangement) for lower health plan costs and cash-flow control – with the added bonus of:

- **Seamless claims and HRA integration,** which means no claims to file
- **No prefunding;** HRA expenses are funded only as incurred
- **Easy fund management** for employees

Our mission:

Helping people increase well-being through better health and greater financial security.

Self-funded plans are administered by Starmark®, and stop-loss insurance is provided by Trustmark Life Insurance Company.

Trustmark: An employee benefits company for more than 100 years

- The Trustmark Companies serve more than 2 million covered lives or plan participants.
- Trustmark Life Insurance Company is rated A- (Excellent) by A.M. Best.

Starmark: Serving the healthcare benefit needs of employer groups for 30 years

With expertise in group healthcare benefits, Starmark offers self-funded plan designs, tools to manage healthcare costs, paperless employee enrollment, nationwide network access and seamless HRA administration for small to mid-size businesses.

The information contained in this product brochure is a general description of features, benefits, requirements and restrictions of the self-funded benefit plan designs. More details are provided in the self-funded plan document, which is the prevailing document and the basis for benefit payment. Plan designs are subject to change to comply with federal healthcare reform, as necessary. Plan design availability and/or stop-loss coverage may vary by state. Subchapter S corporations should consult their tax advisor as benefits from a self-funded plan may be taxable. MyNurse 24/7℠ is a service mark of Health Fitness Corporation, a Trustmark Company.

PERSONAL. FLEXIBLE. TRUSTED.

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MK122-er (1-1-15) rev1