HSA Select Plans

HSA Select Plans and Health Savings Accounts: **A Cost-Effective Solution**

Combat the rising cost of healthcare by combining a Starmark-administered HSA Select Plan with a health savings account (HSA). When used with a qualified high deductible health plan (HDHP), such as an HSA Select Plan, an HSA provides tax advantages and encourages employees to make cost-effective healthcare decisions. All plans include the Price Assurance Program for prescription drug savings and offer attractive options such as maternity and Preventive Care Plus. Once an HSA Select Plan is in force, an HSA can be established through Starmark's recommended HSA trustee, HSA Bank™, or through any other administrator or financial institution that offers HSAs.

Lifetime Maximum Benefit

- Combined In-Network/Out-of-Network –– $5 million
- Out-of-Network or Indemnity Plan –– $2 million

Plan Choices

Customize your plan by choosing up to two calendar-year deductible combinations, as well as one insured percent and coinsurance limit.

Physician/Hospital PPO

Individual Calendar-Year Deductible *(In-Network/Out-of-Network)* ✦		Insured Percent *(In-Network/Out-of-Network)*	Coinsurance Limit *(In-Network/Out-of-Network)*
• $1,000/$2,000	• $2,000/$4,000	• 100/80 ✦	• $5,000/$10,000
• $1,500/$3,000	• $3,000/$6,000	• 90/70	• $10,000/$20,000
		• 80/60	

- The family calendar-year deductible is two times the individual calendar-year deductible. The entire family deductible must be met by one or more family members each calendar year before benefits will be paid. In addition, the family out-of-pocket limit must be met before benefits will be paid at 100 percent.

Indemnity

Individual Calendar-Year Deductible		Insured Percent	Coinsurance Limit
• $1,000	• $2,000	• 100 ✦✦	• $5,000
• $1,500	• $3,000	• 90	• $10,000
		• 80	

- Indemnity plans are available only to groups located in ZIP codes that do not have network physicians or hospitals.
- The family calendar-year deductible is two times the individual calendar-year deductible. The entire family deductible must be met by one or more family members each calendar year before benefits will be paid. In addition, the family out-of-pocket limit must be met before benefits will be paid at 100 percent.

Out-of-Pocket Limits✦

- Individual – the sum of the calendar-year deductible and the percent of covered charges* which must be paid each year.
- Family – two times the individual out-of-pocket limit.

Federal law requires an annual cost-of-living adjustment based on changes in the Consumer Price Index (CPI). This calculation affects calendar-year deductibles and out-of-pocket limits, which may in turn need to be adjusted annually.

✦ *In- and out-of-network deductibles and out-of-pocket limits accrue separately.*
✦ *If the 100/80 insured percent is selected, only the out-of-network coinsurance limit applies.*
✦✦ *If the 100 insured percent is selected, a coinsurance limit does not apply.*
* *"Reasonable and customary fee" is the amount most often charged by a provider for a service or supply, or the amount most often charged in the same geographic region for comparable service or supply by providers with similar training and experience, whichever is less.*

Plan Features

Price Assurance Program

- This program, a service of AdvancePCS, provides prescription drug savings at participating pharmacies. This cost savings program ensures the best price available and provides generic drug savings, prescription monitoring and an oral contraceptive discount program. For more information, refer to the separate brochure, *Understanding Your Price Assurance Program.*

Physician/Hospital PPO Network Selection

- Employers may select one network per business location up to a maximum of five networks. A "business location" is defined as an office location outside the service area where the corporate home office is located.
- If an in-network provider is used, the insured is not responsible for discounted amounts. If an out-of-network provider is used, the insured is responsible for any amounts exceeding reasonable and customary fees.*

Benefit Options

Maternity

- Normal maternity and nursery care covered charges* are payable the same as any other illness.

Preventive Care Plus

- Covers 100 percent of the first $250 of covered charges* for preventive care services per calendar year.
- Additional covered charges* are subject to the calendar-year deductible and insured percent.
- If this option is not selected, preventive care services are subject to the calendar-year deductible and insured percent.
- Preventive care services are described under Covered Charges.

Covered Charges

The following charges (when medically necessary) are payable subject to the calendar-year deductible, insured percent, and reasonable and customary fee*.

- Semi-private hospital room, board and general inpatient nursing care
- Intensive care unit
- Miscellaneous services and supplies provided by a hospital on an inpatient basis
- Miscellaneous services and supplies provided by a hospital or free-standing surgical center and related to outpatient surgery or outpatient treatment of injury
- Anesthetics and their administration
- Blood and blood plasma, oxygen and rental of equipment for its administration
- Physician's fees except as otherwise noted
- Preventive care services
  - Physician office visit for routine physical limited to one visit per calendar year, except for children under age 2 for whom visits are covered at the following age intervals: birth, two, four, six, nine, 12, 15 and 18 months
  - CBC (complete blood count)
  - Chemistry panel
  - Hemocult
  - Urinalysis
  - Pap test
  - Mammograms
    - a. A baseline mammogram for each person age 35 to 39
    - b. An annual screening mammogram for each person 40 years of age or older
  - PSA (prostate-specific antigen) for males age 40 or older
  - Immunizations (including flu and pneumonia shots)
  - Screening ECG (electrocardiogram) for persons over age 40 who have two or more cardiac risk factors
- Local licensed ambulance service to or from a hospital
- Speech, occupational and physical therapist's fees when prescribed by a physician
- X-rays (but not dental x-rays) and laboratory tests performed for diagnosis and treatment
- X-rays, radium, cobalt and radioactive isotope therapy
- Artificial limbs and eyes
- Casts, splints, trusses, crutches and non-dental braces
- Rental of a wheelchair, hospital-type bed or other durable medical equipment
- Prescription drugs and medicines (covered at the in-network insured percent if a Physician/Hospital PPO is chosen)
- Complications of pregnancy
- Outpatient pre-admissions testing
- Hospice care
- Home healthcare
- Skilled nursing care
- RN and LPN fees for private-duty nursing when recommended by a physician are limited to $2,500 per calendar year
- Non-dental treatment of temporomandibular joint dysfunction (TMJ) is limited to $2,500 per lifetime
- $5,000 per calendar-year limit for speech therapy
- $5,000 per calendar-year limit for occupational therapy
- $5,000 per calendar-year limit for physical therapy
- $1,000 per calendar-year limit for manipulative therapy
- Mental illness, nervous disorders, substance abuse and alcohol abuse
  - Outpatient expenses
    - a. 40-visit limit per calendar year, 120 visits per lifetime
    - b. Covered charges* paid at 50 percent; 60 percent for a preferred provider
  - Inpatient expenses
    20 days per calendar-year, 40 days per lifetime. These limits do not apply to inpatient alcohol abuse treatment.
- Organ transplants (refer to the separate organ transplant brochure for more detailed information)
  - Prior authorization for transplant-related services is required
  - Designated transplant facility
    - a. Approved transplant services paid at 100 percent subject to the lifetime maximum of the plan

** "Reasonable and customary fee" is the amount most often charged by a provider for a service or supply, or the amount most often charged in the same geographic region for comparable service or supply by providers with similar training and experience, whichever is less.*

b. Organ procurement or acquisition is covered
c. Coverage provided for transportation, lodging and meals of companion, subject to the following limits:
   – Transportation benefit: $1,000 maximum per transplant procedure
   – Lodging and meals benefit: $250 maximum per day

— Non-designated transplant facility
a. Approved transplant services subject to the calendar-year deductible and insured percent as specified in the Certificate of Insurance
b. Approved transplant services limited to $300,000 per lifetime per person
c. Organ procurement or acquisition is covered
d. No coverage for transportation, lodging or meals for companion

Occupational Coverage

Work-related injuries and illnesses are covered **only** for sole proprietors, partners and executive officers participating in a Starmark-administered plan in states where the purchase of workers' compensation or similar coverage is not required **and** the insured does not have workers' compensation or similar coverage.

Cost Containment Features

Pre-certification

- Pre-certification is required for all hospital, rehabilitation or skilled nursing admissions, behavioral health residential treatment and hospice or home healthcare services.
- To pre-certify, the insured must call the toll-free number listed on the medical identification card.
- In the case of an emergency admission, the call must be made within 48 hours after the admission or on the next regular working day after the start of treatment, if later.
- Failure to pre-certify will result in a $300 penalty per occurrence. These penalties will not count toward the individual or family calendar-year deductibles or out-of-pocket limits.
- No benefits will be paid for any expenses that are not medically necessary, not a covered charge* or for which the person is not eligible at the time of service.

Hospital Bill Reward Program

If an insured detects and resolves an error when checking his or her hospital bills, the insured will be rewarded 50 percent of the savings in benefits, up to $1,000.

Exclusions and Limitations

Major Medical

No benefits are payable for expenses caused by, resulting from or incurred for: services and supplies not prescribed by a physician or required to treat a covered condition, or in excess of the reasonable and customary fee, or not medically necessary; dental care and treatment; hearing aids; eyeglasses and contact lenses; eye or hearing exams; cosmetic surgery; acts of war; participation in a riot; commission of or attempt to commit a felony; engaging in an illegal occupation; charges the insured is not legally required to pay; treatment rendered by a member of the insured's family; suicide, attempted suicide or intentional self-inflicted injury, if not the result of a medical condition; x-rays or tests not related to diagnosis or treatment of sickness or injury, unless noted otherwise; experimental/investigational drugs or treatment; services or supplies furnished by the participating employer or any employee of, or any person in partnership with, the participating employer; occupational sickness and injury, except for some partners, sole proprietors and executive officers; most treatment for weight reduction; some foot treatment; normal pregnancy, elective abortions, routine nursery and well baby care, unless maternity benefits are selected; birth control pills, drugs and devices; custodial care.

Pre-existing Condition Definition

A condition for which, during a six-month period immediately preceding the effective date of coverage, medical advice, diagnosis, care, or treatment was recommended or received.

Pre-existing Condition Limitation

Groups With Previous Medical Coverage

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

Groups Without Previous Medical Coverage; Timely Enrollees; Special Enrollees

No benefits will be paid for pre-existing conditions during the first 12 months of coverage under the plan. If a person had creditable coverage with no more than a 63-day gap in coverage, time covered under the prior plan will be credited toward satisfying the 12-month limitation period. All timely enrollees will be guaranteed issuance of medical coverage. Special enrollees may be eligible to enroll provided that a request for enrollment is made within the 31 days after the qualifying event.

Timely enrollees are eligible employees or dependents who request enrollment **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 employer's waiting period.

Special enrollees are employees or dependents who previously waived coverage but may now be eligible because they have involuntarily lost their other coverage, or they have added a dependent through marriage, or through the birth or adoption of a child.

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Late Enrollees

Late enrollees are eligible employees or dependents who request enrollment following the initial enrollment period. The initial enrollment period is the 31 days following the employer's waiting period.

- **Eligible employees or dependents who waive coverage at the original effective date**
  Coverage will be postponed for up to 18 months following the date the Employee Enrollment Form is signed. If the enrollment form is more than 60 days old, the postponement period will begin the first of the month following the date the enrollment form is received by Starmark. The pre-existing condition limitation period is satisfied at the end of the postponement period.

- **Eligible employees hired after the original effective date who request enrollment for themselves or their eligible dependents following the initial enrollment period**
  Coverage will start on the first day of the month following the date the Employee Enrollment Form is signed. If the enrollment form is more than 60 days old, the effective date will be the first of the month following the date the enrollment form is received by Starmark. No benefits will be paid for a pre-existing condition during the first 18 months of coverage under the plan. If a person had creditable coverage with no more than a 63-day gap in coverage, time covered under the prior plan will be credited toward satisfying this limitation period.

Renewability

No participating employer or individual employee may be canceled or non-renewed on the basis of the health status of one or more insureds. Coverage for a participating employer may be canceled for: failure to meet minimum participation requirements; failure to meet minimum employer contribution requirements; non-payment of premiums; fraud or intentional misrepresentation of material fact in connection with the coverage.

Electronic Funds Transfer

Pre-authorized, electronic transfer of funds eliminates missed premium due dates, reduces the possibility of lapses in coverage, saves time and expense of writing checks, and eliminates postage costs.

Note: ***Benefits may not be payable for conditions not identified on Employee Enrollment Forms. Failure to identify a condition on the Employee Enrollment Form may result in a loss of coverage as of the effective date of coverage.***

Establish an HSA

Once a group's HSA Select Plan is in force, the employer or employee can apply for an HSA through Starmark's recommended HSA trustee, HSA Bank, or through any other administrator or financial institution that offers HSAs. HSA Bank is not affiliated with Starmark or Trustmark. For more information about HSAs, refer to the separate brochure, *Small Business Guide to Health Savings Accounts (HSAs).*

HSA Bank™ (State Bank of Howards Grove)

HSA Bank combines convenience, service and savings with its HSAs. HSA Bank, formerly MSA Bank™, offers low account maintenance fees, high interest rates, 24-hour account access online or through an automated telephone system and outstanding personal service. Please visit their website at www.msabank.com or call the dedicated Starmark toll-free number at 800.341.2116 for further details. HSA Bank has knowledge-able personal bankers available to answer any HSA questions.

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