

Product Features & Descriptions

Trustmark

Group Benefits

Comprehensive Health Plans, Flexible Benefit Choices

Trustmark
GROUP BENEFITS

Trustmark offers a comprehensive variety of health plans designed for employers who want outstanding service, flexible funding options, choice of plan designs and reliability.

This brochure presents a summary of product features and descriptions. For complete information on benefits, insurance plans and products, including availability, please contact your Trustmark representative. Plan benefits will change to comply with federal healthcare reform as necessary.

Comprehensive Plans, Solid Benefits, Flexible Choices

- Attractive Choices
 - PPO plans
 - Indemnity plans
 - Consumer-directed health plans including the HSA (health savings account) and plans that can be paired with an HRA (health reimbursement arrangement)
 - Alternate funding plans
- Nationwide network access
- Easy, online enrollment for employees
- Convenient employer tools for plan administration
- Unparalleled personal customer service

Summary of Plan Features

CareChampion 24/7® - Healthcare Simplified

Trustmark provides employer and employee advocacy services for:

- **Navigating the healthcare system**, including scheduling appointments, understanding health plan benefits and finding a doctor or hospital in-network.
- **Education about healthcare options**, such as understanding test results, diagnosis or treatment options.
- **Support and advisory services**, including helping with the claims appeal process and aid with eldercare issues, *and more!*

CareChampion advisors are available **anytime day or night**, to provide guidance when it's needed most.

A Health and Wellness Management Suite through Healthy Foundations®

Members receive a comprehensive suite of health and wellness resources to help maximize their individual health potential. Healthy Foundations includes the *YourCare* health and wellness outreach program, *MaternaLink*® maternity wellness program, online decision support tools and the Healthy Foundations wellness e-newsletter.

National and Regional Managed Care Networks

An important part of offering a fully integrated health plan is access to healthcare provider networks that exceed client expectations. Our network solutions do that. At Trustmark, we're experts at pairing network options with the unique needs of employers to ensure seamless coverage for all covered members.

Members receive in-network discounts with the freedom to choose hospital and physician care from extensive premier national networks, and more than 50 regional PPOs, depending on location. Plus, employees have network access when outside the primary PPO coverage area.

To help determine specific geographic coverage for an employee population, Trustmark will also provide an analysis report that matches managed care providers to employees based on their ZIP codes.

Prescription Drug Coverage

Members get convenience and cost savings through one of the largest pharmacy benefit managers (PBM) in the nation. Members have access to thousands of pharmacies nationwide, including both national chain stores and independent pharmacies.

Trustmark offers two types of outpatient prescription drug programs:

- 1) Tiered copay plans
- 2) The Price Assurance Program (HSA is available only with the Price Assurance Program.)

Tiered copay plans provide various deductible and copay options. The Price Assurance Program is a prescription drug discount program. Both programs provide coverage for outpatient prescriptions purchased at a network pharmacy or through mail service.

To encourage the safe and appropriate use of prescription drugs, certain drugs covered by the prescription benefit are subject to quantity limits and prior authorization. This feature helps ensure selected drugs prescribed are the most appropriate and cost-effective choice and contain the approved amount of medication covered by your plan for a specific time period.

Outpatient prescription drug coverage is automatically included with all plans; however, members can opt out and not have outpatient prescription drug coverage if they choose.

Outpatient Laboratory Programs

Lab Card® Program

For plans with an in-network deductible of \$1,000 or less.

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.

Lab Card Select Program

For plans with an in-network deductible greater than \$1,000.

This voluntary discount program offers outpatient laboratory testing at significant savings compared with other labs when testing is directed to a participating Quest Diagnostics laboratory as part of the Lab Card Select Program. When using the Lab Card Select Program, in-network benefits apply.

Benefit Options

In-Store Health Clinic Copay

Trustmark offers an option enabling members to pay a copay when they visit an in-store health clinic, such as a clinic within a CVS/pharmacy, Walgreens or Walmart. This option can save members out-of-pocket expenses, since in-store health clinics typically cost less than a visit to a doctor's office or an urgent care center.

Features:

- Select the copay amount, which typically ranges from \$5 to \$50, in \$5 increments.
- The copay applies for both in- and out-of-network in-store health clinic providers.
 - For in-network in-store health clinics, the member will pay the copay at the time of service.
 - For out-of-network in-store health clinics, the member may be asked to pay the retail cost at the time of service, and then must submit a claim to Trustmark.

Wellness Coach Program

The Wellness Coach program is designed to encourage members to become more engaged in their own health by giving them the help they need and the incentive to change. They also will receive referrals to trained wellness providers, as well as free books, educational materials and a monthly wellness newsletter. The goal is to help employees reduce their out-of-pocket costs and be more productive at work.

Covered Services

When medically necessary, charges for the following services are payable subject to deductible, coinsurance, copays and prevailing fees unless noted, and may have benefit limits that are selected by the employer. The list is intended only as a general guideline for covered services.

Hospital and Provider Services

- Semiprivate room charges
- Intensive care unit
- Miscellaneous services and supplies provided by a hospital on an inpatient basis
- Physician's fees
- Outpatient surgery
- Normal pregnancy coverage
- Hospitalization after childbirth (48 hours for vaginal birth; 96 hours for C-section)
- Treatment for complications of pregnancy
- Reconstructive surgery following mastectomy
- Physical therapy
- Hospice care
- Emergency care

Preventive Care Services

Preventive care services, as defined by federal regulation, are paid at 100 percent when received in-network. Age and frequency schedules apply. 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)

Other Services

- Skilled nursing care
 - Limit of 81 days per lifetime
- Manipulation therapy
 - 20 visits per calendar year

- Home healthcare
- Radiologist, Anesthesiologist, and Pathologist (RAP) benefits are payable at an in-network level if services are performed by an out-of-network provider and would relate to the same services performed by an in-network physician or at an in-network facility.
- Diabetic vision services, other than refraction
- Mental health, nervous disorders, and alcohol and chemical dependency
- Speech therapy
 - Choice of 12, 24 or 60 visits per year
- Physical therapy
 - Choice of 12, 24 or 60 visits per year

Organ Transplants

- Designated transplant facility
 - 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. Lodging, meals and transportation benefit: maximum of \$10,000 per approved transplant procedure
 - b. Lodging and meals benefit: maximum of \$200 per day.
- Nondesignated transplant facility
 - Approved transplant services, including organ procurement or acquisition
 - No coverage is provided for transportation, lodging or meals for a companion

Cost-Saving Features

Out-of-Network Services

A complementary network for out-of-network services adds to the coverage of a primary PPO and may offer discounted rates on services. When receiving care outside the primary network, members typically pay a higher coinsurance, but share in the savings achieved by the network discount.

Coordination of Benefits

Available only with the Trustmark PPO plan.

This feature gives members as much coverage as possible, while at the same time eliminating overinsurance. Benefits are coordinated with other group health insurance plans. The primary plan pays benefits as if no other coverage exists, and the secondary plan pays the remaining benefits up to 100 percent reimbursement for allowable expenses. Trustmark can also coordinate benefits with prescription drug benefits, if you choose.

Maintenance of Benefits

Standard with a Trustmark HSA plan; optional with a Trustmark PPO plan.

Maintenance of Benefits refers to the coordination of benefits with other group insurance plans. The primary plan pays as if no other coverage exists. The secondary plan requires that any benefits not paid by the primary insurer will be applied to the deductible of the secondary plan before benefits will be paid. Once the deductible is satisfied, the secondary plan will pay the remainder of allowable expenses.

Prevailing Fee Guidelines

Applies only to out-of-network services.

Trustmark establishes a prevailing fee for services performed out-of-network. Prevailing fee guidelines help ensure that your healthcare plan doesn't pay an excessive amount for healthcare services. The prevailing fee is based on charges for the same service or supply by providers in the same or similar geographic area in which the care is provided. Members may be responsible for provider charges that exceed the prevailing fee.

Additional Plan Provisions

Transfer of Benefits

Any covered member may receive credit for a deductible or out-of-pocket maximum that has been satisfied or partially satisfied under the employer's prior plan immediately preceding coverage with Trustmark. Members must have been actively at work and covered under the employer's prior plan.

Extension of Benefits

Applies where mandated by state law.

Members who are disabled upon termination of the contract may be eligible for an extension of benefits as if coverage were in force for charges due to a covered injury or sickness causing a disability. Benefits will be extended for covered charges prior to the earliest of the following:

- The end of a three-month period (unless prohibited by statute) that began on the date coverage ended.
- The date the member is again covered by the comprehensive medical benefits section.
- The date the disability ends.
- The date the member becomes eligible for coverage under any other medical plan.
- The date the lifetime maximum has been met.

Cash Reward Program

If a member detects and resolves an overcharge on a hospital or physician's bill, he or she can receive a cash reward equal to 20 percent of the amount overcharged, up to a maximum reward of \$500. The overcharge must be for an expense for which insurance benefits were payable, and there is no limit to how many times a member can collect.

Managed Care Services

Managed Care Services completes a comprehensive healthcare package, and helps employers and members better manage their health plan benefits. These services also help ensure members receive appropriate care, while keeping claim costs in check. These services are standard with all Trustmark plans.

Case Management

Case Management gets involved soon after the onset of a serious illness or medical problem to coordinate care and monitor health needs. This promotes the most effective care and the best use of available benefits at a cost savings for employers and members alike.

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 individual or family calendar-year deductibles, or toward out-of-pocket limits.
- Precertification does not guarantee benefits are payable. The person must be eligible at the time of service.

Emergency Admissions

- In the case of an emergency admission, the call must be made within 48 hours after the admission or on the next regular business day after the start of treatment.

Employer Administration Options

Group Effective Date Options

- First day of the month
- 15th of the month (renewal and anniversary date should be the first of the month)

Individual Effective Date Options

- Date first eligible
- First day of the month following eligibility

Eligibility Waiting Period Options

- One month
- Two months
- Three months
- Six months
- One year

Additional Information

Open Enrollment

An open enrollment period may be selected. Open enrollment refers to the 31-day period immediately preceding the plan's anniversary date. If open enrollment is selected, late enrollees may enroll for coverage only during an open enrollment period.

Rate Guarantee

The standard initial rate guarantee is 12 months.

Timely Enrollees

Timely enrollees are employees or dependents who request enrollment during the eligibility waiting period and prior to the end of the initial enrollment period. The initial enrollment period is 31 days following the employer's eligibility waiting period.

Special Enrollees

Special enrollees are employees or dependents who previously waived coverage but may now be eligible because they meet one of the following criteria: have lost their other coverage, or experienced a life-changing event. Special enrollees may be eligible to enroll provided a request for enrollment is made within 31 days after the qualifying event (60 days for special enrollees who have lost their Medicaid or State Children's Health Insurance Program coverage).

Late Enrollees

Late enrollees are employees or dependents who waive medical coverage during the initial enrollment period as either a timely or special enrollee and who subsequently request enrollment following the initial enrollment period. If an open enrollment period is selected, late enrollees may enroll for coverage only during an open enrollment period. Otherwise, late enrollees may enroll for coverage at any time during the plan year.

Pre-existing Conditions

Not applicable to employees or dependents under age 19.

Benefits will not be paid for pre-existing conditions during the first 12 months of coverage under the benefit plan, or 18 months for late enrollees. Benefits will not be paid for conditions for which covered members have received treatment or been recommended treatment, advice or medicine six months prior to the enrollment date. If a member has prior creditable coverage with no more than a 63-day gap in coverage, the member's pre-existing condition limitation will be reduced by the amount of time the member was covered under the prior plan.

General Provisions

All rate quotes are based on the benefits requested for eligible members and the information provided to Trustmark.

- A minimum of 75 percent of the group must have medical and/or dental coverage with Trustmark or elsewhere; and 50 percent of the group must be enrolled with Trustmark.
 - For example, in a group of 120 eligible employees:
 $120 \times .75 =$ at least 90 employees must have coverage with Trustmark or elsewhere; and
 $120 \times .50 =$ at least 60 employees must be enrolled with Trustmark.
- A minimum waiting period of at least one month is required for all new members.
- The final rate will be determined by demographics, occupation and experience data of the actual enrollment. A group must satisfy contribution requirements according to current underwriting standards.
- We reserve the right to inspect payroll records to verify employment, inspect quarterly wage and tax statements, and prior carrier premium statements.
- Pending applications do not become effective until approved in writing by the Trustmark Underwriting department.
- The features, provisions and benefits outlined in this brochure are based on our standard contract

provisions and may vary by state. The contract will govern all conditions of coverage and payment of benefits.

Exclusions and Limitations

Exclusions include, but are not limited to, expenses arising from, or in connection with:

- Charges in excess of the prevailing fee; treatment, services, or supplies which are not medically necessary; experimental or investigational drugs or treatment; or loss due to use of alcohol or drugs or due to an occupational injury or sickness, except for members who are not covered by workers' compensation or similar coverage and are not eligible for such coverage
- War, participating in a riot, a felony or crime; fees for any treatment when the licensed practitioner is not physically present or fees for missed appointments; service or supply furnished by a member of the immediate family; or services of any educational institution
- Loss due to intentionally self-inflicted sickness or injury if not the result of a medical condition; participation in hazardous recreational activities
- Dental care or treatment; eyeglasses; contact lenses; or hearing aid batteries*
- Sex transformations or services related to sexual dysfunction; artificial insemination; surrogate pregnancy; in vitro fertilization and embryo transfer; reversal of vasectomy or tubal ligation
- Loss related to complications arising from a non-covered service
- Treatment outside of the United States except for an emergency
- Telemedicine
- Vitamins, minerals, nutritional substances, supplements or nonprescription drugs*
- Treatment for weight reduction*
- Cosmetic surgery
- Over-the-counter drugs, and drugs used for smoking cessation, weight loss or cosmetic purposes*
- Other plan provisions apply.

**No benefits are payable for these expenses, except as required under federal guidelines for preventive care.*

This is a summary of plan benefits and is a general description of plan highlights only. Limitations, exclusions, renewability, and pre-existing condition limitations apply and are described in the Certificate of Insurance. Plan availability and/or benefits may vary by state.

State mandates apply.

Notice

The information contained in this *Trustmark Features and Descriptions* product brochure is a general description of features, benefits, requirements and restrictions of the current Trustmark Life Insurance Company policy. Plan availability may vary by state. Trustmark Life Insurance Company does not provide investment, tax or legal advice. For these services, consult a licensed professional. Federal and state regulations are subject to change. Plan benefits are subject to change to comply with federal healthcare reform as necessary.

For additional information or to request a quote, please contact your Trustmark representative.

Offer a complete benefit package by selecting:

- Long Term Disability
 - Dental
 - Vision Care
 - Life Insurance
 - Accidental Death and Dismemberment
 - Weekly/Monthly Disability Income
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