

Simple plan design. Tools to manage costs.


Starmark *Healthy*EdgeSM

PPO 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 *HealthyEdge*SM

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 *HealthyEdge*, 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. Alternatively, you may choose not to offer outpatient prescription drug coverage.

Encourage your employees to get and stay healthy with the CareChampion 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 *HealthyEdge*SM 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

Plan design flexibility allows you to tailor your self-funded plan design to meet your needs and budget. Ask your broker for details.

Individual Deductible¹ (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 ²	■ \$ 750/\$1,500	■ \$ 2,000/\$4,000	■ \$ 4,000/\$8,000
■ \$ 250/\$750	■ \$ 1,000/\$2,000	■ \$ 2,500/\$5,000	■ \$ 5,000/\$10,000
■ \$ 500/\$1,500	■ \$ 1,500/\$3,000	■ \$ 3,000/\$6,000	■ \$ 10,000/\$20,000

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

■ 100/70 ²	■ 90/70	■ 80/60	■ 70/50	■ 50/50
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Coinsurance Limit (in-network/out-of-network)

■ \$5,000/\$10,000	■ \$10,000/\$15,000	■ \$15,000/\$20,000	■ \$20,000/\$25,000
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Family Deductible¹ and Out-of-Pocket Limit¹ Multiplier

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

- One time
- Two times
- Three times

Lifetime Maximum Benefit

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

Out-of-Pocket Limits¹

The percentage of covered charges the member must pay each year. The family out-of-pocket limit is one, two or three times the individual out-of-pocket limit, depending on the family deductible and out-of-pocket limit multiplier selected. 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, the \$5,000/\$10,000 coinsurance limit and a family out-of-pocket limit of two times the individual out-of-pocket 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

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

² When the \$0/\$2,000 deductible is selected with the 100/70 coinsurance, the physician/specialist office visit copay, and the prescription drug card or no outpatient prescription drug coverage must also be selected.

Benefit Options

Select a physician/specialist office visit copay and your self-funded plan design will include the corresponding urgent care copay. If desired, a therapy, alternative medicine and/or emergency room copay can be selected, with the amount dependent on the physician/specialist office visit copay selected.

Physician/Specialist Office Visit	Urgent Care	Therapies (optional)	Alternative Medicine (optional)	Emergency Room (optional)
■ \$25 copay	\$45 copay	\$25 copay	\$25 copay	\$250 copay
■ \$35 copay	\$65 copay	\$35 copay	\$35 copay	\$250 copay
■ \$45 copay	\$85 copay	\$45 copay	\$45 copay	\$250 copay
■ Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	\$200 access fee (per occurrence, waived if admitted as inpatient)

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, allergy injections and certain non-surgical injections performed at the same office visit, and billed by the attending physician.

The physician/specialist office visit 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.

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.

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.

Manipulative therapy

The therapy copay applies to in-network manipulative therapy and includes procedures provided at the office visit, except diagnostic x-rays. These are subject to the outpatient diagnostic x-ray and lab benefit selected.

If a copay is not selected, covered services are subject to the plan deductible and coinsurance. Refer to the Covered Services section of this brochure for more information.

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.

Emergency Room

■ **Copay:** Covered charges are paid in full after the copay. The copay is not waived if admitted as inpatient. If a copay is not selected, the separate \$200 emergency room access fee applies.

■ **Access Fee:** After the additional \$200 emergency room access fee is paid, covered charges are subject to the plan deductible and coinsurance.

Charges for non-emergency treatment received in the emergency room are subject to the plan deductible and coinsurance. Copays and the emergency room access fee do not apply toward the plan deductible or out-of-pocket limit. For additional information on emergency admissions, see page 10.

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
- Coinsurance only (deductible waived)¹
- Deductible and coinsurance

Coverage includes in-network x-ray, lab, pathology and radiology services. 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

When the optional inpatient admission and outpatient surgery access fees are selected, an additional \$500 access fee applies to facility charges for each hospital admission and an additional \$500 access fee applies 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 do not apply toward the plan deductible or out-of-pocket limit. 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.

CareChampion 24/7[®] Option

CareChampion 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!

YourCare Option

Choose the optional YourCare health and wellness outreach program to help your employees protect their most important asset – their health. YourCare 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

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

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

Outpatient Prescription Drug Benefit Choices Offer Flexibility

Starmark *HealthyEdge*SM self-funded plan designs offer 3 prescription drug benefit options to meet your group’s needs: a prescription drug card, the Price Assurance Program or no outpatient prescription drug coverage.

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
- \$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
■ \$15	\$30	\$ 60	\$30	\$ 75	\$180
■ \$15	\$45	\$ 75	\$30	\$110	\$225
■ \$20	\$60	\$100	\$40	\$150	\$300

The \$0 generic prescription drug copays can be selected only with the \$0 prescription deductible. The prescription copay and deductible do not apply toward the individual or family deductibles, or toward out-of-pocket limits. Credit from prior plan drug card deductibles and carry-over provisions do not apply to the prescription deductible.

2 | 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.

OR

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.

OR

3 | No Outpatient Prescription Drug Coverage

You may choose to waive coverage for outpatient prescription drugs. Members do not receive a discount and pay the full price for prescriptions filled at a retail, mail service or specialty pharmacy. Prescription drugs received inpatient or administered in a physician’s office are covered under your self-funded plan design, subject to the plan deductible and coinsurance.

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[®] Program

All *HealthyEdge* 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: 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 Fee².

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.

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 Fee¹.

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 services²

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) performed for diagnosis and treatment
- 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 counseling³
 - 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; 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 MyNurse 24/7®, MaternalLink® maternity wellness program, online support tools and the Healthy Foundations wellness e-newsletter. Plus, you can elect to add the optional YourCare health and wellness outreach program 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 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.

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

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 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 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 exams¹; 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 reduction¹; smoking deterrent medications¹; 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 supplements¹; 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.



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.

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.



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