Understanding the New Plan Year Process

This informative guide explains the contents of your group's New Plan Year offer and the steps you can take for a quick and efficient experience.

Your important New Plan Year documents and helpful resources are conveniently available online in advance of your New Plan Year. Should you have any questions, please feel free to contact your broker or Client Management.

It is our mission to help you build a healthy future for your business and employees through our offering of flexible health benefit plan designs, convenient online tools to administer your self-funded group health plan, cost-savings and health and wellness tools, stop-loss insurance coverage from Trustmark Life Insurance Company, as well as freedom of provider choice for plans with and without a PPO network.

Small Business Benefits

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What is the timeline* to prepare for the upcoming new plan year?

Annual Certification Process - An email will be sent to you notifying you to complete the online participation forms. Complete the forms within 10 days of notification.

Benefit Design Changes Notifications - A letter may be mailed to you, if applicable.

Offer - Your broker will receive your New Plan Year offer and then share it with you.

Open Enrollment - Your open enrollment period is the month prior to your anniversary date.

New Plan Year Offer - Your offer will be posted to the Document Center.

New Plan Year Forms — Sign and return appropriate Administrative Services Agreement and Plan Document forms. This is required to avoid holds on claim processing.

Plan Year Begins/ Open Enrollment Ends

*These are approximate dates.

What is included with my group's New Plan Year offer?

- **Cover Letter —** Important information about your group including your group number, effective date of new plan year, broker name and more
- **Health plan summary for my group's current plan(s) —** Summary of your utilization experience, which includes a demographic assessment report on enrollment throughout your plan year, cost analysis, components of plan year cost change and experience summary
- **New Plan Year offer —** Your group's self-funded health benefit plan design, stop-loss insurance coverage and Administrative Services Agreement reflect the new rates and/or terms
- **Alternative quote for a lower-cost plan design —** Changes to your group's self-funded health benefit plan design reflecting cost savings
- **Healthcare Utilization Reports —** Set of comprehensive reports providing greater transparency of how your group's healthcare dollars are being used
- **Summary of Benefits and Coverage (SBC) —** Standardized summary of your group's self-funded health benefit plan to help you and your members easily understand your plan design and compare different plan designs
- **Administrative Services Agreement —** Outlines the duties of both you, the employer and Star Marketing and Administration, Inc.
- **Plan Document/Summary Description —** Provides a detailed summary plan description of your group's self-funded health benefit plan
- **Stop-Loss Statement —** Includes claims versus claim prefund as well as specific stop-loss reimbursement.

The following may be included in an important Federal Notice mailing to you:

- **Employer-Sponsored HRA Renewal Letter —** If you have a plan-year benefit period, the HRA Renewal letter provides an annual renewal of the administration of your group's Health Reimbursement Arrangement (HRA).
- **Health Reimbursement Arrangement (HRA) Summary of Benefits and Coverage (SBC) —** Standardized summary of your group's HRA to help you and your members easily understand your self-funded health benefit plan design and compare different plan designs

When is my group's open enrollment period?

Your group's annual open enrollment period is the month prior to the new plan year. Employee Eligibility Statements must be received by us within the open enrollment period.

There are three ways to enroll:

- Email a completed Employee Eligibility Statement to AdministrationSB@trustmarkbenefits.com.

  Employee Eligibility Statements are available by logging in to our website at TrustmarkSB.com/login.

- Complete an Employee Eligibility Statement online with Manage My Group (employer only).
- Provide MARK™ by Trustmark® paperless enrollment instructions to employees so they can enroll online or via telephone.

Remember, after the open enrollment period ends, enrollees will not be permitted to enroll for self-funded coverage until the next annual open enrollment period unless they experience a qualifying event.

If you have any questions, please contact Administration at AdministrationSB@trustmarkbenefits.com.

What affects my group's rates?

Providing an affordable health benefits package to your employees is important. Our goal is to help you offer affordable coverage and help you understand your new plan year rates. Multiple factors go into the rate changes from year to year.

Some examples of the items that impact your new rates are provided below:

Trend – Medical inflation, deductible leveraging, claim utilization and technological and medical advances are just some of the components that could affect the cost of healthcare. Trend is calculated based on these factors and applied to your new rates.

Group Demographics – Group demographics are likely to change from one year to the next. The group demographics are comprised of gender, aging, size and medical enrollment. Fluctuations in member additions, terminations and age bracket increases also have a bearing on rating factors.

Health Status and Plan Change Adjustments – The new group demographics are reviewed for medical history to determine known health risks. This risk assessment will be used as part of the overall expected claims cost, also referred to as the "Minimum Aggregate Attachment Point." Health statuses can fluctuate from one year to the next, varying the rate from the previous year as the amount of expected claim cost may increase or decrease.

Adjustments could include changes to the area factors, PPO network costs, benefit changes in the plan design, pricing changes, etc.

The breakdown of costs for stop-loss insurance premium and claim prefunding adjust according to the anticipated claims cost for the new plan year.

The stop-loss insurance premium and the claim prefunding are impacted by the expected medical claims for the new plan year. With each new plan year, there may be a noticeable variance as the expected claims shift from one category to the next. This impacts the stop-loss insurance premium. Or vice versa, when anticipated claims are less likely to impact the stop-loss insurance, claims below the specific deductible impact the claim prefund.

My Group's Plan and the Affordable Care Act

The Affordable Care Act (ACA) may affect your group during your new plan year. Certain provisions apply to self-funded health benefit plans designs, including:

Employer Mandate – This mandate generally applies to employers with 50 or more full-time employees, including full-time equivalents.

An employer may be subject to a financial penalty if it either does not provide minimum essential coverage[1] to 95% of its full-time employees and their dependent children to age 26,[2] or if that coverage is unaffordable or does not provide minimum value.[3]

An employer's health plan is unaffordable if the employee's contribution to the cost of employee-only coverage (in the lowest plan option) in 2024 is more than 8.39 percent of the employee's household income for the year, according to Healthcare.gov. An employer also can use safe harbors identified by the IRS to determine if its health plan is affordable.

Patient-Centered Outcomes Research Institute (PCORI) Fee – The ACA requires health insurance issuers and plan sponsors of self-funded health plans be assessed an annual PCORI fee.

The fee for plan years ending on or after Oct. 1, 2023, and before Oct. 1, 2024, is $3.22 per average number of covered lives. The filing date is July 31 of the subsequent calendar year.

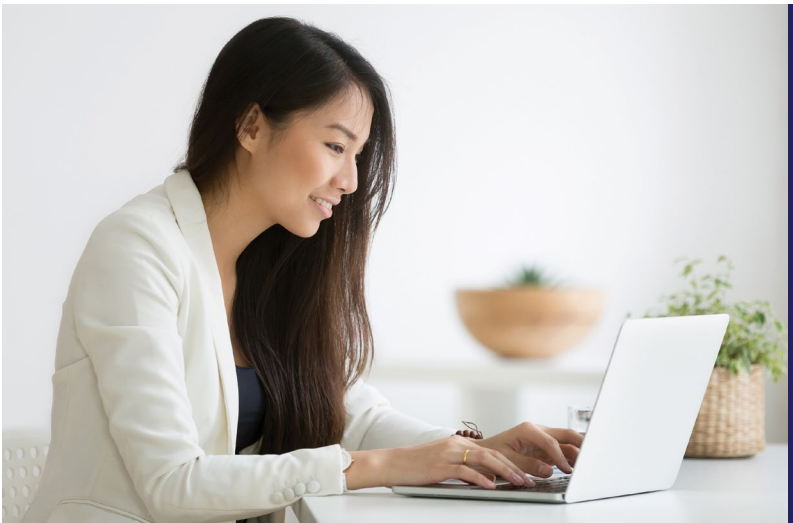
Cost-Sharing Limits – Group health plans must limit cost sharing for in-network out-of-pocket expenses on Essential Health Benefits (EHBs) for non-grandfathered plans. The out-of-pocket limit for EHBs cannot be greater than $9,200 individual/$18,400 family for in-network EHBs for plan years on or after Jan. 1, 2025. The out-of-pocket limit includes the plan deductible, coinsurance, copays, access fees, and prescription deductibles, coinsurance and copays. The ACA individual out-of-pocket limit of $9,200 will apply to individuals covered under family coverage with a qualified high-deductible plan. The same cost-sharing limits on EHBs apply to non-grandfathered plans administered by Star Marketing and Administration, Inc., that do not offer a PPO network.

Employer Reporting Requirements – ACA requires employers that provide minimum essential coverage to file an annual information report under Sections 6055 and 6056 of the IRS code indicating the individuals who were covered each month by minimum essential coverage. Additionally, large employers subject to the employer mandate must report coverage information to the IRS and to all employees that were offered health coverage by the employer.

[1] Minimum essential coverage refers in general to health coverage under a government-sponsored program, such as Medicare or Medicaid; an eligible employer-sponsored plan; a plan offered in the individual market; or other coverage described in applicable regulations. It does not include HIPAA-excepted benefits such as critical illness or hospital indemnity insurance.

[2] To avoid possible penalties, businesses subject to the employer mandate must provide health coverage to a dependent child through the end of the month in which he or she attains age 26. If coverage extends beyond the 26th birthday, the value of the coverage can continue to be excluded from the employee's income for the full tax year (generally a calendar year) in which the adult dependent child turns 26.

[3] A group health plan provides minimum value if the percentage of the total allowed costs of benefits provided under the plan is at least 60 percent, and it includes substantial coverage of both inpatient hospital and physician services.



To learn more about the Affordable Care Act, view the Trustmark Regulatory Updates blog at **trustmarkhcr.wordpress.com**.

Plan Year Checklists

- ❑ Complete the Annual Certification process. A notification email will be sent to you with a link to the Participation form approximately 120 days prior to your anniversary date. If we don't have your current email address, please email updated information to AdministrationSB@trustmarkbenefits.com.

What should I do if my group is keeping the same plan design next year?

- ❑ Sign, date and return the New Plan Year Acceptance form. Your Administrative Service Agreement and Plan Document will be sent for your electronic signature.
- ❑ Email the completed form to Client Management at ClientManagementSB@trustmarkbenefits.com.

What else should I consider for my group's new plan year?

- ❑ Hold an annual open enrollment meeting with your employees. Employees who previously declined coverage for themselves or dependents may enroll by completing enrollment via MARK™ paperless enrollment or with an Employee Eligibility Statement form. Open enrollment is the month prior to your anniversary.
- ❑ If adding employees to your self-funded health benefit plan, submit completed Employee Eligibility Statement forms for each employee to AdministrationSB@trustmarkbenefits.com. Or, you can complete and submit the Employee Eligibility Statement online using Manage My Group.
- ❑ If you have dual plans and an employee is switching between plans, please submit a letter or list of employee(s) identifying who will be changing their plan.
- ❑ Review your Healthcare Utilization Report for indications where a possible plan change could be beneficial.
- ❑ If you haven't already reviewed your New Plan Year offer with your broker, you may access it online via the Document Center.

How can a plan design change benefit my group?

Plan design change options are available to help lower your group's cost, improve benefits or offer a more complete benefit package, including:

- Changing deductible, coinsurance or out-of-pocket amounts
- Changing copay amounts and options
- Adding a qualified high-deductible health plan design with a health savings account (HSA)
- Multiple plan options
- Trustmark Healthy Choices℠ self-funded reference-based pricing plan designs enable employers to offer freedom of provider choice, with few exceptions.[1]
- Trustmark Preventive Plus℠ self-funded plan designs provide affordable preventive-only healthcare benefits to help your employees stay healthy.
- Fully insured dental and Life/AD&D plans from Trustmark Life Insurance Company
- Optional Lifestyle Management health improvement program and *Care*Champion 24/7® health advocacy service
- Adding or changing a health reimbursement arrangement (HRA) plan design
- Adding the self-funded Enhanced Health Benefits Package and Infertility Health Benefits Package

What should I do to complete a plan design change?

- ❑ Have your broker request a proposal for the plan design you desire if one is not included in your New Plan Year offer.
- ❑ Sign and date the appropriate page(s) of the alternative plan design proposal where it requires the officer's signature. Have your broker return it to us for processing. Plan design changes must be received 15 days prior to the effective date for on-anniversary changes.
- ❑ Once we receive your signed offer, a revised Administrative Services Agreement and Plan Document will be provided for your signature and must be returned within 10 days. A new Summary of Benefits and Coverage (SBC) will be sent to you as well. New ID cards will be issued and mailed to your covered employees within 14 days after processing.
- ❑ Distribute the employee plan documents and SBCs to your covered employees.

[1] Except in the instance of organ transplants, where benefits are available when performed at a designated transplant facility, and specialty drugs, where benefits are available when provided by the designated specialty pharmacy as outlined in the plan document.

What happens after my new plan year begins?

Once we receive the signed acceptance – Administrative Services Agreement (ASA)/Plan Document forms, we will execute the documents and a new **Stop-Loss Insurance Contract** will either be posted in the Document Center if you opted to view your documents electronically, or a physical copy will be sent to you for your files.

Insurers are required by the Affordable Care Act to send a Summary of Benefits and Coverage (SBC) to groups with fully insured plans, and employers are required to send one to their self-funded employee benefit plan participants. As an added service, we will send an SBC to groups with self-funded plans. A Summary of Benefits and Coverage (SBC) will be mailed to you under a separate cover.

Once we receive acceptance of the New Plan Year offer, SBCs and Plan Documents will be sent to you to distribute to your employees. Please note, you will not receive Plan Documents for those employees who have opted to receive their documents online via the Document Center.

New ID cards will not be issued at your new plan year unless a benefit or network change occurs.

DISCLAIMER: Our procedures may change with each new plan year. Changes to completing open enrollment, forms needed for the annual certification process and other adjustments are possible.

What cost-saving services are available?

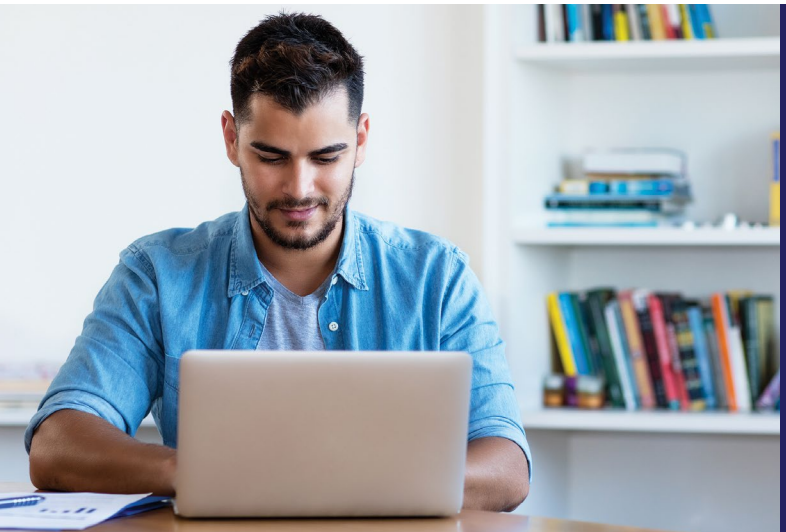
- **Included Health** medical second opinion service*
- **Healthcare Bluebook™** quality and cost transparency tool that helps locate doctors and facilities in the area with the best quality and price on a medical procedure. Covered employees can see their estimated out-of-pocket costs, based on their health benefit plan
- **Teladoc® Health** phone and video consults with U.S. board-certified doctors
- **Active&Fit™ Direct** discounted fitness centers
- **Vori Health** virtual treatment for back, neck and joint pain*
- **Prescription Drug Card Choices** feature lower copay for generic drugs to steer members to less expensive alternatives*
- **Choice of PPO networks,** including Cigna® PPO Network or Aetna Signature Administrators® (ASA) PPO Network
- ***Care*Champion 24/7® health advocacy service**** provides an advisor to help navigate, educate, support and advise employers and members about healthcare-related issues
- **Healthy Foundations,** health and wellness management tools, including the Lifestyle Management** health improvement program, online resources powered by Vitality, the maternity wellness program and a wellness education newsletter

*Available only with Trustmark Small Business Benefits® major medical plan designs.

**Available as an optional benefit on some plan designs. Cigna® is a trademark of Cigna Intellectual Property, Inc. All other trademarks are the property of their respective owners, which are not affiliates of Star Marketing and Administration, Inc., and Trustmark Life Insurance Company.

Who do I contact if I have questions?

We are here to help. If you have any questions, please contact your broker or our Client Management Team at ClientManagementSB@trustmarkbenefits.com.



All of the tools you need are at your fingertips by logging in at **TrustmarkSB.com/login.**

Experience the Trustmark difference:

We are part of the Trustmark family of companies, which serves more than 2 million covered lives or plan participants.

Tailored self-funded benefit solutions for small to mid-size businesses.

A pioneer in self-funding for small businesses, we provide affordable health benefit solutions.

Seamless integration of self-funded health plan administration, claim payment and stop-loss insurance.

Plan designs with and without PPO networks provide freedom of choice in healthcare providers.

Exceptional personal service helps ensure satisfaction.

Big benefits for small businesses.

Trustmark Small Business Benefits®
Plan design availability and/or coverage may vary by state. Plans are administered by Star Marketing and Administration, Inc., and stop-loss insurance and ancillary coverage are provided by Trustmark Life Insurance Company.

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