

This insert is part of the Health Care Benefits Brochure and reflects insurance benefits mandated by the State of Michigan.

- **Eligible Employees:** An eligible employee means an employee who works on a full-time basis with a normal workweek of 30 or more hours. Eligible employee includes an employee who works on a full-time basis with a normal workweek of 17.5 to 30 hours, if an employer so chooses and if this eligibility criterion is applied uniformly among all the employer's employees and without regard to health status-related factors.
- **Eligible Dependents:** A dependent includes an unmarried child over age 19 who is incapable of self-support due to mental retardation or physical disability, and who is dependent upon the insured for support and maintenance. The Insured must submit satisfactory proof of such dependent's incapacity to the Administrator within 31 days after the dependent's 19th birthday.
- **Newborn Child Coverage:** The plan will pay benefits for charges for the treatment of a physical illness or injury of a newly born child from the moment of birth, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- **Mammogram Examination:** The plan will pay benefits for one baseline low-dose mammogram for a female participant who is age 35 through age 39 and one mammogram every year for a female participant who is age 40 or older.
- **Mastectomy Coverage:** Federal law requires that this plan pay benefits for charges for (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.
- **Diabetes:** When prescribed by a physician, the plan will pay benefits for charges for diabetic self-management training and covered equipment and supplies for the treatment of diabetes, as outlined in the certificate of insurance.
- **Substance Abuse:** This plan will provide benefits for charges for inpatient and outpatient treatment of substance abuse (drugs and alcohol) as follows: **INPATIENT:** Benefits are provided at 50% of the charge after any applicable deductibles or copayments have been satisfied to a maximum of \$1,000 per calendar year. **INTERMEDIATE AND OUTPATIENT CARE:** Benefits are paid the same as any other illness subject to the cost-sharing provisions of the plan. The maximum benefit limit is adjusted by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31. The maximum benefit limit through March 31, 2005 is \$3,350.
- **Waiting Periods for Pre-Existing Conditions:** The policy excludes coverage for health care services relating to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to a participant's enrollment. For groups of 2-50 employees, the waiting period for pre-existing conditions will not exceed a period of 12-months from the participant's enrollment date. For groups of 51 or more employees, the waiting period for pre-existing conditions will not exceed a period of 6-months from the participant's enrollment date.

RATE AND RENEWABILITY DISCLOSURE

Many states are requiring insurance companies to establish small health group health rates within specific guidelines outlined by the state. They also require companies to provide written disclosure of their rating practices to you at the time of sale.

Class of Business

This notice pertains to small employer groups who enroll for coverage insured by Guarantee Trust Life Insurance Company.

Establishing Initial Group Rates

The rating guidelines we follow were designed and developed to promote fairness in the small group marketplace. These guidelines promote fairness by acknowledging the similarities of each group while recognizing some diversity.

The premium rates for groups enrolling for coverage with us for the first time are established through projections or estimates of future claims. These projections consider the specific benefits we currently offer, as well as the projected cost of health care and anticipated medical claims, for all groups. We also consider health status or duration of coverage in establishing or adjusting rates. In addition, rates are adjusted in accordance with the laws of your particular state.

Rate Guarantees and Changes

Our current practice is to guarantee each employer group's initial rates for 6 to 12 months from the effective date of coverage. This guarantee holds true provided the group's composition, geographic location, and benefits remain unchanged. The group's rates may be adjusted during the rate guarantee period whenever any one of the following occurs:

- If a group adds or eliminates employees;
- If age composition of the group changes;
- If the business moves from one geographic rate area to another; or
- If the group changes its benefits in any way.

Our rate guarantees will change with market conditions. In general, we have the right to change premium rates on any date the terms of the plan are changed or on any premium due date as long as we provide advance written notice as provided by state law.

How Rate Increases are Determined

A group's rate increase will be adjusted due to factors such as medical inflation, claims experience, duration of coverage and current market conditions. We control the group's rate increase to the sum of the following:

- A percentage change made to new business rates since the last time rates were increased for the group;
- An adjustment of up to 15% annually and adjusted pro rata for rating periods of less than a year due to changes in rating factors for geographic area, age, industry, group size and health status; and
- Any adjustment due to any change in coverage.

How Coverage is Renewed

All employers have the option to continue coverage with us, except in any of the following situations:

- Required premiums are not paid;
- Fraud or misrepresentation of the employer or an individual;
- Noncompliance with plan provisions, including minimum participation requirements and eligibility requirements of the plan; or
- Nonrenewal of all plans by us in a particular class of business, in which case all affected participating employers will be notified in advance according to state law.

Pre-existing Conditions and Late Entrants

A pre-existing conditions provision may apply to an employee or dependent. When it does, pre-existing conditions will not be covered for a period of time or benefits will be limited under the policy. The pre-existing condition waiting period may be reduced by the length of time an employee was covered by a prior qualifying plan. Late entrants may also be excluded from coverage for a period of time. These provisions will be described in the certificates issued to the employees and will never be more restrictive than the applicable laws of your state. Please refer to your outline of coverage for a listing of exclusions, limitations and pre-existing condition provisions.