

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, Illinois 60025

Iowa

State Mandated Benefits

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

- **Newborn Children:** A child born to an insured with employee only or employee/spouse coverage will automatically be covered for the first 31 days from the moment of birth. To continue coverage beyond 31 days, you must apply for family coverage using our application form within 31 days of the date of birth and pay the required premium. If you make application after that 31-day period, your newborn child will be a late enrollee. If you decide not to continue coverage for your newborn child beyond the 31-day period, premium will be charged for the 31 days coverage was in force. The coverage, from the moment of birth for newborn children, shall consist of coverage for illness or injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.
- **Maternity Services:** Maternity services are covered under the policy regardless of the size of the employer group. Services are covered for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section, excluding the day of delivery. If a participant is discharged prior to the aforementioned minimum stay requirements, a post-discharge follow-up visit will be provided to the mother and newborn, if determined medically appropriate, as directed by the attending physician.
- **Skilled Nursing Care:** This plan will pay benefits for charges for skilled nursing care in a hospital if the level of care needed by the participant has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the hospital or in another hospital or health care facility within a 30-mile radius of the hospital.
- **Mammogram Examination:** This plan will pay benefits for charges for: (1) one baseline mammogram for a female participant who is age 35 through 39; (2) one mammogram every two years, or more frequently based on the participant's physician's recommendation, for a female participant who is age 40 through 49; and (3) one mammogram every year for a female participant who is age 50 or older.
- **Well-Child Care Services:** This plan will pay benefits for charges for well-child care services at approximately the following age intervals: birth, two weeks, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years, four years, five years and six years. The annual deductible amount, if applicable, will not apply to these services.
- **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 a 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.
- **Diabetic Program:** This plan will pay Charges for equipment, Supplies, and self-management training and education for the Treatment of diabetes, when determined to be Medically Necessary by the Administrator and will require a written prescription by a Health Care Provider. Benefits include blood glucose meter and glucose strips for home monitoring and payment for diabetes self-management training and education. Initial training shall cover up to ten hours of initial outpatient diabetes self-management training within a continuous twelve-month period for an individual that meets the conditions specified in the plan. A Participant who receives the initial training shall be eligible for a single follow-up training session of up to one hour each year.
- **Contraceptives:** Oral contraceptive and devices, including intrauterine devices (IUD); subdermal contraceptive implants (Norplant) and related Treatments, Services and Supplies.
- **Emergency Medical Care:** covered inpatient and outpatient health care services that are provided by a health care provider who is qualified to provide the services that are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is a medical condition that manifests itself by symptoms of sufficient severity, including but not limited to severe pain, that an ordinarily prudent person, possessing average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in one of the following: (a) placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of a bodily organ or part. When a Participant receives covered Emergency Medical Care, from other than a Preferred or Network Provider, those Services will be paid as if they were received from a Preferred or Network Provider.
- **Iowa State Continuation of Coverage:** This plan provides up to 9 months of continuation coverage for qualifying employees and their dependents who are Iowa residents and who lose coverage. 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.

(See Reverse Side)

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 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 and sex compositions 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 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.