

Aetna Life Insurance Company



Summary Concerning Coverage, Limitations, and Exclusions under the Alaska Life and Health Insurance Guaranty Association Act

A resident of Alaska who purchases life insurance, annuities, or accident and health insurance should know that an insurance company licensed in this state to write these types of insurance is a member of the Alaska Life and Health Insurance Guaranty Association. The purpose of this association is to assure that a policyholder will be protected within statutory limits if a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state, and in some cases, to keep coverage in force. However, the valuable extra protection provided by these insurers through the guaranty association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

The state law that provides for this safety net coverage is called the Alaska Life and Health Insurance Guaranty Association Act. The full text of the act can be found in AS 21.79.010 -21.79.990. Provided below is a brief summary of this law's coverages, exclusions, and limits. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations under the act or the rights or obligations of the guaranty association.

COVERAGE

Generally, an individual will be protected by the life and health insurance guaranty association if the individual lives in Alaska and holds a life or health insurance contract or annuity contract, or if the insured is insured under a group insurance contract issued by a member insurer. The beneficiary, payee, or assignee of an insured person is protected as well, even if a non-resident of Alaska.

EXCLUSIONS FROM COVERAGE

The association does not protect a person holding a policy if:

- the individual is eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state); the insurer was not authorized to do business in this state; or
- the policy is issued by an organization that is not a member of the Alaska Life and Health Insurance Guaranty Association.

The association does not provide coverage for:

- a policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk,
- such as a variable contract sold by prospectus;
- a policy of reinsurance (unless an assumption certificate was issued);
- an interest rate yield that exceeds an average rate;
- a dividend;
- a credit given in connection with the administration of a policy by a group contract holder;
- an employer's plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;

- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer;
- certain obligations to provide a book value accounting guaranty for defined contribution benefit plan participants; or
- that part of a policy or contract that provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract.

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the association is obligated to pay. The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for anyone insured life, no matter how many policies or contracts were issued by the same company, even if such contracts provided different types of coverages, the association will pay a maximum of:

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- for health insurance benefits, \$100,000 for coverages not defined as disability income, health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;
- \$300,000 for disability income insurance and long-term care insurance;
- \$500,000 for health benefit plans;
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- with respect to a structured settlement annuity, \$250,000 in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- \$250,000 in the aggregate, of present-value annuity benefits, including net cash surrender and net cash withdrawal values with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. 401, 26 U.S.C. 403(b), or 26 U.S.C. 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased; or
- \$5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts held by that contract holder, with respect to anyone contract holder or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GIGs, OAGs, etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under sections 401 (k), 403(b), or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than \$300,000 in the aggregate per individual. For covered unallocated annuities that fund other plans, a special limit of \$5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases the contract limits also apply.

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege violation of any provision of the Alaska Life and Health Insurance Guaranty Association Act must be filed with the Division of Insurance, 550 West Seventh Avenue, Suite 1560, Anchorage, Alaska, 99501-3567; telephone (907) 269-7900. Financial information for an insurance company, if the insurance information is not proprietary, is available at the same address and telephone number. The guaranty association should not be contacted regarding the financial information of an insurance company.

The association is not an agency of the State of Alaska nor are there any guarantees by the State of Alaska regarding the payment of claims by the association. The guaranty association is not your insurance company.
Alaska Life and Health Insurance Guaranty Association
P.O. Box 220207
Anchorage, Alaska 99522-0207
(907) 243-2311

Division of Insurance
550 West Seventh Avenue,
Suite 1560
Anchorage, Alaska 99501-3567
(907) 269-7900

Aetna Life Insurance Company



NOTICE OF PROTECTION PROVIDED BY CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

▪ **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association and the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

▪ **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows.

▪ **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

▪ **Life Insurance**

80% of death benefits but not to exceed \$300,000.

80% of cash surrender or withdrawal values but not to exceed \$100,000.

▪ **Annuities and Structured Settlement Annuities**

80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed \$250,000.

The maximum amount of protection provided by the Association to an individual, for all life insurance, annuities and structured settlement annuities is \$300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is \$546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association's website <https://www.califega.org/>.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P.O Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927- 4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

Aetna Life Insurance Company



Notice Of Protection Provided By Illinois Life And Health Insurance Guaranty Association

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity, health maintenance organization or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage, pay claims, or otherwise provide protection in accordance with Illinois law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association per insured in each insolvency are:

- Life Insurance
 - \$300,000 for death benefits
 - \$100,000 for cash surrender or withdrawal values
- Health Insurance
 - \$500,000 for health benefit plans*
 - \$300,000 for disability insurance benefits
 - \$300,000 for long-term care insurance benefits
 - \$100,000 for other types of health insurance benefits
- Annuities
 - \$250,000 for withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except special rules apply with regard to health benefit plan benefits for which the maximum amount of protection is \$500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at <https://www.ilhiga.org/> or contact:

Illinois Life and Health Insurance Guaranty Association
901 Warrenville Road, Suite 400
Lisle, Illinois 60532-4324

Illinois Department of Insurance
320 West Washington Street 4th Floor
Springfield, Illinois 62767

Insurance companies, health maintenance organizations and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company or health maintenance organization, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

The Association is not an insurance company or health maintenance organization. If you wish to contact your insurance company or health maintenance organization, please use the phone number found in your policy or contact the Illinois Department of Insurance at DOI.InfoDesk@illinois.gov.

Aetna Life Insurance Company



Notice Of Protection Provided By Maryland Life And Health Insurance Guaranty Corporation

This notice provides a brief summary of the Maryland Life and Health Insurance Guaranty Corporation (the Corporation) and the protection it provides for policyholders and contract holders. This safety net was created under Maryland law, which determines who and what is covered and the amounts of coverage.

The Corporation is not a department or unit of the State of Maryland and the liabilities or debts of the Life and Health Insurance Guaranty Corporation are not liabilities or debts of the State of Maryland.

The Corporation was established to provide protection in the unlikely event that your health maintenance organization or your life, annuity, or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Corporation will typically arrange to continue coverage and pay claims, in accordance with Maryland law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Corporation are:

Life Insurance

- \$300,000 in death benefits
- \$100,000 in cash surrender or withdrawal values

Health Insurance or Health Benefit Plans

- \$500,000 for coverage provided by health benefit plans
- \$300,000 for disability insurance
- \$300,000 for long-term insurance
- \$100,000 for a type of health insurance not listed above, including any net cash surrender and net cash withdrawal values under the types of health insurance listed above

Annuities

- \$250,000 in the present value of annuity benefits, including net cash withdrawal values and net cash surrender values
- With respect to each payee under a structured settlement annuity, or beneficiary of the payee, \$250,000 in present value annuity benefits, in the aggregate, including any net cash surrender and net cash withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contracts is:

\$300,000 in aggregate for all types of coverage listed above, with the exception of coverage provided by health benefit plans

\$500,000 in aggregate for coverage provided by health benefit plans

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Maryland law.

Insurance companies, health maintenance organizations, and insurance producers are not allowed by Maryland law to use the existence of the Corporation or its coverage to encourage you to purchase any form of insurance or a health benefit plan. When selecting an insurance company, you should not rely on Corporation coverage. If there is any inconsistency between this notice and Maryland law, then Maryland law will control.

To learn more about the above protections, please visit the Corporation's website at <https://www.mdlifega.org/> or contact:

***Maryland Life and Health
Insurance Guaranty Corporation
6210 Guardian Gateway
Suite 195APG
Aberdeen, Maryland 21005
410-248-0407***

Aetna Life Insurance Company



New Jersey Life And Health Insurance Guaranty Association Act

Residents of New Jersey who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the New Jersey Life and Health Insurance Guaranty Association.

The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force.

The valuable protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

Disclaimer

The New Jersey Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in New Jersey. You should not rely on coverage by the New Jersey Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The New Jersey Life and Health Insurance Guaranty Association
521 Newman Springs Road, Suite 22
Lincroft, NJ 07738

State of New Jersey
Department of Banking and Insurance
20 West State Street
P.O. Box 325
Trenton, NJ 08625

The state law that provides for this safety-net coverage is called the New Jersey Life and Health Insurance Guaranty Association Act, N.J.S.A. 17B:32A-1, et seq. (the "Act").

Coverage

The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, individuals will be protected by the Life and Health insurance Guaranty Association if they live in New Jersey and hold a life, health or long-term care insurance contract, annuity contract, or if they are insured under a group insurance contract, issued by a member insurer.

Generally, the beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons owning such policies are not protected by this association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- the policy was issued by an organization which is not a member of the New Jersey Life and Health Insurance Guaranty Association.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate as more fully described in Section 3 of the Act;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

Limitations of Coverage

The Act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy of contract.

With respect to any one insured individual, regardless of the number of policies or contracts, and subject to other limitations imposed by the Act, for life insurance policies, the Association will not pay more than \$100,000 in cash surrender values or \$500,000 in life insurance death benefits; for annuity contracts, the Association will not pay more than \$250,000 in cash surrender value or, for annuity contracts with no cash surrender value, benefits payments of up to \$500,000 in present value. These limits apply no matter how many policies and contracts were with the same company, and no matter how many different types of coverages.

The Association will not pay more than \$2,000,000 in benefits to any one contract holder under any one unallocated annuity contract.

There are no limits on the benefits the Association will pay with respect to any one group, blanket or individual accident and health insurance policy.

Aetna Life Insurance Company



Summary

Coverage, Limitations and Exclusions Under Rhode Island Life and Health Insurance Guaranty Association Act ("Act")

A resident of Rhode Island who purchases life insurance, annuities, long-term care, or accident and health insurance should know that an insurance company licensed in Rhode Island to write these types of insurance is a member of the Rhode Island Life and Health Insurance Guaranty Association ("Association"). The purpose of the Association is to assure that a policyholder will be protected within the statutory limits, if a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will, within the statutory limits, pay the claims of insured persons who live in this state, and, in some cases, keep coverage in force. However, the protection provided through the Association is not unlimited. This protection is not a substitute for your care in selecting a company that is well managed and financially stable.

Important Disclaimer

Rhode Island Life And Health Insurance Guaranty Association
235 Promenade Street, #426 Providence, RI 02908
Tel (401) 273-2921

The Rhode Island Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. **COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY.** Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on residence in this state. Other conditions may also preclude coverage.

The Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association when selecting an insurer.

Rhode Island Division Of Insurance
1511 Pontiac Avenue, Cranston, RI 02920
TEL (401) 462-9520

The full text of the state law that provides for this safety net coverage, Rhode Island Life and Health Insurance Guaranty Association Act, (“the Act”), can be found beginning at R.I. Gen. Laws §27-34.3-1. A brief summary of the Act is provided below. This summary does not cover all provisions of the law, nor does it in any way change your rights or obligations or those of the Association under the Act.

Coverage: Generally, individuals will be protected by the Association if the individual lives in Rhode Island and: Holds a life or health insurance contract, long-term care contract or annuity contract; or is insured under a group insurance contract issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live elsewhere.

Exclusions from Coverage: The Association does NOT protect a person holding a policy if:

- the individual is eligible for protection under a similar law of another state;
- the insurer was not authorized to do business in this state;
- the policy is issued by an organization that is not a member of the Association;
- the policy was issued by a nonprofit hospital or medical service organization (such as, the “Blues”), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments or by an insurance exchange.

The Association does not provide coverage for:

- a policy or portion of a policy not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus; a policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed a rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- an employer’s plan to the extent that it is self-funded (that is, not insured by an insurance company, even if an insurance company administers the plan);
- an unallocated annuity contract issued to an employee benefit plan protected under the United States Pension Benefit Guaranty Corporation;
- that part of an unallocated annuity contract not issued to a specific employee, union, association of natural persons benefit plan, or a government lottery;
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer;
- any portion of a policy or contract to the extent that the required assessments are preempted by federal or state law;
- an obligation that does not arise under the express written terms of the policy or contract issued by the insurer.
- a policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D) or any regulations issued pursuant thereto.

Limitations on Coverage: The Act limits the amount the Association is obligated to pay. The Association cannot pay more than what the insurer would have owed under a policy or contract. Also, for any one insured life, no matter how many policies or contracts were in force with the same insurer, the Association will pay no more than:

- \$300,000 in net life insurance death benefits and no more than \$100,000 in net cash surrender and net cash withdrawal values for life insurance;
- \$100,000 for health insurance benefits, coverages not defined as disability, basic hospital, medical, and surgical, or major medical insurance, or long-term care insurance including any net cash surrender and net cash withdrawal values;
- \$300,000 for disability insurance;
- \$300,000 for long-term care insurance;
- \$500,000 for basic hospital, medical, and surgical or major medical insurance;
- \$250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- \$250,000 in present value per payee with respect to a structured settlement annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values;
- \$250,000, in the aggregate, of the present value of annuity benefits, including net cash surrender and net cash withdrawal values, with respect to an individual participating in a governmental retirement plan established under 26 U.S.C. §§401, 403(b), or 457 and covered by an unallocated annuity contract, or to a beneficiary of the individual if the individual is deceased;
- \$5,000,000 in unallocated annuity contract benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor whose plan owns, directly or in trust, one or more unallocated annuity contracts.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, etc.) covered by the Act: for unallocated annuities that fund governmental retirement plans under sections 401(k), 403(b), or 457 of the Internal Revenue Code, the limit is \$250,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the Association be liable to spend more than \$300,000 in the aggregate per individual except hospital insurance up to \$500,000 per individual. For covered unallocated annuities that fund other plans, a special limit of \$5,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, the contract limits also apply.

These general statements as to Limitations on Coverage are only summaries of the law. The actual limitations are set forth in R.I. Gen. Laws §27-34.3-3.

Any alleged violations of the provisions of the Rhode Island Life and Health Insurance Guaranty Association Act may be reported to the Rhode Island Division of Insurance at the address and telephone number above.

This information is provided by: The Association and by the Division of Insurance, whose respective addresses are provided in the Important Disclaimer, above.

Aetna Life Insurance Company



Notice Concerning Coverage Under The Tennessee Life and Health Insurance Guaranty Association Act

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. **This summary does not cover all provisions of the law, or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.**

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

- (1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);
- (2) the insurer was not authorized to do business in this state;
- (3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

- (1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- (2) any policy of reinsurance (unless an assumption certificate was issued);
- (3) interest rate yields that exceed an average rate;
- (4) dividends;
- (5) credits given in connection with the administration of a policy by a group contractholder;
- (6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- (7) unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- \$300,000 for policies and contracts of all types, except as described in the next point
- \$500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - \$300,000
- life insurance cash surrender value - \$100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - \$100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - \$250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - \$100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
 - \$100,000 for limited benefits and supplemental health coverages
 - \$300,000 for disability and long term care insurance
 - \$500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Insurance Guaranty Association
150 Third Avenue South
Suite 1600
Nashville, TN 37201

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Aetna Life Insurance Company

Group policy

The **group policy** is by and between
Aetna Life Insurance Company
(**Aetna**®, we, us, or our)
and
Windmill Health Products, LLC
(**Policyholder**, you, or your)

Group policy number: GP-0251955-G
Date of issue: December 23, 2024
Effective date: January 1, 2025
Renewal date: January 1, 2026
Policyholder situs: New Jersey

This **group policy** takes effect on the **effective date** if we have received your signed group application and the initial **premium**. It remains in force until terminated.

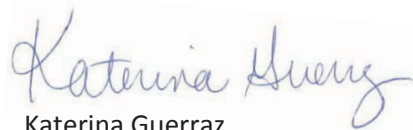
Term of the group policy: The initial term shall be 12 consecutive months beginning on the **effective date**. Subsequent terms shall be 12 consecutive months beginning with the **renewal date**.

Premium due dates: The **effective date** and the first day of each succeeding calendar month.

Signed at **Aetna's**® Home Office 151 Farmington Avenue Hartford, Connecticut 06156.

This **group policy** is non-participating.

This **group policy** is governed by applicable federal law and the laws of New Jersey.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Table of contents

	Page
The group policy	1
If you want to discuss your coverage	2
Glossary	3
Premium	4
Fees for special services	6
Some of our other responsibilities	7
Some of your other requirements and responsibilities	8
Termination	10
Intentional deception	12
Responsibility for conduct	13
General provisions	14
Final rates and fees schedule	19

The group policy

The **group policy** consists of several documents taken together. These documents are:

- Your group application
- This **group policy**
- The booklet-certificate(s)
- The schedule of benefits
- Any riders and amendments to the **group policy**, the booklet-certificate, and the schedule of benefits as stated below

If you want to discuss your coverage

If you have questions about your coverage under the **group policy**, contact your agent. If you have additional questions, you may contact us at:

Aetna

151 Farmington Avenue
Hartford, Connecticut 06156
1-877-238-5200

Please have your **group policy** number available when you contact us. It is on the front page of this **group policy**.

Glossary

You will see some words in bold type in the **group policy**. The bold type means we have defined those words. The definitions are in this section and in the *Glossary* section of the booklet-certificate.

Covered person

An employee or a dependent of an employee for whom all of the following applies:

- The person is eligible for coverage as defined in the booklet-certificate
- The person has enrolled for coverage and paid any required **premium** contribution
- The person's coverage has not ended

Dates:

Effective date

Date your coverage begins under the **group policy**.

Final rates and fees schedule effective date

Date stated on the final rates and fees schedule.

Premium due date

The **effective date** and the first day of each succeeding calendar month.

Renewal date

Date that is 12 months after the **effective date** and each 12 month date thereafter.

Termination date

The date coverage ends according to the *Termination* section.

Policyholder

Windmill Health Products, LLC and entities associated with it for purpose of coverage under this **group policy**.

Premium

Premium – rates and amount due

The premium rates are stated in the *Final rates and fees schedule* section. We will provide you with a new Final rates and fees schedule if and when the **premium** rates change. Any new schedule will state its **effective date**.

We charge **premium** based on the **premium** rates in effect on the **premium due date**. The **premium** due on any **premium due date** is the sum of the **premium** charges for the coverage we provide. When we calculate **premium** due, we will use our records to determine who is a **covered person**.

You owe **premium** for a **covered person** starting with the first **premium due date** on or after the day the person's coverage starts. You stop paying **premium** for a **covered person** as of the first **premium due date** on or after the day the person's coverage ends.

Premium – changes in rates

We may change the **premium** rates as of a **premium due date** during the initial term only if:

- There is a change in factors that materially affects the risk we assumed with this coverage. We identify these factors in our rate quote to you.
- There is a change in law or regulation, or there is a judicial decision, that materially affects the cost of providing coverage.

We may change the **premium** rates as of a **premium due date** during any subsequent term.

We will provide 60 days prior written notice to you of any change in **premium** rates.

Premium – experience credit

We may declare an experience credit at the end of a plan year. We do not have to declare any experience credit.

If we declare an experience credit, we may return the amount of the credit to you:

- By electronic fund transfer
- By application of the amount to **premium** due in the current or succeeding plan year, or
- By any other manner that we and you agree to

We can require you to share an experience credit with your employees in a manner reasonably acceptable to us, as a condition of our giving the credit. If the sum of employee contributions for coverage exceeds the sum of **premium** paid less any experience credits, we will require you to apply at least the excess experience credit for the sole benefit of employees.

Premium – reduction due to performance guarantees

We may agree to meet specific levels of service when we administer the **group policy**. We may also agree to reduce our **premium** if we failed to meet the guaranteed levels of service. The reduction is an agreed-upon percent of **premium** due during the period we fail to meet the performance guarantees. We will apply any credit at the end of the plan year, to either prior **premium** paid or to future **premium** due. This agreement will be in writing.

Premium – when due

Premium is due on the **premium due date**. You have a payment grace period of 31 days immediately following the **premium due date**. The **group policy** will remain in force during the grace period. If we have not received all **premiums** due by the end of the grace period, this **group policy** will automatically terminate at the end of the grace period.

Premium – how billed and paid

We may bill you electronically. You shall pay **premium** due by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Premium – overdue amounts

You shall pay us interest on the total **premium** amount that is overdue. Overdue **premium** includes amounts due but not yet paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid **premium**, including reasonable attorney fees and costs.

Premium – eligibility corrections

We will retroactively drop a **covered person** from coverage and credit to you **premium** payments if:

- The eligibility information included a person who was not eligible for coverage, and
- You request that we retroactively drop the person from coverage

Your request that we retroactively drop coverage is your representation that the person did not pay the required **premium** contribution for the period.

We will retroactively cover eligible persons whom you did not include in the eligibility information you provided us. We will cover them retroactively no more than 60 days before the date you both notify us and pay all applicable past **premium**.

Premium – waiver

Payment of premiums

We may waive up to one month's billed **premium** payments during any **group policy** term.

The **premium** waiver will not apply for those employees if after that month's **premium** has been billed, employees are added or removed from the plan coverage. For that month of coverage, additional **premium** will be due or credited.

Repayment of the waived premium

We may require you to pay back the **premium** waived if the **group policy** is terminated within 12 months of your original **effective date**. We will give at least 60 days prior written notice to you of the requirement for the repayment of the waived **premium**.

Fees for special services

Special services

You may request that we provide special services beyond the routine administration of this **group policy**. We will charge you a fee for each special service we provide.

Special services – fees

The special service fees are stated in the *Final rates and fees schedule*. We may change any fee on 60 days advance written notice to you. We will provide you with a new *Final rates and fees schedule* if and when the amount of any fee changes. The new schedule will state its **effective date**.

Fees – when due

Fees are due on the **premium due date** immediately following our invoicing you.

Fees – how billed and paid

We may bill you electronically. You shall pay fees by electronic fund transfer. Payment occurs when we receive good funds.

We may accept a partial payment but this does not waive our right to collect the entire amount due.

Fees – overdue amounts

You shall pay us interest on the total amount of fees that is overdue. Overdue fees include amounts due but not paid during the grace period. The interest rate will be up to 1 1/2% per month for each month or partial month an amount due remains unpaid.

We may also recover from you the costs of collecting any unpaid fees, including reasonable attorney fees and costs.

Some of our other responsibilities

We will prepare the booklet-certificate and schedule of benefits that are part of the **group policy**, as required by applicable laws. We will provide them to you in electronic form. We will also provide them to you in paper form if you request it.

We will provide the coverage stated in the booklet-certificate and schedule of benefits that are part of the **group policy**. We will administer the coverage as required by the **group policy** and applicable laws.

We will protect the personal health information of **covered persons** as required by federal and state laws. We will use it and share it with others as needed for their care and treatment. We will also use and share it to help us process **providers'** claims and otherwise help us administer the **group policy**. For a copy of our Notice of Privacy Practices log in to <https://www.aetna.com> or call us.

Our duties in this section survive termination of the **group policy**.

Some of your other requirements and responsibilities

Participation and contribution

You must comply with our participation and contribution requirements.

Distribution – certain Employee Retirement Income Security Act (ERISA) of 1974 requirements

You are responsible for creating and distributing all reports and disclosures required by ERISA. These include:

- Summary plan descriptions
- Summary of material modifications
- Summary annual reports.

Distribution – booklet-certificate and schedule of benefits

You will distribute the booklet-certificate and schedule of benefits that we provide you, as required by applicable laws.

Information – access

You shall make payroll and other records directly related to a person's coverage under this **group policy** available to us for inspection. This will occur:

- Upon our reasonable advance request
- At our expense
- At your office
- During regular business hours

Your duties and our rights in the Information – access provision survive termination of the **group policy**.

Information – enrollment

You shall send us enrollment information we request to administer the **group policy**. We will request the information monthly or as otherwise required. You will send us the information on our form, or through such other means, as we require.

The enrollment information includes but is not limited to data needed to:

- Enroll your employees and their dependents
- Process terminations
- Make changes in family status

By sending the information to us, you represent that it is correct. You acknowledge that we can and will rely on the information.

You shall:

- Maintain a reasonably complete record of the information you send us for at least seven years, and until the final rights and duties under the **group policy** have been resolved
- Send us information you sent us before, upon request

We will not start covering a person under the **group policy** until you send us the information to enroll that person. Subject to applicable laws and the **group policy**, we will not stop covering a person until you send us the information to terminate coverage.

You shall notify us within 15 business days of the date in which:

- An employee's employment ceases, or
- A dependent loses eligibility under the **group policy**

You must notify us when a request for retroactive termination is a result of a **covered person**:

- Performing an act or omission that constitutes fraud, or
- Making an intentional misrepresentation of material fact

to get coverage or to get a benefit under the **group policy**.

Your duties and our rights in this Information – eligibility provision survive termination of the **group policy**.

Notices – termination of coverage

You shall notify **covered persons** in writing, of their rights when coverage stops.

In particular, you shall notify all eligible **covered persons** of their right to continue coverage pursuant to the *Special coverage options after your plan coverage ends* provisions in the booklet-certificate and applicable laws.

Your notification will include:

- A description of plans available
- **Premium** rates
- Application forms

You will give the notification within 15 calendar days of a person becoming eligible for continuation coverage.

Your duties and our rights in this provision survive termination of the **group policy**.

Workers' compensation coverage

You must comply with workers' compensation coverage laws applicable to your employees covered by the **group policy**. Prior to the **effective date** and upon our request after the **effective date** you will provide us reasonable evidence of your satisfying applicable workers compensation coverage laws.

You will provide us with monthly reports of all workers' compensation coverage cases. The report will list for each case, the employee name, identifying number, date of loss and diagnosis.

Termination

Automatic termination

The **group policy** and all coverage end as of the last day of the grace period if you have not paid us all **premiums** and fees due as of the beginning of the grace period. The grace period is described in the *Premium* section.

Termination by you

You may end coverage under this group policy if you give us 30 days advance written notice. Your termination notice may apply to all classes or any class of your employees covered under the **group policy**. You can send us a termination notice during a period for which you have paid **premium**, but your **termination date** must be after that period.

Termination by us

We may end the **group policy** and all coverage it provides:

- Immediately upon notice to you:
 - If you perform any act or practice that constitutes fraud or if you make any intentional misrepresentation of a material fact relevant to the coverage
 - If you are a member of an association and your membership in the association ceases
- Upon 60 days written notice to you:
 - If you breach a provision of the **group policy** and you do not cure the breach within the notice period
 - If you cease to be a group as defined under applicable state law
 - If you fail to meet our contribution or participation requirements applicable to this **group policy**
 - If you do not certify your compliance with our policies and procedures upon request
 - If you change your eligibility or participation requirements without our consent
- Upon 90 days written notice to you (or such longer notice period as applicable laws require,) if we cease to offer the product lines provided by this **group policy**.
- Upon 90 days written notice to you (or such longer notice period as applicable laws require,) if we act as required by applicable laws for uniform termination of coverage.

Non-renewal for failure to respond

We may request that you tell us whether you intend to renew the **group policy**. You must reply:

- Within two weeks of your receipt of the request or
- Within 15 days prior to the **renewal date**

whichever is later. Your reply must be in writing unless we authorize an oral reply. If you do not reply, we will not continue coverage on and after the **renewal date** and:

- You will owe us any unpaid **premium**
- We will owe you a refund if you overpaid **premium**.

Effective time of termination

The **group policy** and its coverage end at 11:59 p.m. on the day of termination.

Effect of termination

You, **covered persons**, and we continue to be responsible following termination for the duties we each incur prior to the termination of the **group policy**. One of your duties includes payment of **premium** due for coverage through any grace period up to the day of termination. You, **covered persons**, and we also continue to be responsible for your, their, and our duties that the **group policy** states are to occur following termination.

You, **covered persons**, and we have the rights and duties following termination of the **group policy**, as stated specifically in the **group policy**.

You shall notify **covered persons** of the termination of the **group policy**. Your notice will comply with applicable laws. We have the right to notify employees of termination of the **group policy**.

Reinstatement

You may request that we reinstate the **group policy** and coverage after we end it. You must make the request within 30 days of the **termination date**. We will reinstate the **group policy** as of the **termination date** upon payment of all amounts due, and you giving us reasonable assurances that you can and will fulfill all of your obligations under the **group policy**.

Intentional deception

If we learn that you or a **covered person** defrauded us or that a **covered person** intentionally misrepresented material facts, we can and may take actions that can have serious consequences for coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at some time in the past. If we paid claims for past coverage, we are entitled to receive money back.
- Loss of coverage going forward
- Denial or termination of benefits
- Recovery of amounts we already paid

We also may report fraud to law enforcement.

Responsibility for conduct

Employees and agents

We are responsible to you for what our employees and other agents do.

We are not responsible to you for what is done by others, such as providers. They are not our employees or agents. Providers in our network are what the law calls our independent contractors. That simply means we have a business relationship with them and they are not our employees or agents.

Indemnification – in general

We agree to indemnify and hold you harmless against that portion of your liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by our willful misconduct, criminal conduct or material breach of this **group policy**.

You agree to indemnify and hold us harmless against that portion of our liability to third parties as determined by a court of final jurisdiction or by binding arbitration caused directly by your negligence, breach of the **group policy**, breach of applicable laws, willful misconduct, criminal conduct, fraud, or your breach of a fiduciary responsibility in the case of an action under ERISA, related to or arising out of this **group policy** or your role as employer or Plan Sponsor, as defined by ERISA.

These indemnification obligations end with the **group policy**, except as to any matter concerning a claim that has been made in writing within 365 days after termination.

Indemnification – federal law requirements

You shall indemnify us and hold us harmless for our liability that is directly caused by your:

- Negligence
- Breach of the **group policy**
- Breach of laws
- Willful misconduct

and by your act or failure to act that was related to or arose out of your obligation to deliver the Summary of benefits and coverage and Notices of material modification.

Your and our rights and duties in this *Responsibility for conduct* section survive termination of the **group policy**.

General provisions – content and interpretation of the group policy

Applicable law

Applicable law means all federal and state laws that apply to the matters covered by the **group policy**. Federal and state law means statutes, regulations, official agency direction and guidance, and judicial decisions and orders, as they may be passed or issued, or as they may be amended, from time to time.

Compliance with law

You and we shall interpret the **group policy** so it complies with applicable laws.

If the **group policy** omits or misstates any right or duty under applicable laws, you and we shall implement the **group policy** as though the right or duty is stated correctly in the **group policy**.

If any provision of the **group policy** is invalid or illegal, you and we shall implement the **group policy** as though the provision is not in the **group policy**.

Changes to the group policy

The **group policy** may be amended by mutual consent in a writing.

We may change or end some or all coverage under this **group policy** by notice, if we act as required by applicable laws for uniform modification of coverage and uniform termination of coverage.

We may amend the **group policy** by notice. We must give you 60 days advance written notice. Our amendment:

- Will not reduce benefits or coverage
- Will not eliminate benefits or coverage or
- Will not increase benefits or coverage with a concurrent increase in **premium** during the current **group policy** term, other than increased benefits or coverage required by law.

Written consent or payment of the applicable **premium** on the **effective date** of any amendment is your consent to any amendment requiring your consent.

Changes to the **group policy** do not require the consent of any employee or of any other person. All agreements made by us are signed by an authorized executive officer of **Aetna**. Only an authorized officer of **Aetna** may change or waive any of the policy terms or make any agreement binding us. No change in the group policy shall be valid unless approved by an authorized executive officer of Aetna and evidenced by endorsement on the group policy, or by amendment to the group policy signed by you and us.

The **group policy** shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. You will not have to give written agreement of a change in the **group policy** if:

- You asked for the change and we have agreed to it.
- The change is needed to correct an error in the **group policy**, including any booklet-certificate issued to anyone.
- The change is needed so that the **group policy** will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this **group policy**; or the Federal Government.
- We initiated the change and is not resulting in either a reduction or elimination in benefits or coverage or an increase in **premium**.

You will have to give written agreement of a change in the **group policy**:

- That reduces or eliminates benefits or coverage, or
- That increases benefits or coverage with a concurrent increase in **premium** during the policy term, except if the increased benefits or coverage is required by law.

Payment of the applicable **premium** after notice of the proposed changes will be deemed to constitute your written agreement of those changes on behalf of all persons covered under this **group policy**.

Entire group policy

The **group policy** replaces and supersedes:

- All other prior group policies of vision coverage between us
- Any other prior written or oral understandings, negotiations, discussions or arrangements between us related to this vision coverage

Waiver

Only an officer of **Aetna** may waive a requirement of the **group policy**.

We may fail to implement or fail to insist upon compliance with a provision of the **group policy** at any given time or times. Our failure to implement or to insist on compliance is not a waiver of our right to implement or insist upon compliance with that provision at any other time or times.

General provisions – administration of the group policy

Aetna name, symbols, trademarks and service marks

We control the use of our name and of our symbols, trademarks and service marks presently existing or subsequently established. You shall not use any of them in advertising or promotional materials or in any other way without our prior written consent. You shall stop any and all use immediately upon our direction or upon termination of the **group policy**.

Assignment and delegation

You shall not assign any right or delegate any duty under the **group policy** unless we approve it in writing in advance.

We may delegate some of our functions under the **group policy** to third parties. We may also change or end these delegations. We do not need to give you advance notice to enter into, change or end these arrangements, and we do not need your consent.

Claim determinations - ERISA claim fiduciary

We are a fiduciary for the purpose of section 503 of Title 1 of the Employee Retirement Income Security Act of 1974. We have with complete authority to review all denied claims for benefits under this **group policy**. In exercising this fiduciary responsibility, we have discretionary authority:

- To determine whether and to what extent **covered persons** are entitled to benefits
- To construe any disputed or doubtful terms under the **group policy**. We shall be deemed to have properly exercised our authority unless we abuse our discretion by acting arbitrarily and capriciously.

Our review of claims for benefits may include the use of software and other tools to take into account factors such as:

- An individual's claim history
- A **provider's** billing patterns
- Complexity of the service or treatment
- Amount of time and degree of skill needed
- The manner of billing

Correcting our administrative errors

A clerical error in keeping records or a delay in making an entry will not alone determine whether there is coverage. We will determine the facts and decide if coverage is in force and its amount. We will make a fair adjustment in **premium** if correction of the error or delay changes coverage.

We may correct, withdraw, or replace the **group policy**, any booklet-certificate, any schedule of benefits and any other document issued with an error or issued in error.

Correcting your honest mistakes

If you or any employee make an honest mistake of fact, we may make a fair change in **premium**. If the misstatement affects the existence or amount of coverage, we will use the true facts to determine whether coverage is or remains in effect and its amount.

Discrimination prohibited

You shall not encourage or discourage enrollment in the coverage provided by the **group policy** based on health status or health risk.

You shall act so as not to discriminate unfairly between persons in like situations at the time of the action.

Financial Sanctions Exclusions

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, we cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. Visit <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx> for more information.

Incontestability

We will not use a statement you make to void this **group policy** after it has been in force for 2 years from its **effective date**.

We will use only a statement in writing that you or a **covered person** makes, to do any of the following:

- To void coverage of the **covered person**
- To deny coverage of the **covered person**
- To deny a claim for benefits by the **covered person**

We will not use a statement by a **covered person** to deny a claim for benefit more than 2 years after the statement was made.

Notices

The **group policy** requires or permits notice to each other. These notices shall be in writing.

Notice may be delivered:

- In person, and is effective upon delivery
- By United States mail, sent first class, postage prepaid, and is effective five U.S. Postal Service delivery days following the date of mailing
- By commercial carriers UPS and FedEx, effective upon delivery or
- By e-mail, facsimile or other electronic means, effective upon sending

Notice sent to us by mail and commercial carrier shall be sent to:

Aetna

151 Farmington Avenue
Hartford, Connecticut 06156

Notice sent to you by mail and commercial carrier shall be sent to:

Windmill Health Products, LLC
Attention: Roberto Barillari, Chief Financial Officer
10 Henderson Drive
West Caldwell, NJ 07006

You and we must designate specific e-mail addresses, facsimile numbers or other electronic means in writing for purpose of notices.

Policies and procedures

We have the right to adopt reasonable policies, procedures, and rules of the **group policy** in order to promote orderly and efficient administration. You and all **covered persons** are bound by and shall comply with them. You will certify your compliance with them upon our request or as required specifically by the **group policy**. We have the discretion to make an initial interpretation as to the terms of the policy or contract, but that such interpretation can be reversed by an internal utilization review organization, a court of law, arbitrator or administrative agency having jurisdiction.

Third parties rights

This **group policy** does not give any rights or impose any duties on third parties except as specifically stated.

Final rates and fees schedule

The current **premium** rates for all of the coverages provided under the policy are on record with us and the **policyholder**.