Trustmark *HealthyEdge*℠

PPO Plan Designs

Self-Funded Health Benefit Solutions for Small to Mid-Size Employers

Trusted

Personal Service

Cost Effective

Provider Choice

Flexible

Small Business Benefits

Trustmark®
benefits beyond benefits

Trustmark *Healthy*Edge℠
PPO Plan Designs

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 these employer-sponsored self-funded plan designs, 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*.

Expertise in Small Business 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, Cigna® PPO Network and PHCS.

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®, a medical second opinion from Included Health, the *Care*Champion 24/7® health advocacy service, and Healthy Foundations® health and wellness management suite.

Access personalized online resources via our website to help manage your plan. Employers and members can log in to the Document Center to access key health benefit documents. Plus, members can look up claims and access cost-savings resources to help educate and empower them as healthcare consumers.

Convenient enrollment options for quick and easy onboarding.

Offer a complete benefits package by adding dental, life/accidental death and dismemberment, and short-term disability plans.

Self-funded plans are administered by Star Marketing and Administration, Inc., and stop-loss insurance and ancillary coverage are provided by Trustmark Life Insurance Company.

More than great benefits!

- Experience our unparalleled **personal** service.
- Choose from **flexible** plan designs to create a plan to meet your needs and budget.
- Smaller employers have **trusted** us to serve the healthcare benefit needs of their employees since 1985.

We are headquartered in this prairie-style building in Lake Forest, Illinois.

Trustmark *Healthy*Edge℠
PPO Plan Designs

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

Our 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.

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.			
Individual Deductible[1] (in-network/out-of-network)	■ $ 0/$3,000	■ $2,000/$5,000	■ $5,000/$10,000	■ $8,000/$15,000
	■ $ 250/$3,000	■ $2,500/$5,000	■ $5,500/$15,000	■ $8,500/$15,000
	■ $ 500/$3,000	■ $3,000/$7,500	■ $6,000/$15,000	■ $9,000/$20,000
	■ $ 750/$3,000	■ $3,500/$7,500	■ $6,500/$15,000	
	■ $1,000/$3,000	■ $4,000/$10,000	■ $7,000/$15,000	
	■ $1,500/$5,000	■ $4,500/$10,000	■ $7,500/$15,000	
Coinsurance (in-network/out-of-network)	■ 100/70	■ 90/60	■ 80/50	■ 70/50 ■ 50/50
Individual Out-of-Pocket Limit[1] (in-network/out-of-network)	■ $1,000/$7,500	■ $3,500/$10,000	■ $6,000/$17,500	■ $8,000/$20,000
	■ $1,500/$7,500	■ $4,000/$15,000	■ $6,500/$17,500	■ $8,500/$20,000
	■ $2,000/$7,500	■ $4,500/$15,000	■ $7,000/$17,500	■ $9,000/$25,000
	■ $2,500/$7,500	■ $5,000/$15,000	■ $7,500/$20,000	
	■ $3,000/$10,000	■ $5,500/$17,500		
	The individual out-of-pocket limit is the amount of covered charges the member must pay each year. The out-of-pocket limit includes the plan deductible, coinsurance, copays, access fees, and prescription deductibles, coinsurance and copays.			
Family Deductible[1] **and Out-of-Pocket Limit**[1] **Multiplier**	A multiple of the individual deductible and out-of-pocket limit. ■ One time ■ Two times			
Lifetime Maximum Benefit	Unlimited for essential health benefits (as defined by federal regulation)			

[1]The in-network out-of-pocket limit must be greater than the in-network deductible. However, if the 100/70 coinsurance option is selected, the in-network out-of-pocket limit and in-network deductible can be equal.

Benefit Options

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

Physician/Specialist Office Visit	Therapies (optional copay)	Alternative Medicine (optional copay)	Urgent Care Center[1]
■ $20 copay	$20 copay	$20 copay	■ $40 copay
■ $25 copay	$25 copay	$25 copay	■ $45 copay
■ $30 copay	$30 copay	$30 copay	■ $50 copay
■ $35 copay	$35 copay	$35 copay	■ $60 copay
■ $40 copay	$40 copay	$40 copay	■ $65 copay
■ $45 copay	$45 copay	$45 copay	■ $75 copay
■ $50 copay	$50 copay	$50 copay	■ $80 copay
■ $60 copay	$60 copay	$60 copay	■ $85 copay
■ Deductible and coinsurance	Deductible and coinsurance	Deductible and coinsurance	■ $100 copay
			■ $125 copay
			■ Deductible and coinsurance

Physician/Specialist Office Visit

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

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

Therapies

Speech, occupational and physical therapy

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

Alternative Medicine

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

Urgent Care Center

Covered charges are paid in full after the in-network urgent care center 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 center copay does not apply to preventive care services or any surgical procedure. Coverage for preventive care services is described in the Covered Services section of this brochure. Surgical procedures, as well as services when a copay is not selected, are subject to the plan deductible and coinsurance.

Emergency Room

Copay Choices: ■ $250 | ■ $500 | ■ $750

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

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

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

Outpatient Diagnostic X-Ray and Lab

Choices:

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

Coverage includes in-network x-ray, lab, pathology and radiology services. This benefit does not apply to outpatient advanced imaging such as CT, CTA, MRA, MRI, NCI, PET, PET CT and 3D Rendering, which is subject to the outpatient advanced imaging benefit selected.

Note: Covered charges exceeding the maximum or services received out-of-network, may be subject to the plan deductible and coinsurance.

Outpatient Advanced Imaging

Choices:

- $300 copay | Deductible and coinsurance

Covered charges are paid in full after the in-network outpatient advanced imaging copay. The copay applies per procedure and includes professional fees associated with the service. Additionally, the copay applies to the out-of-pocket limit; however, it does not apply to the deductible. Covered services received out-of-network may be subject to the out-of-network plan deductible and coinsurance.

Outpatient advanced imaging performed in the emergency room or urgent care center is instead subject to the emergency room copay or urgent care center copay, if selected.

Inpatient Admission and Outpatient Surgery Access Fees Option

Choices:

- $250 | $500 | $750 | $1,000 | $1,500 | $2,000

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

Note: These access fees cannot be selected individually.

Supplemental Accident Option

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

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

Maternity Option

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

*Care*Champion 24/7® Health Advocacy Service Option

This optional health advocacy service 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!

Lifestyle Management Health Improvement Program Option

Choose the optional Lifestyle Management health improvement program to help your employees protect their most important asset – their health. This program provides members with:

- Timely age- and gender-appropriate reminders to encourage preventive tests and screenings.
- Personalized notifications and one-on-one clinical coaching for certain common chronic health conditions.
- Online tools and resources powered by Vitality, including a health risk assessment. Members can complete activities to earn Vitality Points and rewards.*
- Coaching outreach for lifestyle improvement needs identified in the health risk assessment.
- Seamless, interactive and personalized support to maintain a healthy lifestyle.

*Employers are responsible for all applicable payroll taxes and withholdings. Consult your financial advisor.

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

Unparalleled Personal Service

- **We contact each new group** to welcome them and follow up to ensure satisfaction continues throughout the year.
- Our **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 TrustmarkSB.com and can quickly access claim status using their telephone keypad.
- Representatives assist to **make transitioning to future contract years easy**.

Outpatient Prescription Drug Benefit Choices Offer Flexibility

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

1 Prescription Drug Card

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

■ $0 per person | ■ $100 per person | ■ $250 per person | ■ $500 per person

	30-Day Supply			90-Day Supply		
	Retail Copay		Specialty Drug Copay*	Mail Service Copay		
	Generic (Tier 1)	Preferred Brand (Tier 2)	Nonpreferred Brand (Tier 3)	Specialty Drug Copay* (Tier 4)	Generic (Tier 1)	Preferred Brand (Tier 2)	Nonpreferred Brand (Tier 3)
■	$ 0	$50	$80	$200	$0	$125	$240
■	$10	$35	$ 55	$200	$20	$85	$165
■	$15	$35	$ 65	$200	$30	$ 85	$195
■	$15	$50	$ 80	$200	$30	$125	$240
■	$20	$65	$ 95	$200	$40	$160	$285
■	$20	$75	$105	$300	$40	$185	$315

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

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

***Specialty Drugs:** Members order specialty drugs and related supplies by paying a specialty drug copay and using a designated specialty pharmacy. The specialty drug copay applies to generic, preferred brand and nonpreferred brand specialty drugs. Specialty drugs not obtained through the designated specialty pharmacy may not be covered.

OR

2 Price Assurance Program

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

When members present their medical ID card at a designated 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, our 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 promote proper prescription utilization and clinically appropriate quantities. Additionally, Specialty Guideline Management, provided by the designated specialty pharmacy, helps 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 Designated Pharmacy to Maximize Benefits

Designated pharmacies have contracted with our pharmacy benefit manager to charge a discounted amount for prescription drugs. Nondesignated pharmacies may charge a price significantly above this amount, which may mean higher prescription expenses for members. When a nondesignated pharmacy is used, the member pays the full price of the prescription drug at the time of purchase.

Cost-Savings Features

Our self-funded health benefit plan designs offer several ways to help reduce healthcare costs.

Get Better Quality and Prices with Healthcare Bluebook™

Healthcare Bluebook helps members control healthcare spending by providing Fair Price™ transparency for medical tests and procedures, as well as transparent, comprehensive quality metrics. This online solution lets members:

- Compare providers based on quality data
- See price ranges to avoid overpaying for healthcare
- Be better shoppers to help them find the best providers at the best price

Optional Rewards Program

By choosing the optional Go Green to Get Green rewards program, employees and their eligible dependents can earn up to $100 per eligible procedure by using a Fair Price Provider.

Note: Employers are responsible for funding all rewards, and for all applicable payroll taxes and withholdings. Consult your financial advisor. The rewards program is not available for groups in WA.

Quality Virtual Care with Teladoc®

General Medical

Teladoc gives members 24/7 access to U.S. board-certified doctors via phone or video consults for nonemergency medical conditions. It's an affordable alternative to costly urgent care and ER visits when care is needed now.

Mental Health

With Teladoc's Mental Health services, adults 18 and older can get confidential treatment for anxiety, depression, grief, family issues and more. Members can choose their provider, schedule an appointment and speak with a therapist from anywhere in the U.S.

Note: In states where the age of majority is greater than 18 years, parental consent may be required.

Dermatology

Teladoc's licensed dermatologists can diagnose and treat common skin conditions like acne, eczema, psoriasis and more. Members simply request a consult, describe their symptoms and upload photos online or via the Teladoc app. A dermatologist will review their submission and send a custom treatment plan within two days.

Note: Teladoc availability and services may vary by state.

Get a Second Opinion from Experts with Included Health

Included Health provides medical second opinions from a personal care team – at no additional cost and without any required travel, extra exams or appointments. A top specialist will review employees' or covered dependents cases, so they can have peace of mind with the right diagnosis or treatment path. And, there could be cost savings if unnecessary, costly procedures are avoided.

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.

The Oncology Care Integration program is provided by American Health Holding, Inc., and is not available when the Cigna® PPO Network or the Arizona Foundation Network is selected.

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 may be responsible for any amount exceeding the Reasonable 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, First Health® Network or 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 any PHCS Network provider for out-of-area access.

For more information, including how to locate a PHCS Network provider for out-of-area access, refer to the separate flyer (B680-MK60b-ee).

[1]Reasonable 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.

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 some out-of-network providers, Reasonable 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

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. Some 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
- PSA (prostate-specific antigen)
- Colorectal cancer screening
- Screening for tobacco use
- Women's preventive services
  - Well-woman visits, including prenatal routine office visits
  - Mammograms: baseline and annual
  - Screening for cervical cancer
  - 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 6 for details on outpatient prescription drug benefits.)
- Blood and blood plasma, oxygen and rental of equipment for its administration
- Local licensed ambulance service to or from a hospital
- X-rays (not dental x-rays) and laboratory tests performed for diagnosis and treatment
- X-ray, cobalt, radioactive isotope therapy, radiation therapy, chemotherapy, and advanced imaging services, including but not limited to CT, CTA, MRA, MRI, NCI, PET, PET CT and 3D Rendering
- 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; covered charges are not subject to the deductible and coinsurance
- Gender dysphoria, excluding cosmetic services

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 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; 50 percent for an out-of-network provider.
- Inpatient expenses
  - 20 days per year; 40 days while covered under this plan.
  - 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. 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. Groups with 51 or more employees automatically have this benefit.
- 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.

Help Members Get and Stay Healthy

Our Healthy Foundations® health and wellness management suite includes the maternity wellness program and Healthy Foundations wellness newsletter. Plus, you can elect to add the optional Lifestyle Management health improvement program, with online tools and resources powered by Vitality to help members live their healthiest life. To learn more, visit TrustmarkSB.com.

Precertification

To avoid penalties, precertification is required for all non-emergency 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 or the attending physician must follow the instructions provided 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

Notification is required within 48 hours or the next business day of an emergency admission by calling the number shown on the ID card.

Out-of-Network Emergency Care

The member responsibility for out-of-network emergency care will be calculated using the lesser of: the billed amount or Qualifying Payment Amount[1], which is generally the median of the applicable contracted rates. This amount will be applied to the in-network deductible and in-network out-of-pocket limit.

Notice and Consent

Most out-of-network providers must notify a member that they are not in the patient's PPO network and obtain the patient's written consent before providing non-emergency care.

Continuity of Care

In certain situations, if an in-network provider becomes an out-of-network provider, and the member is a continuing care patient, we will provide the member with notice and an opportunity to elect continuing care from such provider. This election will allow the member to continue to receive in-network benefits, beginning on the date of the notice and continuing until the earlier of: 90 days from the date of the notice; or the date on which the member is no longer a continuing care patient with the provider.

[1]Unless a State All-Payor Model Agreement or specified state law dictates otherwise.

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. Only plan designs with a deductible greater than $0 are eligible to receive deductible credit. 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 plan administered by Star Marketing and Administration, Inc., and 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 alife-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.

Early Terminations

If the administrative services agreement and stop-loss insurance contract terminate 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 for any advances, including all aggregate advances.
- The employer is responsible for funding all covered claims, below the specific deductible, if applicable, that were incurred and not processed while the agreement was in effect.
- 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.

Exclusions and Limitations

Major Medical

No benefits are payable under your self-funded health benefit 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 Fee[1], or not medically necessary
- 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 weight reduction[3]; 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, prescription drugs, services or supplies provided by a medical department, treatment center, pharmacy 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; smoking deterrent medications[3]; 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; treatment, services, supplies or prescription drugs designed or used to diagnose, treat, alter, impact, or differentiate genetic make-up or genetic predisposition, including but not limited to genetic therapy
- 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, training or other forms of education, except as otherwise specified in the plan document; 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 health benefit 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 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.

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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. Subchapter S corporations should consult their tax advisor as benefits from a self-funded plan may be taxable.

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Plan design availability and/or coverage may vary by state. Self-funded plans are administered by Star Marketing and Administration, Inc., and stop-loss insurance coverage is provided by Trustmark Life Insurance Company.

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