Plan designs to pair with an HSA.
More engaged employees.

Starmark *Healthy*Edge℠

CDHP Advantage Plan Designs

Self-Funded Health Plan Designs and Stop-Loss Insurance Specifically for Businesses With Ten or More Employees

Trustmark LIFE INSURANCE COMPANY | Starmark®

PERSONAL. FLEXIBLE. TRUSTED.

Starmark *Healthy*Edge℠

The benefits you want.
The protection you need.

Employers like you often struggle to find healthcare benefits 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, *Understanding how Starmark HealthyEdge funding works for businesses with 10 or more employees.*

Why Starmark?

For more than 25 years, Starmark has served thousands of employers with expertise in group healthcare benefits.

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 and 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[SM] CDHP Advantage

Get the advantage of a consumer-directed health plan design that can be paired with an HSA, and the cost-saving feature of separate accruals; one for in-network and another for out-of-network services.

Customize Your Health Plan Design

Plan design flexibility allows you to tailor your self-funded plan to meet your needs and budget. In order to stay within the government-established guidelines for maximum out-of-pocket expense for an HSA qualified plan, certain deductible, coinsurance and coinsurance limit combinations are not available. Refer to the separate flyer, *Pairing a Starmark HealthyEdge[SM] Plan Design with an HSA* and ask your broker for details.

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.

Individual	Family
$ 1,200/$2,400	$ 2,400/$4,800
$ 1,500/$3,000	$ 3,000/$6,000
$ 2,000/$4,000	$ 4,000/$8,000
$ 2,500/$5,000	$ 5,000/$10,000
$ 3,000/$6,000	$ 6,000/$12,000
$ 4,000/$8,000	$ 8,000/$16,000
$5,000/$10,000	$10,000/$20,000

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

- 100/70
- 90/70
- 80/60
- 70/50

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

- $5,000/$10,000
- $10,000/$20,000
- $15,000/$30,000

Deductible Type *Choose one.*

- **Aggregate:** Benefits are payable once the entire family deductible is met.
- **Embedded:** Benefits are payable for a member once either the individual deductible is met, or for the entire family once the family deductible is met.

In order for the self-funded plan to be qualified for use with an HSA, the embedded deductible must be selected only with individual deductibles of $2,500 ($5,000 for families) or higher.

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

Out-of-Pocket Limits[1]

The percentage of covered charges the member must pay each year before benefits will be paid at 100 percent. The family out-of-pocket limit is two times the individual out-of-pocket limit. Note: For members with family coverage, benefits are paid at 100 percent once the entire family out-of-pocket limit is met. The out-of-pocket limit does not include the deductible. Refer to your proposal for the out-of-pocket limits applicable to your self-funded plan design.

- Example: Using an 80/60 coinsurance and the $5,000/$10,000 coinsurance limit, the out-of-pocket limits are calculated as follows:

	In-network	Out-of-network
Individual	20% of $5,000 = $1,000	40% of $10,000 = $4,000
Family	2 x $1,000 = $2,000	2 x $4,000 = $8,000

The deductibles and out-of-pocket limits are based on the Consumer Price Index (CPI). Federal law requires an annual cost-of-living adjustment based on changes in the CPI; therefore, these plan designs may be adjusted annually.

[1] In- and out-of-network deductibles and out-of-pocket limits accrue separately.

Starmark® Provides Unparalleled Personal Service

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

Benefit Options

Select from the following options to enhance your self-funded benefit plan design.

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.

*Care*Champion 24/7® Option

*Care*Champion 24/7 is a 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 outreach 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

Outpatient Prescription Drug Benefit

Price Assurance Program

This program provides prescription drug savings at participating pharmacies nationwide.

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. Covered prescription drugs are subject to the in-network plan deductible and coinsurance when the prescription is filled at a participating pharmacy. 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 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.

Covered Services

When medically necessary, 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]

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

Other Services and Supplies

- Prescription drugs (See page 5 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
- Complications of pregnancy
- Outpatient pre-admissions testing
- Hospice care
  — Maximum of six months per lifetime
- 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

- 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, naturopathic services
  — 12-visit limit per therapy, per year
  — Maximum of $250 per therapy, per visit
- Nutritional counseling[3]
  — 3-visit limit per lifetime, except for diabetic counseling

[1] Reasonable and Customary Fee is the lesser of the provider's actual charge, or a percentage of the Medicare reimbursement rate in effect at the time services are provided.

[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

- Outpatient expenses
  - — 40-visit limit per year; 120 visits per lifetime
  - — Covered charges are paid at 60 percent for an in-network provider (100 percent of the 100 in-network coinsurance is selected); 50 percent for an out-of-network provider.
- Inpatient expenses
  - — 20 days per year; 40 days per lifetime. 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 per lifetime
- 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.

Healthy Foundations® Helps Members Get and Stay Healthy

Healthy Foundations provides a comprehensive suite of health and wellness management tools to help maximize the health potential of every member. Healthy Foundations includes *My*Nurse 24/7®, 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 outreach program to help employees protect their most important asset – their health.

To learn more, visit www.starmarkinc.com.

Self-Funded Plan Design Features

Preventive Care Services

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

- Physician office visits for preventive care services
  - Adult physicals
  - Routine ob/gyn visits
  - Well-child visits
- Routine mammograms
- PSA (prostate-specific antigen)
- Colonoscopy
- Adult and child immunizations (including flu and pneumonia shots)

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

In no event will benefits for preventive care services be less than that which is required by state or federal law, as applicable. Reasonable medical management techniques may be used to determine appropriate frequency, method or setting for a preventive care service to the extent such service is not specified in the guidelines or recommendations.

Lab Card® Select Program

All *Healthy*Edge CDHP Advantage plan designs include the Lab Card Select Program. This voluntary discount program offers outpatient laboratory testing at significant savings compared with other labs when testing is directed to a participating Quest Diagnostics laboratory as part of the Lab Card Select Program. For more information, visit **www.labcardselect.com**.

Note: Quest Diagnostics Incorporated is a provider of laboratory testing, information and services, and is not affiliated with 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].

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 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 or Private Healthcare Systems (PHCS) as their network maintain in-network status 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 a percentage of the Medicare reimbursement rate in effect at the time services are provided.

Precertification

Precertification is required for all hospital, rehabilitation or skilled nursing admissions, behavioral health residential treatment, hospice, home healthcare or transplant-related services, and high-tech outpatient radiology services, including CT, MRI and PET 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.

Pre-existing Conditions

A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a six-month period immediately preceding the effective date of coverage.

For persons ages 19 and older, benefits will not be paid for a pre-existing condition during the first 12 months of coverage under the self-funded plan design (18 months for late enrollees). If a person had creditable coverage with no more than a 63-day gap in coverage, time covered under the prior plan will be credited toward satisfying the 12- or 18-month pre-existing condition limitation period.

Deductible Credit for New Groups

A member continuously covered under a prior individual or group health plan with a calender-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 or for employees added to a self-funded plan after the group's initial effective date.

Enrollee Definitions

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 or 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).

Late Enrollees

Late enrollees are eligible employees or dependents who request enrollment *following* the initial enrollment period. The initial enrollment period is the 31 days following the employer's waiting period or special enrollment event.

Special guidelines apply for special enrollees and late enrollees. For more details, refer to the *Important Notice for Pre-existing Condition Limitations and Special Enrollment Rights* (UW105 SF) or ask your broker.

Limited Occupational/ 24-Hour Coverage

Work-related injuries and illnesses are covered under your self-funded plan design for members when the member is not covered by workers' compensation or similar coverage and is not eligible for such coverage.

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.

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, or not medically necessary
- Dental care and treatment; hearing aids, eyeglasses and contact lenses; eye or hearing exams[1]; some foot treatment, including orthotics
- 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; work-hardening programs; occupational sickness and injury, except for members who are not covered by workers' compensation or similar coverage and are not eligible for such coverage
- Normal pregnancy, elective abortions and routine nursery care, unless maternity benefits are selected; surrogate parenting; reversal of sterilization; some assisted conception
- Weight reduction[1]; smoking deterrent medications[1]; sex transformation or its reversal; restoration or enhancement of sexual activity
- Sensory integration therapy, central auditory processing disorder; 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
- Maintenance speech, occupational and physical therapy; speech therapy for psychosocial speech delay, behavioral problems (including impulsive behavior and impulsivity syndrome), attention disorder, conceptual handicap or mental retardation
- Most dietary supplements[1]; 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; home traction devices; custodial care
- Suicide, attempted suicide or intentional self-inflicted injury, if not the result of a medical condition; injury resulting from one's own negligent or illegal use of alcohol, drugs or over-the-counter medications
- Acts of war; participation in a riot; commission of or attempt to commit a felony; engaging in an illegal occupation

[1] No benefits are payable under your self-funded plan design for these expenses, except as required under federal guidelines for preventive care.

Pair Your Plan with an HSA

Freedom of Choice

By selecting a *Healthy*Edge CDHP Advantage plan design, you can:

- Save on health plan costs by choosing the cost-savings feature of a high-deductible self-funded health plan design compared to a traditional self-funded health plan design.
- Design a self-funded plan with options that help attract and retain valued employees.
- Use the self-funded plan design on a stand-alone basis or pair it with a health savings account (HSA).
- Establish an HSA through a Starmark®-recommended HSA custodian, or through any other administrator or financial institution that offers HSAs.

Ask your broker to help determine the self-funded plan design that best suits your business needs and budget.

Why an HSA?

Tax Advantages

Contributions to an HSA can be made by anyone and are either made pretax or are tax deductible. Any balances in the account are not taxed when used to pay for qualified medical expenses. Additionally, interest on the HSA grows tax deferred. Note: Tax advantages vary by state.

Full-Year Contribution

Employees can open an HSA in any month and still have the ability to make the maximum annual contribution to the account, regardless of the effective date. Restrictions apply. Consult your financial advisor.

Portability

Funds roll over at the end of each year and belong to the employee, even when changing employers or switching to a different high-deductible health plan.

Choice

Employees select how their HSA funds are spent and invested. Funds can also be accumulated to enhance a retirement portfolio.

What Is an HSA?

An HSA is a personal bank account owned by an individual with a high-deductible health plan and used to pay for qualified medical expenses not reimbursed under the health plan.

For more information about HSAs, refer to the separate brochure, *Get the Most Out of Your Health Plan. HDHPs and HSAs: A Powerful Combination.* For investment, tax or legal advice, consult a licensed professional.

Trustmark, an employee benefits company for nearly 100 years, is dedicated to providing financial security, improving health and well-being, and helping people navigate the healthcare system. Serving more than 2 million covered lives or plan participants, Trustmark is rated A- (Excellent) by A.M. Best. Self-funded plans are administered by Starmark, and stop-loss insurance is provided by Trustmark Life Insurance Company.

Starmark® is a distinguished leader in group healthcare benefits offering self-funded and fully insured plan designs. With paperless employee enrollment, health and wellness programs, nationwide network access and seamless HRA administration, Starmark is the choice in employer healthcare benefits.

The information contained in this product brochure is a general description of features, benefits, requirements and restrictions of the benefit plan design. 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. If the stop-loss insurance contract is terminated before the end of the contract period, the annual aggregate attachment point will be deemed not satisfied and the employer remains responsible for funding eligible claims incurred during the time the self-funded plan was in force. Subchapter S corporations should consult their tax advisor as benefits from a self-funded plan may be taxable.

PERSONAL. FLEXIBLE. TRUSTED.

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