

GEORGIA

State-Mandated Benefits



NORTH CAROLINA MUTUAL LIFE INSURANCE COMPANY

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

■ **Eligible Dependents:** A dependent includes the employee's unmarried child, step child, legally adopted child, or any child for whom a family or domestic court ordered decree requires an insured person to provide health coverage, under age 19 or under age 25 if the child is a full time student. A dependent also includes an unmarried child of any age who is or becomes disabled due to mental retardation or physical handicap before age 19 and is dependent upon the employee.

■ **Preventive Care:** The plan will provide benefits for an annual Pap Smear test; mammography screening for female participants as follows: (1) one baseline mammogram for a female participant who is age 35 to 39; (2) a mammogram every two years for a female participant who is age 40 to 49, (3) a mammogram each year for a female participant who is age 50 or older; and (4) a mammogram whenever ordered by a physician for a female at risk. Female at risk means a woman who has a personal history of breast cancer or biopsy proven benign breast disease, whose grandmother, mother, sister or daughter has had breast cancer, or who has not given birth before age 30 years of age. Chlamydia screening test for a female participant who is not more than 29 years of age. Surveillance tests for female participants who are 35 years of age and older for ovarian cancer. Prostate Antigen Test (PSA) for a male participant 45 years of age or older, or for a male participant who is 40 years of age or older if ordered by a Physician. Colorectal cancer screening services in accordance with the most recently published guidelines and recommendations established by the American Cancer Society, in consultation with the American College of Gastroenterology and the American College of Radiology.

■ **Maternity Benefits:** If the duration of inpatient care is less than 48 hours following a vaginal delivery or 96 hours following a cesarean section, we'll pay benefits for charges for post delivery care which includes up to 2 follow-up home visits, provided that the first such visit shall occur within 48 hours of discharge. Such visits shall be conducted by a physician, a physician's assistant, or a registered professional nurse with experience and training in maternal child health nursing.

■ **Congenital Defects and Birth Abnormalities:** The plan will provide benefits for charges incurred for a covered illness or injury, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities for the following: (1) newly born children who are participants, from the moment of birth;

or (2) adopted children who are participants, from the date of final decree of adoption.

■ **Diabetes:** The plan will provide benefits for charges incurred for medically necessary equipment, supplies, pharmacologic agents, and outpatient self-management training and education, including medical nutrition therapy, for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes as prescribed by a licensed 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.

■ **General Anesthesia in conjunction with Dental Care:** The plan will provide benefits for general anesthesia and associated hospital or ambulatory surgical facility charges in conjunction with dental care provided to a participant if such participant is: (1) 7 years of age or younger or developmentally disabled; (2) an individual for which a successful result cannot be expected from dental care provided under local anesthesia because of a neurological or other medically compromising condition of the participant; or (3) an individual who has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance.

■ **Child Wellness Benefits:** The plan will provide benefits for well-child care from birth through age 5 rendered under the supervision of a single physician, during the course of one visit, not subject to the policy deductible. This plan also covers benefits for well-child care services from age 6 through age 16 for periodic health examinations, lab tests in connection with health evaluations; and screening for blood lead levels. These benefits are covered in the same manner as any other covered service.

■ **Prescription Contraceptive Drugs and Devices:** The plan will provide benefits for charges for any prescribed drug or device approved by the United States Food and Drug Administration for use as a contraceptive.

■ **Temporomandibular Joint Disorder, Orofacial Pain and Craniomandibular Disorder Coverage:** The plan will provide benefits for charges for Temporomandibular

Joint Disorder, Orofacial Pain and Craniomandibular Disorder coverage as mandated by the state of Georgia and outlined in the certificate.

■ **Drug Treatment of Children's Cancer:** This plan will cover treatment for dependent children in connection with approved clinical trial programs as outlined in the certificate.

■ **Neurological Disorders of Autism:** This plan will cover treatment of neurological disorders of autism as outlined in the certificate.

■ **Georgia State Continuation of Coverage:** This plan provides for a 3 month continuation of coverage for qualifying Georgia residents 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 six months prior to termination, with special provisions for persons age 60 or older. This continuation would run concurrent with any COBRA continuation for which the individual may be entitled.

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 are insured by North Carolina Mutual 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 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 60 days 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;
- 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;
- 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.