

# Starmark Signature Series



Health plans for businesses with two to 50 employees

Choose from a familiar, traditional series of comprehensive health plans:

- Signature Advantage
- Signature Select
- Signature Freedom

 **Starmark**<sup>®</sup>  
Small business is our only business.

**REPRESENTING THE STANDARD** in healthcare benefits, the Starmark Signature Series features several options that enable employers to tailor the plan to their group's specific needs. Plus, this classic choice is the time-tested preference for those employers who want to provide their employees with a familiar health plan.



## Rich Benefit Choices Offer Ultimate Flexibility

**Signature Series** plans are ideal if you're seeking a health plan that offers:

- True **flexibility** with the ability to customize coverage to meet your needs
- **Familiarity** for your employees
- An office visit feature with **copays**
- **Prescription drug card** with \$0 deductible on generic drugs
- **Options**, such as preventive care and supplemental accident coverage
- **Freedom** to choose any provider
- Online healthcare **decision support tools** for your employees

Plus, by choosing a Signature Series plan, you'll receive Starmark's unparalleled personal service and advanced technology.

A familiar plan. A traditional choice.

## Select a Signature Series Plan

Plan design flexibility allows you to tailor your plan by selecting up to two deductibles and coinsurances, as well as one coinsurance limit and an office visit feature. Ask your agent for details about the available combinations. Refer to the separate state insert page (MK10) for state-specific plan variances, if applicable.

Signature Advantage	Signature Select	Signature Freedom
A PPO plan that features separate accruals; one for in-network and another for out-of-network services. Ideal for areas with robust networks.	A PPO plan that features a combined accrual of in- and out-of-network services. Ideal for areas with limited networks.	An indemnity plan that is generally available only to groups located in ZIP codes without network physicians or hospitals.
<p style="text-align: center;"><b>Individual Calendar-Year Deductible<sup>1</sup></b> <i>(in-network/out-of-network)</i></p> <ul style="list-style-type: none"> <li>• \$ 250/\$750</li> <li>• \$ 500/\$1,500</li> <li>• \$ 750/\$1,500</li> <li>• \$1,000/\$2,000</li> <li>• \$1,500/\$3,000</li> <li>• \$2,000/\$4,000</li> <li>• \$ 2,500/\$5,000</li> <li>• \$ 3,000/\$6,000</li> <li>• \$ 4,000/\$8,000</li> <li>• \$ 5,000/\$10,000</li> <li>• \$10,000/\$20,000</li> </ul>	<p style="text-align: center;"><b>Individual Calendar-Year Deductible</b> <i>(combined in- and out-of-network)</i></p> <ul style="list-style-type: none"> <li>• \$ 250</li> <li>• \$ 500</li> <li>• \$ 750</li> <li>• \$1,000</li> <li>• \$1,500</li> <li>• \$2,000</li> <li>• \$ 2,500</li> <li>• \$ 3,000</li> <li>• \$ 4,000</li> <li>• \$ 5,000</li> <li>• \$10,000</li> </ul>	<p style="text-align: center;"><b>Individual Calendar-Year Deductible</b></p> <ul style="list-style-type: none"> <li>• \$ 250</li> <li>• \$ 500</li> <li>• \$ 750</li> <li>• \$1,000</li> <li>• \$1,500</li> <li>• \$2,000</li> <li>• \$ 2,500</li> <li>• \$ 3,000</li> <li>• \$ 4,000</li> <li>• \$ 5,000</li> <li>• \$10,000</li> </ul>
<p style="text-align: center;"><b>Coinsurance</b> <i>(in-network/out-of-network)</i></p> <ul style="list-style-type: none"> <li>• 90/70</li> <li>• 80/60</li> <li>• 70/50</li> <li>• 60/40</li> </ul>	<p style="text-align: center;"><b>Coinsurance</b> <i>(in-network/out-of-network)</i></p> <ul style="list-style-type: none"> <li>• 90/70</li> <li>• 80/60</li> <li>• 70/50</li> <li>• 60/40</li> </ul>	<p style="text-align: center;"><b>Coinsurance</b></p> <ul style="list-style-type: none"> <li>• 80</li> <li>• 70</li> <li>• 60</li> </ul>
<p style="text-align: center;"><b>Coinsurance Limit</b> <i>(in-network/out-of-network)</i></p> <ul style="list-style-type: none"> <li>• \$ 5,000/\$15,000</li> <li>• \$10,000/\$20,000</li> <li>• \$15,000/\$30,000</li> </ul>	<p style="text-align: center;"><b>Coinsurance Limit</b> <i>(combined in- and out-of-network)</i></p> <ul style="list-style-type: none"> <li>• \$ 5,000</li> <li>• \$10,000</li> <li>• \$15,000</li> </ul>	<p style="text-align: center;"><b>Coinsurance Limit</b></p> <ul style="list-style-type: none"> <li>• \$ 5,000</li> <li>• \$10,000</li> <li>• \$15,000</li> </ul>
<p style="text-align: center;"><b>Office Visit Feature</b> <i>(in-network encounter fee)</i></p> <ul style="list-style-type: none"> <li>• \$20</li> <li>• \$30</li> <li>• \$40</li> <li>• No office visit feature</li> </ul>	<p style="text-align: center;"><b>Office Visit Feature</b> <i>(in-network encounter fee)</i></p> <ul style="list-style-type: none"> <li>• \$20</li> <li>• \$30</li> <li>• \$40</li> <li>• No office visit feature</li> </ul>	<p style="text-align: center;"><b>Office Visit Feature</b> <i>(office visit deductible)</i></p> <ul style="list-style-type: none"> <li>• \$20</li> <li>• \$30</li> <li>• \$40</li> <li>• No office visit feature</li> </ul>
<p><b>Lifetime Maximum Benefit:</b> Total in-network and out-of-network – \$5 million Total out-of-network or Signature Freedom – \$2 million</p>		
<p><b>Family Calendar-Year Deductible<sup>1</sup>:</b> Three times the individual calendar-year deductible.</p>		
<p><b>Annual Out-of-Pocket Limits<sup>1</sup>:</b> The percent of covered charges the insured must pay each year. The family out-of-pocket limit is 2.5 times the individual out-of-pocket limit. The annual out-of-pocket limit does not include the deductible. Refer to your rate proposal for the annual out-of-pocket limits applicable to your plan.</p>		

<sup>1</sup> In- and out-of-network deductibles and out-of-pocket limits accrue separately on Signature Advantage.



## Office Visit Feature

Selecting the Office Visit Feature provides your employees with a sense of security. Each time they visit their healthcare provider, they know – up front – the in-network encounter fee or office visit deductible amount. These amounts do not apply toward the calendar-year deductible or out-of-pocket limit.

### **\$200 per Office Visit**

The first \$200 of covered charges per office visit is paid in full after the encounter fee or office visit deductible. This includes charges for the visit, necessary x-rays and nonsurgical injections performed at the same office visit and billed by the attending physician.

Any balance – as well as covered charges when no office visit feature is selected – is subject to the calendar-year deductible and coinsurance.

The office visit feature does not apply to preventive care services or any surgical procedure. They are subject to the calendar-year deductible and coinsurance. Choose the Preventive Care Plus option for first-dollar coverage for select preventive care services.

### **Laboratory Testing Options**

Choose from two options:

- Labs included under the office visit feature
- Labs not included under the office visit feature

When labs are not included under the office visit feature, they are subject to the calendar-year deductible and coinsurance. All Signature Series plans include the Lab Card<sup>®</sup> Program whether or not laboratory testing is included under the office visit feature. More information on the Lab Card program is available under the Plan Features section of this brochure or at [www.labcard.com](http://www.labcard.com).

## Benefit Options

### **Preventive Care Plus Option**

Preventive Care Plus gives insureds first-dollar coverage for select preventive care services, such as a routine physical and child wellness visits. For a list of preventive care services, refer to the Covered Services section of this brochure.

Choose from two options:

- \$250 per person
- \$500 per person

Depending on the selection, either the first \$250 or \$500 of covered preventive care services per calendar year are paid at 100 percent. Additional covered charges are subject to the calendar-year deductible and coinsurance.

If this option is not selected, preventive care services are subject to the calendar-year deductible and coinsurance.

### **Supplemental Accident Option**

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

- The first \$500 of covered charges per accident is paid at 100 percent.
- Additional covered charges are subject to the calendar-year 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 insureds with peace of mind when planning for childbirth and delivery. Normal maternity and nursery care covered charges are payable the same as any other covered service.

Tailor your plan to meet your group's needs.

## Prescription Drug Card Choices Offer Flexibility

With Americans spending more than \$179 billion on prescription drugs every year, selecting a prescription drug card benefit that meets your employees' needs is crucial. That's why Starmark gives you deductible and copay choices for prescriptions filled at participating pharmacies.

### Prescription Calendar-Year Deductible

Tailor your plan by selecting a separate prescription calendar-year deductible. The deductible does not apply to generic drugs and must be met in full every year by each insured.

### Prescription Drug Card Copay

Choose the copay combination that best suits the needs of your employees. Choosing the \$20/\$60/\$100 or 30 percent retail copay combination offers a lower-cost alternative for providing prescription drug coverage to your employees while reducing your overall health plan premium.

Prescription Calendar-Year Deductible <i>(does not apply to generics)</i>	Retail Copay <i>(up to a 30-day supply)</i>			Mail Service Copay <i>(up to a 90-day supply)</i>		
	<i>Generic</i>	<i>Preferred Brand</i>	<i>Nonpreferred Brand</i>	<i>Generic</i>	<i>Preferred Brand</i>	<i>Nonpreferred Brand</i>
<ul style="list-style-type: none"> <li>\$0 per person</li> <li>\$250 per person</li> <li>\$500 per person</li> </ul>	<ul style="list-style-type: none"> <li>\$10</li> </ul>	<ul style="list-style-type: none"> <li>\$30</li> </ul>	<ul style="list-style-type: none"> <li>\$50 or 30%, whichever is greater; up to \$200 per prescription</li> </ul>	<ul style="list-style-type: none"> <li>\$20</li> </ul>	<ul style="list-style-type: none"> <li>\$75</li> </ul>	<ul style="list-style-type: none"> <li>\$150</li> </ul>
	<ul style="list-style-type: none"> <li>\$20</li> </ul>	<ul style="list-style-type: none"> <li>\$60</li> </ul>	<ul style="list-style-type: none"> <li>\$100 or 30%, whichever is greater; up to \$200 per prescription</li> </ul>	<ul style="list-style-type: none"> <li>\$40</li> </ul>	<ul style="list-style-type: none"> <li>\$150</li> </ul>	<ul style="list-style-type: none"> <li>\$300</li> </ul>

The prescription copay and calendar-year deductible do not apply toward the individual or family calendar-year deductibles, or toward out-of-pocket limits. Credit from prior plan drug card deductibles and carryover provisions do not apply to the prescription calendar-year deductible.

### Prescription Safeguards

To encourage the safe and appropriate use of prescription drugs, Starmark has implemented 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.

For more information about the prescription drug card benefit, specialty pharmacy services and ways to save on prescriptions, refer to the separate brochure, *Prescription Benefit Overview*.

### Visit a Participating Pharmacy to Maximize Benefits

Participating pharmacies have contracted with Starmark's 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 insureds. When a nonparticipating pharmacy is used, the insured pays the full price of the prescription drug and Starmark reimburses at the out-of-network coinsurance, using the drug cost as determined by the manufacturer.

Comprehensive coverage provides peace of mind.

## Covered Services

When medically necessary, charges for the following services are payable subject to the calendar-year deductible, coinsurance and, for out-of-network providers, Reasonable and Customary Fee\*:

### Hospital and Provider Services

- Semi-private 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<sup>1</sup>

### Preventive Care Services

- Physician office visit for a routine physical is limited to one visit per calendar year.
- Children under age 2 are covered for visits at the following age intervals: birth, 2, 4, 6, 9, 12, 15 and 18 months.
- CBC (complete blood count)
- Chemistry panel
- Hemocult
- Urinalysis
- Pap test
- Mammograms
  - A baseline mammogram for each person aged 35 to 39
  - An annual screening mammogram for each person aged 40 or older
- PSA (prostate-specific antigen) for males aged 40 or older
- Immunizations (including flu and pneumonia shots)
- Screening ECG (electrocardiogram) for persons over age 40 who have two or more cardiac risk factors

### Other Services and Supplies

- Prescription drugs
- 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) performed for diagnosis and treatment<sup>1</sup>
- Laboratory tests performed for diagnosis and treatment<sup>1</sup>
- 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 calendar year
- Skilled nursing care
  - Maximum of 81 days per calendar year
- RN and LPN fees for private-duty nursing recommended by a physician
  - Maximum of \$2,500 per calendar year
- Nondental treatment of temporomandibular joint dysfunction (TMJ)
  - Maximum of \$2,500 per lifetime
- Chronic pain treatment programs
  - Maximum of \$5,000 per calendar year

\* 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.

<sup>1</sup> These covered charges may be payable under the office visit feature, if selected.



## Therapies

- Speech, occupational and physical therapist's fees, when prescribed by a physician
  - 60-visit limit per therapy per calendar year
- \$1,000 per calendar-year limit for manipulative therapy

## Mental Illness, Nervous Disorders, Substance Abuse and Alcohol Abuse

- Outpatient expenses
  - 40-visit limit per calendar year; 120 visits per lifetime
  - Covered charges are paid at 60 percent for an in-network provider; 50 percent for an out-of-network provider or Signature Freedom.
- Inpatient expenses
  - 20 days per calendar year; 40 days per lifetime. These limits do not apply to inpatient alcohol abuse treatment.

## Organ Transplants

- Designated transplant facility
  - Approved transplant services, including organ procurement or acquisition, are paid at 100 percent, subject to the Lifetime Maximum Benefit of the plan.
  - 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
  - Approved transplant services, including organ procurement or acquisition, are limited to \$100,000 per lifetime, per person.
  - No coverage is provided for transportation, lodging or meals for a companion.

**HEALTHY FOUNDATIONS** is an integrated, online portal to help insureds make smart, informed choices. It's about helping people get and stay healthy. The benefits may include more productive employees, lower medical costs and a "healthier" bottom line for your business. Healthy Foundations features the following decision support tools:

- **HealthAtoZ** – Health information and interactive health management tools, such as detailed fitness, nutrition and safety guidance, and information about medical conditions and how to monitor them
- **Rx Price Comparison** – Lower-cost alternatives for more than 200 prescription drugs for chronic, or ongoing, conditions
- **Treatment Cost Comparison** – A range of cost estimates for in- and out-of-network providers based on ZIP code for a variety of services, such as physician office visits, diagnostic tests, lab tests and treatment of common medical conditions

For a demo of Healthy Foundations decision support tools, access the Visitor section of Starmark's website at [www.starmarkinc.com](http://www.starmarkinc.com).

Plan features enhance your coverage.

## Plan Features

### Lab Card® Program

This program offers covered outpatient laboratory testing provided through LabOne, now a part of Quest Diagnostics, at no additional cost. Provider collection and handling fees may apply and are subject to health benefit plan provisions. For more information, visit [www.labcard.com](http://www.labcard.com).

### Physician/Hospital PPO Network Selection

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

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

### Receive Network Access While Outside the Primary PPO Service Area

PHCS Healthy Directions provides in-network benefit levels and PHCS-negotiated discounts for insureds with a PPO network other than Private Healthcare Systems. Insureds 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

For more information, refer to the separate flyer, *PHCS Healthy Directions*. Insureds with Signature Freedom can also visit a PHCS Healthy Directions provider and receive PHCS-negotiated discounts at any time.

### Maternity Assessment Program Available at No Additional Cost

The Daily Developments maternity assessment program supplements the care provided by the physician. The program encourages prenatal care, provides educational materials and encourages insureds to take an active role in helping infants receive a healthy start.

Plus, Daily Developments participants receive **two free books** – one upon joining the program and another upon completion. To participate in the program, insureds simply call the toll-free number during the first five months of pregnancy.

**CONVENIENT NETWORK ACCESS** for multilocation/multistate and single-location businesses offers your employees:

- **Access to national and regional PPO networks**, including PHCS, one of the nation's largest PPO networks with nearly 450,000 providers and more than 4,000 facilities
- **Freedom of choice** in provider care
- **Negotiated discounts** when using in-network providers
- PHCS-negotiated **discounts when outside the primary PPO service area** through PHCS Healthy Directions



## Emergency Room Deductible

- Additional \$75 emergency room deductible per occurrence; waived if admitted as inpatient.
- After the additional emergency room deductible is met, covered charges are subject to the calendar-year deductible and coinsurance.
- The emergency room deductible does not apply toward individual or family calendar-year deductibles, or toward out-of-pocket limits.

## Precertification

Precertification is required for all hospital, rehabilitation or skilled nursing admissions, behavioral health residential treatment, hospice, home healthcare or transplant-related services.

- To precertify, the insured must call the toll-free number listed on the medical identification card.
- In the case of an emergency admission, the call must be made within 48 hours after the admission or on the next regular business day after the start of treatment, if later.
- Failure to precertify will result in a \$300 penalty per occurrence. This penalty will not count toward the individual or family calendar-year deductibles, or toward out-of-pocket limits.
- Precertification does not guarantee benefits are payable. The person must be eligible at the time of service.

**SAVE MONEY** on monthly administration fees. You may be able to reduce your monthly group administration fee by doing all three of the following:

- Sign up to use Starmark's Internet-based Automated Customer Environment (ACE) to access enrollment records and premium payment history.
- Use electronic funds transfer (EFT) to make premium payments.
- Sign up to receive billing statements by e-mail.

## 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.

### Groups With Previous Medical Coverage

Benefits are payable for a pre-existing condition, without pre-existing condition limitation, for insureds continuously covered under the prior carrier's plan and the Starmark-administered plan. Any portion of the deductible satisfied under the prior carrier's plan will be credited.

### Groups Without Previous Medical Coverage

Benefits will not be paid for a pre-existing condition during the first 12 months of coverage under the plan. 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-month limitation period.

## Enrollee Definitions

### Timely Enrollees

Timely enrollees are eligible employees who *complete and sign* an Employee Enrollment Form 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 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.

### 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 separate state insert page (MK10) or ask your agent.

#### **STARMARK GIVES YOU** unparalleled service:

- Starmark's customer contact specialist calls each new group personally to welcome them and to answer any questions.
- Starmark's website provides employers and insureds with around-the-clock access to helpful tools and important information.
- Starmark representatives are available by telephone to answer any questions.

## Limited Occupational/ 24-Hour Coverage

Work-related injuries and illnesses are covered only for sole proprietors, partners and executive officers of the company sponsoring a Starmark-administered plan where:

- The sole proprietor, partner or executive officer is covered by the plan; and
- The purchase of workers' compensation or similar coverage is not required; and
- The sole proprietor, partner or executive officer does not have workers' compensation or similar coverage.

## Renewability

Coverage for a participating employer or individual employee may not be canceled or nonrenewed on the basis of the health status of one or more insureds.

Coverage for a participating employer may be canceled for:

- Failure to meet minimum participation requirements
- Failure to meet minimum employer contribution requirements
- Nonpayment of premiums
- Fraud or intentional misrepresentation of material fact(s) in connection with the coverage

## Hospital Bill Reward Program

If an insured detects and resolves an error when reviewing hospital bills, he or she will be rewarded 50 percent of the savings, up to \$1,000.

## OFFER A COMPLETE BENEFIT PACKAGE

by selecting:

- Dental
- Life/Accidental Death and Dismemberment
- Short Term Disability
- Long Term Disability

All products are listed on a single bill. For more information, refer to the separate product brochures.



## Exclusions and Limitations

### Major Medical

No benefits are payable 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; some foot treatment, including orthotics
- Cosmetic surgery; hair prosthesis and transplants; treatment for abnormal male breast enlargement
- Charges the insured 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 insured's family; work hardening programs; occupational sickness and injury, except for some partners, sole proprietors and executive officers
- Normal pregnancy, elective abortions, routine nursery and well baby care, unless maternity benefits are selected; surrogate parenting; reversal of sterilization; some assisted conception
- Weight reduction; smoking deterrent medications; 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
- Nutritional counseling for chronic fatigue and ADD/HDD; most dietary supplements; alternative treatments; 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

As an expert in small group healthcare benefits, Starmark provides businesses with two to 50 employees a flexible healthcare benefits portfolio, including HSA- and HRA-compatible health plans, as well as convenient online services, nationwide network access and the personal service they deserve. Plans administered by Starmark are fully insured by Trustmark Life Insurance Company. Plan availability and/or coverage may vary by state.



The information contained in this product brochure is a general description of features, benefits, requirements and restrictions of Trustmark Life Insurance Company policy number SMP/1003. More details are provided in the Certificate of Insurance, which is the prevailing document and the basis for benefit payment.



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[www.starmarkinc.com](http://www.starmarkinc.com)

# Illinois

## Insert Page for State-Specific Product and Underwriting Information

This information replaces or supplements corresponding sections in the product brochure. Please refer to the Certificate of Insurance for more details.

## Plan Choices

### Coinsurance

The 60/40 in-network/out-of-network coinsurance is not available.

### Combinations for the Consumer Health Series

For 2006, the maximum out-of-pocket expense for an HSA-qualified plan cannot be greater than \$5,250 for individual coverage and \$10,500 for family coverage; therefore, the guidelines listed below apply.

Note: For plans with networks, the numbers refer to the in-network amounts. For example, 70 coinsurance refers to the 70/50 in-network/out-of-network coinsurance.

- The 60 coinsurance can be selected only with the \$5,000 coinsurance limit.
- The 70 coinsurance can be selected only with deductibles of \$2,000 or less when the \$10,000 coinsurance limit is chosen.
- The \$4,000 deductible can be selected only with the 100 or 90 coinsurance when the \$10,000 coinsurance limit is chosen.
- The \$4,000 deductible can be selected only with the 100, 90 or 80 coinsurance when the \$5,000 coinsurance limit is chosen.
- The \$5,000 deductible can be selected only with the 100 coinsurance.



## **IMPORTANT NOTICE**

### **PRE-EXISTING CONDITION LIMITATIONS and SPECIAL ENROLLMENT RIGHTS**

#### **Pre-existing Condition Limitation**

This group health plan contains a pre-existing condition exclusion that is limited to a maximum of 12 months (18 months for late enrollees). This exclusion period can be reduced by the number of days of your prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan is not required to take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you, you may present your certificate or certificates of prior creditable coverage.

Creditable coverage can include coverage under another group health plan, an individual health policy including a short term plan, Medicare, Medicaid, CHAMPUS, Federal Employees Health Benefit Plan (FEHBP), a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, governmental plans, church plan or a health plan issued under the Peace Corps Act, Social Security, or State Children's Health Insurance Program. You may request a certificate of creditable coverage from a previous employer, insurance company or Health Maintenance Organization (HMO). If necessary, we will assist you in obtaining a certificate from any of these entities. This Pre-existing Condition Limitation notice is being issued to you pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and reflects the protections afforded under federal law. If the state law applicable to your plan is more beneficial to covered individuals as to the length of the pre-existing condition limitation and permissible break in coverage, the relevant state law provisions will apply to and be part of your plan.

#### **Special Enrollments**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after the involuntary loss of other coverage. In addition, if your current coverage changes or you have a life-changing event, such as your marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the qualifying event. Coverage will become effective on the date of the qualifying event.

#### **Late Enrollees**

If you waive coverage at the original effective date of your employer's plan and do not qualify as a special enrollee, coverage will be postponed for up to 18 months following the date the Employee Enrollment Form is signed. If the enrollment form is more than 60 days old, the postponement period will begin the first of the month following the date the updated enrollment form is received by Starmark. The pre-existing condition limitation period is satisfied at the end of the postponement period.

If you are hired after the original effective date of your employer's plan and request enrollment for yourself or eligible dependents following the initial enrollment period, coverage will start on the first day of the month following the date the Employee Enrollment Form is signed. If the enrollment form is more than 60 days old, the enrollment form will be returned for updated information and signature and the effective date will be the first of the month following the date the enrollment form is received by Starmark. The pre-existing condition limitation above applies.

For more information, refer to your Certificate of Insurance or plan sponsor/employer.