

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, Illinois 60025

North Dakota

State Mandated Benefits

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

- **Eligible Employees:** An eligible employee for small employer groups of 2-50 eligible employees is defined as an individual with a normal work week of 30 or more hours. A small employer has the discretion to define which employees are eligible for coverage provided that the employer consistently applies a written policy that does not discriminate based on health or class. For employer plans of 51 or more eligible employees, an eligible employee may work a minimum of 20 hours per week or more, as determined by the employer.
- **Eligible Dependents:** A dependent includes the employee's unmarried child under age 22 or under age 26 if the child is a full time student. A dependent also includes the employee's unmarried child over age 21 who is unable to attend school as a full time student or is unable to hold self-sustaining employment because of mental retardation or physical handicap. A dependent also includes the natural child of an employee's unmarried dependent.
- **Newborn Child/Adopted Child Exception:** A child born to, or adopted by, a participant with employee only, or employee/spouse, coverage will be covered automatically for the first 31 days following the birth of the newborn child or date of placement of the adopted child and will terminate on the 32nd day. To continue coverage beyond 31 days, a participant must apply for coverage using our application form within 31 days of the date of birth or date of placement and pay the required premium. If application is made after that 31 day period, the child will be a late enrollee. If a participant decides not to continue coverage for his/her dependent beyond the 31 day period, premium will be charged for the 31 days coverage was in force.
- **Mammograms:** This plan will pay benefits for one baseline mammogram for a woman between the ages of 35 and 39; and one mammogram every year for a woman 40 years of age or older, or more frequently based on the recommendation of the participant's physician.
- **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.
- **Prostate-specific Antigen Test:** This plan will pay benefits for charges for an annual prostate-specific antigen test for an asymptomatic male aged 50 or older, a black male aged 40 or older and a male aged 40 or older with a family history of prostate cancer.
- **Anesthesia in Conjunction with Dental Care:** This plan will pay benefits for charges for anesthesia and hospitalization in conjunction with dental care provided to a participant who: (1) is eight years of age or younger; (2) is severely disabled; or (3) has a medical condition that requires hospitalization or general anesthesia for dental care treatment. Coverage applies regardless of whether the services are provided in a hospital or an ambulatory surgical center.
- **Inherited Metabolic Disease:** This plan will pay benefits for charges for medical foods and low protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease for a participant born after December 31, 1962. Benefits for charges for low protein modified food products are limited to a maximum of \$3,000 per year.
- **Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder:** This plan will pay benefits for TMJ and Craniomandibular disorders up to a lifetime maximum of \$10,000 for surgical treatment and a lifetime maximum of \$2,500 for nonsurgical treatment.
- **Nervous or Mental Disorders and Alcoholism and Drug Abuse:** Benefits will be paid the same as for any other illness subject to: a) a combined maximum benefit of 60 days per calendar year for inpatient treatment except that no more than 45 days may be used for treatment of a nervous or mental disorder; b) a combined maximum of 120 days per calendar year for partial hospitalization; c) a combined maximum of 120 days per calendar year for residential treatment of nervous or mental disorders; d) a maximum benefit of 30 hours per calendar year for outpatient treatment of nervous or mental disorders; e) a maximum benefit of 20 visits per calendar year for out patient treatment of alcoholism and drug abuse. Up to 46 unused days of inpatient treatment of alcoholism and drug abuse can be traded for additional days of partial hospitalization. Up to 23 unused days of inpatient treatment of nervous or mental disorders can be traded for additional days of residential treatment. One day of inpatient treatment is equal to two days of partial hospitalization or residential treatment.

■ **North Dakota State Continuation of Coverage:** This plan provides for up to a 39 week continuation of coverage provision for employees for qualifying North Dakota residents who lose coverage. Thirty-six months continuation is available for a former spouse and dependent children pursuant to a divorce or annulment from a covered employee. This provision is mandatory for all eligible employer plans and applies to individuals who meet the terms for loss of coverage outlined in the certificate and who have been insured under this policy for at least three months prior to termination. This continuation would run concurrent with any COBRA continuation for which the individual may be entitled.

■ **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 date. The waiting period for pre-existing conditions will not exceed a period of 12 months from the participant's enrollment date if the participant enrolled when initially eligible or during a special enrollment period or 18 months (for groups with 2-50 employees) or 12 months (for groups with more than 50 employees) if the participant is a late enrollee.

RATE AND RENEWABILITY DISCLOSURE

Many states are requiring insurance companies to establish small 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 elect to subscribe to and participate in the National Health Care Trust, 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 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 change;
- 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; and
- Any adjustment due to any change in coverage or case characteristics.

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. "Class of business" means small employer versus large employer.

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.