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

Starmark *HealthyEdge*℠

CDHP Advantage Plan Designs

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

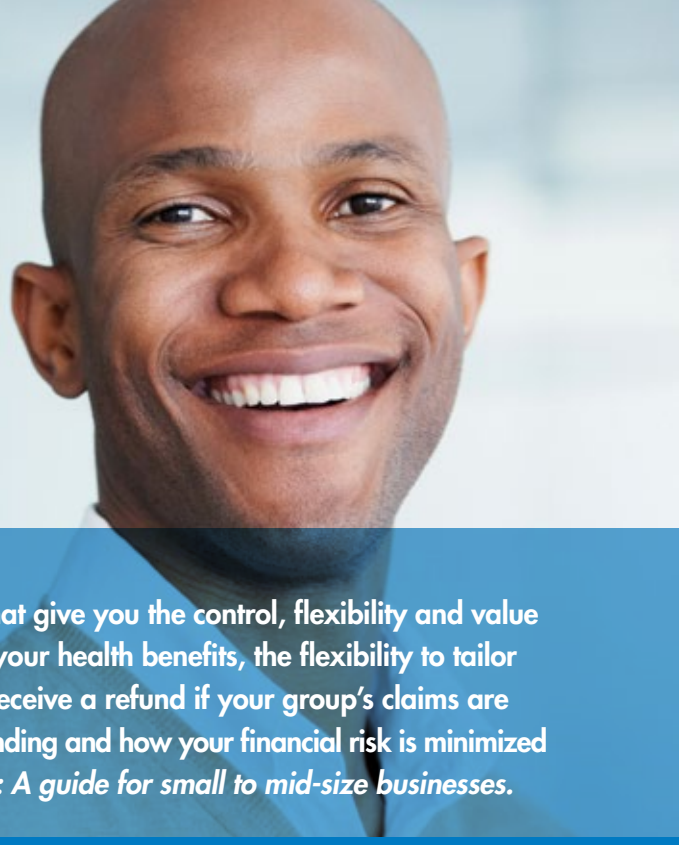
Starmark® *A Trustmark Company*

PERSONAL. FLEXIBLE. TRUSTED.®

Trustmark® LIFE INSURANCE COMPANY

Starmark *Healthy*Edge℠

The benefits you want.
The protection you need.



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

Why Starmark?

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

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

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

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

Encourage your employees to get and stay healthy with telemedicine services via Teladoc®, second opinions via Grand Rounds®, 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.

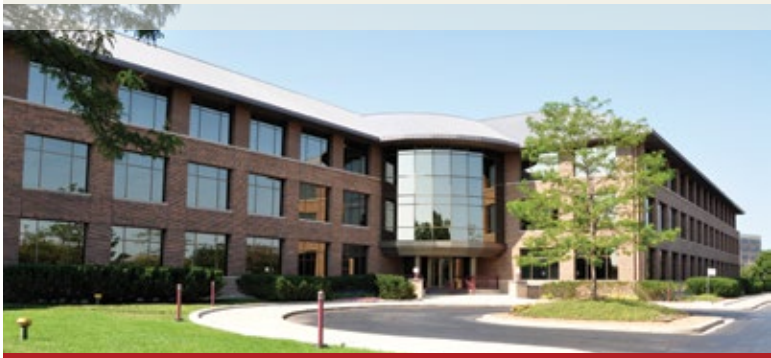
Offer a complete benefits package by adding Starmark *Healthy*Dental℠ to complement your self-funded health plan and encourage good dental health. Fully insured ancillary plans are also available.

Provide employees choice and a low-cost alternative to major medical coverage with Starmark Preventive Plus℠.

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℠ CDHP Advantage

Get the advantage of a consumer-directed health plan design that can be paired with an HRA or 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

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

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

Individual	Family
$ 1,300/$3,000	$ 2,600/$6,000
$ 1,500/$5,000	$ 3,000/$10,000
$ 2,000/$5,000	$ 4,000/$10,000
$ 2,600/$5,000	$ 5,200/$10,000
$ 3,000/$7,500	$ 6,000/$15,000
$ 3,500/$7,500	$ 7,000/$15,000
$4,000/$10,000	$ 8,000/$20,000
$4,500/$10,000	$ 9,000/$20,000
$5,000/$10,000	$10,000/$20,000
$6,000/$15,000	$12,000/$30,000
$6,550/$15,000	$13,100/$30,000

Benefit Period

- **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.

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

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

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

$1,300/$7,500	$2,600/$7,500	$4,000/$15,000	$5,500/$15,000
$1,500/$7,500	$3,000/$10,000	$4,500/$15,000	$6,000/$17,500
$2,000/$7,500	$3,500/$10,000	$5,000/$15,000	$6,550/$17,500

The individual out-of-pocket limit is the amount 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. When family coverage is selected, an individual's in-network out-of-pocket limit cannot exceed the 2016 ACA cost-sharing limit of $6,850 or the 2017 ACA cost-sharing limit of $7,150, depending on the effective date of the plan year.

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 includes the plan deductible and coinsurance.

Deductible Type
Choose one.

- **Aggregate:** Benefits are payable once the entire family deductible is met. When family coverage is selected, an individual's in-network out-of-pocket limit cannot exceed the 2016 ACA cost-sharing limit of $6,850 or the 2017 ACA cost-sharing limit of $7,150, depending on the effective date of the plan year.
- **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 design to be qualified for use with an HSA, the embedded deductible must be selected only with individual deductibles of $2,600 ($5,200 for families) or higher.

Lifetime Maximum Benefit

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

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 in- and out-of-network out-of-pocket limits accrue separately, and accumulate according to the benefit period selected. The in-network deductible must be less than or equal to the in-network out-of-pocket limit.

Starmark® Provides Unparalleled Personal Service

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

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

*Your*Care Option

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

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

Outpatient Prescription Drug Benefit

Price Assurance Program

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

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

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

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

Prescription Safeguards

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

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

Visit a Participating Pharmacy to Maximize Benefits

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

Covered Services

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

Hospital and Provider Services

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

Preventive Care Services

Covered preventive care services received in-network will be paid under your self-funded plan design at 100 percent.[2] Age and frequency schedules apply. Out-of-network services are subject to the plan deductible and coinsurance. Covered preventive care services include, but are not limited to:

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

For a complete list of preventive care services, visit **www.healthcare.gov/preventive-care-benefits** and **www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations.** In no event will benefits for preventive care services be less than that which is required by state or federal law, as applicable.

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
- Habilitative and rehabilitative devices
- Complications of pregnancy
- Outpatient pre-admissions testing
- Hospice care
  – Maximum of 6 months while covered under this plan
- Home healthcare
  – Maximum of 100 days per year
- Skilled nursing care
  – Maximum of 81 days per year
- RN and LPN fees for private-duty nursing recommended by a physician
- Nondental treatment of temporomandibular joint dysfunction (TMJ)
- Chronic pain treatment programs
  – Maximum of 10 visits per year
- Hair prosthesis for alopecia resulting from cancer treatment that involves chemotherapy or radiation therapy
  – Maximum of one hair prosthesis per member, per year

Therapies

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

Alternative Medicine

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

[1]Reasonable and Customary Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. May vary by state. Refer to the proposal for details.

[2]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.

Mental Illness, Nervous Disorders, Substance Abuse and Alcohol Abuse

Groups with up to 50 employees[1]

- Outpatient expenses
  - 40-visit limit per year; 120 visits while covered under this plan
  - Covered charges are paid at 60 percent for an in-network provider (100 percent if the 100 in-network coinsurance is selected); 50 percent for an out-of-network provider.
- Inpatient expenses
  - 20 days per year; 40 days while covered under this plan. These limits do not apply to inpatient alcohol abuse treatment.
  - Covered charges are paid according to the in- and out-of-network coinsurance selected.

Groups with 51 or more employees

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

Organ Transplants

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

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

Optional Health Benefits Packages for Your Plan Design

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

Enhanced Health Benefits Package

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

Infertility Health Benefits Package

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

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

Exclusions and limitations apply.

Healthy Foundations® Helps Members Get and Stay Healthy

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

To learn more, visit www.starmarkinc.com.

Cost-Savings Features

Starmark® self-funded plan designs offer several ways to help reduce healthcare costs.

Talk to a Doctor Anytime with Teladoc®

Teladoc gives members 24/7/365 access to U.S. board-certified doctors via phone or video consults for nonemergency medical conditions. The consult fee is the lesser of $45 or the office visit copay, if selected. It's an affordable alternative to costly urgent care and ER visits when care is needed now. Availability and services may vary by state.

Note: The consult fee is subject to change during the plan year. Teladoc is not an affiliate of Starmark or Trustmark® Life Insurance Company.

Get a Second Opinion from Experts with Grand Rounds®

Grand Rounds provides medical second opinions to patients from physicians specializing in the area of need — without any required travel. Available at no additional cost, this service helps members choose the most appropriate care for themselves or covered dependents.

When using Grand Rounds, a dedicated Care Team helps ensure a smooth process, including collecting medical records. The second opinion is delivered online for anytime, anywhere access. And, there could be cost savings if unnecessary, costly procedures are avoided.

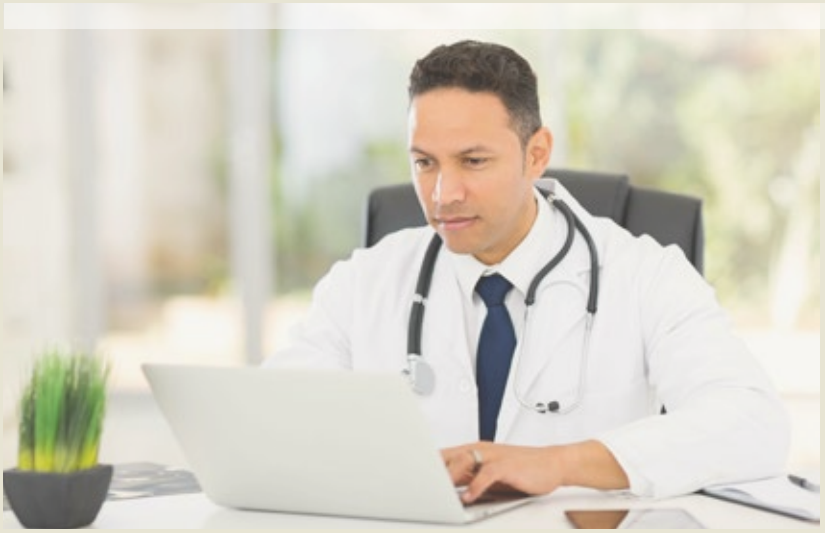
Contact a Nurse Around-the-Clock

MyNurse 24/7℠ provides around-the-clock access to a registered nurse, so members get the answers they need, when they need them most. Members can reach a registered nurse via telephone or online chat. MyNurse 24/7 provides members with decision support based on clinical guidelines and evidence-based resources, and could help identify emerging conditions before they become serious health issues.

Oncology Management Program Supports Patient Care

The Oncology Care Integration program manages cancer patients from detection to transitional care and features expert support provided by a physician panel, including board-certified oncologists. The program offers clinical, financial and emotional support for members/families, and care coordination based on their prognosis, stage and goals. Plus, treatment plans are proactively reviewed using nationally recognized, evidence-based clinical criteria. Eligible members are contacted by an oncology nurse specialist to enroll them in the program.

Note: The Oncology Care Integration program is not available when the Cigna® PPO Network or the Arizona Foundation Network is selected. American Health Holding, Inc. is not an affiliate of Starmark or Trustmark Life Insurance Company.



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[1].

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

Network Access Outside the PPO Service Area

Members and their eligible dependents can have peace of mind knowing they have access to in-network providers when outside their primary PPO service area. When the primary PPO network is Aetna Signature Administrators® (ASA) PPO Network, Cigna® PPO Network or Private Healthcare Systems (PHCS), members maintain provider access through their network.

Members with a different network can take advantage of in-network benefit levels, subject to the terms of your plan, and PHCS-negotiated discounts by using PHCS Healthy Directions. For more information, including how to locate a PHCS Healthy Directions provider, refer to the separate flyer (MK60b).

[1]Reasonable and Customary Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. May vary by state. Refer to the proposal for details.

Precertification

To avoid penalties, precertification is required for all hospital, rehabilitation or skilled nursing admissions, behavioral health residential treatment, hospice, home healthcare or transplant-related services, home infusion therapy, outpatient radiation and chemotherapy, and outpatient advanced imaging including, but not limited to, CT, CTA, MRA, MRI, NCI, PET, PET CT and 3D Rendering.

- 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.

Note: Precertification requirements may vary by network. Refer to the plan document for more details.

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.

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 (other than amounts applied to the deductible), prescription drug card deductibles or for employees added to a self-funded plan after the group's initial effective date.

Limited Occupational/ 24-Hour Coverage

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

Enrollment

Annual Open Enrollment Period

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

Waiting Period

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

Timely Enrollees

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

Special Enrollees

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

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

Off-Anniversary Terminations

If the stop-loss insurance contract terminates before the end of the contract period, there is no aggregate stop-loss insurance available for the months the contract was in force. As a result, the employer is responsible for reimbursing Trustmark® Life Insurance Company and/or Starmark for any advances, including all aggregate advances. The employer is also responsible for paying all covered claims, below the specific deductible, if applicable, that were incurred and not paid while the plan was in force. Additionally, if the 1/2 Administrative Fee Credit Surplus, the 2/3 Administrative Fee Credit Surplus or the 2/3 Administrative Fee Credit, 2/3 Cash Surplus option was selected, the employer forfeits the surplus.

Hospital Bill Reward Program

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

Exclusions and Limitations

Major Medical

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

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

Optional Infertility Health Benefits Package

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

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

[1]Reasonable and Customary Fee is the lesser of the provider's actual charge, negotiated fee, or 150, 200 or 500 percent (depending on the service) of the Medicare reimbursement rate in effect at the time services are provided. May vary by state. Refer to the proposal for details.

[2]If the Enhanced Health Benefits Package is selected, hearing aids and routine adult hearing and vision screenings are covered, subject to plan provisions.

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

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 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.

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.

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.

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.

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

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

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

Our mission:

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

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

Trustmark: An employee benefits company for more than 100 years

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

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

Starmark administers self-funded health benefit plans, offering extensive plan design choices, exceptional personal service and nationwide provider access.

Starmark – The leader in self-funding for small groups.

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

Starmark® *A Trustmark Company*

PERSONAL. FLEXIBLE. TRUSTED.®

Trustmark® LIFE INSURANCE COMPANY

400 Field Drive • Lake Forest, IL
www.starmarkinc.com