ARLINGTON COUNTY, VIRGINIA
OFFICE OF THE PURCHASING AGENT
2100 CLARENDON BOULEVARD, SUITE 500
ARLINGTON, VIRGINIA 22201

NOTICE OF AWARD OF CONTRACT

TO:

AETNA LIFE INSURANCE COMPANY
509 PROGRESS DRIVE,
SUITE 118
LINTHICUM, MARYLAND 21090

DATE ISSUED: AUGUST 16, 2012

CURRENT REFERENCE NO: 638-12

CONTRACT TITLE: LIFE INSURANCE

THIS IS A NOTICE OF AWARD OF CONTRACT AND NOT AN ORDER. NO WORK IS AUTHORIZED UNTIL THE VENDOR RECEIVES A VALID COUNTY PURCHASE ORDER ENCUMBERING CONTRACT FUNDS.

Your firm is awarded the above referenced contract in accordance with the response submitted by you on FEBRUARY 21, 2012. The contract term covered by this Notice of Award is effective **AUGUST 16, 2012** and expires on **JUNE 30, 2017.**

The contract documents consist of the terms and conditions of Agreement No. 638-12 including any exhibits, attachments or amendments thereto.

ATTACHMENTS:

AGREEMENT 638-12

CONTRACT PRICING:

REFER TO AGREEMENT 638-12 - EXHIBIT B

EMPLOYEES NOT TO BENEFIT:

NO COUNTY EMPLOYEE SHALL RECEIVE ANY SHARE OR BENEFIT OF THIS CONTRACT NOT AVAILABLE TO THE GENERAL PUBLIC.

VENDOR CONTACT: KIM THIELEMANN — VENDOR TEL. NO.: 443-285-1710

VENDOR PAYMENT TERMS: NET 30 DAYS — VENDOR FAX. NO.: 860-754-2083

EMAIL ADDRESS: thielemannk@aetna.com

COUNTY CONTACT: AMY ROZIER — COUNTY TEL. NO.: 703-228-3489

CONTRACT AUTHORIZATION

IVETTE GONZALEZ
PROCUREMENT OFFICER

8/16/12
DATE

DISTRIBUTION

FOLDER: 1

ARLINGTON COUNTY, VIRGINIA
OFFICE OF THE PURCHASING AGENT
2100 CLARENDON BOULEVARD, SUITE 500
ARLINGTON, VA 22201

AGREEMENT NO. 638-12

THIS AGREEMENT (hereinafter "Agreement" or "Contract") is made, on the date of execution by the County, between Aetna Life Insurance Company, 151 Farmington Avenue, Hartford CT 06156 ("Contractor"), a Connecticut Corporation authorized to do business in the Commonwealth of Virginia, and the County Board of Arlington County, Virginia ("County"). The County and the Contractor, for the consideration hereinafter specified, agree as follows:

1. CONTRACT DOCUMENTS

The following documents (hereinafter "Contract Documents") consist of the following:

All Subsequent Amendments
Agreement No. 638-12
Exhibit A - Scope of Work
Exhibit B - Fee Schedule & Billing Rates
Exhibit C - Performance Guarantees
Exhibit D - Group Policy
Exhibit E - Nondisclosure & Data Security Agreement
Exhibit F - Excerpts from Initial Written Proposal

Where the terms and provisions of this Agreement, or any properly executed amendment thereto, vary from the terms and provisions of the other Contract Documents, the terms and provisions of this Agreement (or amendment) shall prevail over the other Contract Documents and the remaining Contract Documents shall be complementary to each other and if there are any conflicts the most stringent terms or provisions shall prevail. However, To the extent that the notification requirements of the Termination provisions of this Agreement differ from the notification requirements of the termination provision of the Group Policy (Exhibit D), the Group Policy notification requirements will prevail.

The Contract Documents set forth the entire agreement between the County and the Contractor. The County and the Contractor agree that no representative or agent of either of them has made any representation or promise with respect to the parties agreement which is not contained in the Contract Documents. The Contract Documents may be referred to herein below as the "Contract" or the "Agreement."

2. SCOPE OF WORK

The Contractor agrees to perform the services described in the Contract Documents (hereinafter "the Work"). The primary purpose of the Work is to administer the Life and Disability Plans for the County's eligible population. The Contract Documents set forth the minimum work estimated by the County and the Contractor to be necessary to complete the Work. It shall be the Contractor's responsibility, at the Contractor's sole cost, to provide the specific services set forth in the Contract Documents and sufficient services to fulfill the purposes of the Work. Nothing in the Contract Documents shall be construed to limit the Contractor's responsibility to manage the details and execution of the Work.

3. CONTRACT TERM

The Work shall commence on July 1, 2012, and the Work shall be completed no later than June 30, 2017, subject to any modifications as provided for in the Contract Documents. Upon satisfactory performance by the Contractor and with the concurrence of the Contractor, the County may authorize continued operations of the Contractor under the same contract unit prices for not more than 5 additional twelve (12) month periods from July 1, 2017 to June 30, 2022 (Each such period shall be referred to as a "Subsequent Contract Term").

4. CONTRACT AMOUNT

The County will pay the Contractor in accordance with the terms of the Payment paragraph below, and Exhibit B for the Contractor's completion of the Work described and required in the Contract Documents. The Contractor agrees that it shall complete the Work for the total amount specified in this section ("Contract Amount") unless such amount is modified as provided in this Agreement.

5. PAYMENT

The Policyholder will pay premiums and fees by the Premium Due Date. Payment occurs when we receive good funds. They must be paid at our home office or its authorized agent.

If Contractor does not receive payment by the Premium Due Date, the County shall pay Contractor interest on the total premium amount and any fees overdue after the Premium Due Date including the premiums due for the Grace Period. The interest rate will be up to 1 ½% per month for each month; or partial month; the balance remains unpaid. Contractor may recover from the County: costs of collecting any unpaid premiums or fees, including reasonable attorney's fees; and cost of suit.

6. PROJECT OFFICER

The performance of the Contractor is subject to the review and approval of the County Project Officer ("Project Officer") who shall be appointed by the Director of the Arlington County department or agency requesting the work under this Contract. However, it shall be the responsibility of the Contractor to manage the details of the execution and performance of its work pursuant to the Contract Documents.

7. ADJUSTMENTS FOR CHANGE IN SCOPE

The County may order changes in the Work within the general scope of the Work consisting of additions, deletions or other revisions. No claim may be made by the Contractor that the scope of the work or that the Contractor's services have been changed requiring adjustments to the amount of compensation due the Contractor unless such adjustments have been made by a written amendment to the Contract signed by the County and the Contractor. If the Contractor believes that any particular work is not within the scope of the Work or is a material change or otherwise will call for more compensation to the Contractor, the Contractor must immediately notify the Project Officer after the change or event occurs and within ten (10) calendar days thereafter must provide written notice to the Project Officer. The Contractor's notice must provide to the Project Officer the amount of additional compensation claimed, together with the basis therefor and documentation supporting the claimed amount. The Contractor will not be compensated for performing any work unless a proposal complying with this paragraph has been submitted in the time specified above and a written Contract amendment has been signed by the County and the Contractor and a County purchase order is issued covering the cost of the services to be provided pursuant to the amendment.

8. ADDITIONAL SERVICES

The Contractor shall not be compensated for any goods or services provided except and included in the Contract Amount unless those goods or services are covered by a written amendment to this Contract signed by the County and the Contractor, and a County Purchase Order is issued covering the expected cost of such services.

Additional services agreed upon by the parties will be billed at the rates set forth in Exhibit B unless otherwise agreed by the parties in writing.

9. NON-APPROPRIATION

All funds for payments by the County to the Contractor pursuant to this Contract are subject to the availability of an annual appropriation for this purpose by the County Board of Arlington County, Virginia. In the event of non-appropriation of funds by the County Board of Arlington County, Virginia for the goods or services provided under this Contract or substitutes for such goods or services which are as advanced or more advanced in their technology, the County will terminate the Contract, without termination charge or other liability to the County, on the last day of the then current fiscal year or when the appropriation made for the then current year for the services covered by this Contract is spent, whichever event occurs first. If funds are not appropriated at any time for the continuation of this Contract, cancellation will be accepted by the Contractor on thirty (30) days prior written notice, but failure to give such notice shall be of no effect and the County shall not be obligated under this Contract beyond the date of termination specified in the County's written notice.

10. COUNTY PURCHASE ORDER REQUIREMENT

County purchases are authorized only if a County Purchase Order is issued in advance of the transaction, indicating that the ordering agency has sufficient funds available to pay for the purchase. Such a Purchase Order is to be provided to the Contractor by the ordering agency. The County will not be liable for payment for any purchases made by its employees without appropriate purchase authorization issued by the County Purchasing Agent. If the Contractor provides goods or services without a signed County Purchase Order, it does so at its own risk and expense.

11. PROJECT STAFF

The County will, throughout the Initial Contract Term and any Subsequent Contract Term, have the right of reasonable rejection and approval of staff or subcontractors assigned to the project by the Contractor. If the County reasonably rejects staff or subcontractors pursuant to this section, the Contractor must provide replacement staff or subcontractors satisfactory to the County in a timely manner and at no additional cost to the County. The day-to-day supervision and control of the Contractor's employees, and employees of any of its subcontractors, shall be the sole responsibility of the Contractor.

12. SUPERVISION BY CONTRACTOR

The Contractor shall at all times enforce strict discipline and good order among the workers performing under this Contract, and shall not employ on the work any person not reasonably proficient in the work assigned.

13. EMPLOYMENT DISCRIMINATION BY CONTRACTOR PROHIBITED

During the performance of this Contract, the Contractor agrees as follows:

A. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability or any other basis prohibited by state law related to discrimination in employment except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

B. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an Equal Opportunity Employer.

C. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.

D. The Contractor will comply with the provisions of the Americans with Disabilities Act of 1990 which prohibits discrimination against individuals with disabilities in employment and mandates their full

participation in both publicly and privately provided services and activities.

E. The Contractor will include the provisions of the foregoing paragraphs in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

14. EMPLOYMENT OF UNAUTHORIZED ALIENS PROHIBITED

In accordance with §2.2-4311.1 of the Code of Virginia, 1950, as amended, the Contractor acknowledges that it does not, and shall not during the performance of this Contract for goods and/or services in the Commonwealth, knowingly employ an unauthorized alien as that term is defined in the federal Immigration Reform and Control Act of 1986.

15. DRUG-FREE WORKPLACE TO BE MAINTAINED BY CONTRACTOR

During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor by Arlington County in accordance with the Arlington County Purchasing Resolution, the employees of which contractor are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

16. SAFETY

The Contractor shall comply with, and ensure that the Contractor's employees and subcontractors comply with, all current applicable local, state and federal policies, regulations and standards relating to safety and health, including, by way of illustration and not limitation, the standards of the Virginia Occupational Safety and Health program of the Department of Labor and Industry for General Industry and for the Construction Industry, the Federal Environmental Protection Agency standards and the applicable standards of the Virginia Department of Environmental Quality.

The Contractor shall provide, or cause to be provided, all technical expertise, qualified personnel, equipment, tools and material to safely accomplish the work specified to be performed by the Contractor and subcontractor(s).

The Contractor shall identify to the County Project Officer at least one (1) on-site person who is the Contractor's competent, qualified, and authorized person on the worksite and who is, by training or experience, familiar with and trained in policies, regulations and standards applicable to the work being performed. The competent, qualified and authorized person must be capable of identifying existing and predictable hazards in the surroundings or working conditions which are unsanitary, hazardous or dangerous to employees, shall be capable of ensuring that applicable safety regulations are complied with, and shall have the authority and responsibility to take prompt corrective measures, which may include removal of the Contractor's personnel from the work site.

The Contractor shall provide to the County, at the County's request, a copy of the Contractor's written safety policies and safety procedures applicable to the scope of work. Failure to provide this information within seven (7) days of the County's request may result in cancellation of this Contract.

17. WARRANTY

The Contractor warrants to furnish the services described herein at the times and places and in the manner and subject to the conditions set forth. The Contractor shall enter upon and complete the performance of services with all due diligence and dispatch and shall exercise the highest degree of skill and competence.

18. UNSATISFACTORY WORK

If any of the work done, or material or equipment provided, by the Contractor is unsatisfactory to the County, the Contractor shall, on being notified by the County, immediately remove at the Contractor's expense such unsatisfactory work or material or equipment and replace the same with work or material or equipment satisfactory to the County and, in the event the Contractor fails within fifteen (15) days after receipt of written notice to remove improper or unsuitable work or material or equipment and replace it with suitable and satisfactory work or material or equipment, the County shall have the right, but not the obligation, to remove the rejected work or material or equipment and replace it with proper work or material or equipment at the expense of the Contractor. This paragraph applies during the Initial Contract Term, any Subsequent Contract Term, and during any warranty or guarantee period. The County shall be entitled to offset such expense against any sums owed by the County to the Contractor under this Contract. If the Project Officer and the County deem it expedient not to require correction or replacement of the work which has not been done in accordance with the Contract, an appropriate adjustment to the Contract Amount may be made therefor.

19. TERMINATION FOR CAUSE, INCLUDING BREACH AND DEFAULT; CURE

The termination provision to the extent that this provision of this agreement and the Group Policy on termination differ the notification, provision of the Group Policy will prevail.

The Contract shall remain in force for the Initial Contract Term or any Subsequent Contract Term(s) and until the County determines that all of the following requirements and conditions have been satisfactorily met: the County has accepted the Work, and thereafter until the Contractor has met all requirements and conditions relating to the Work under the Contract Documents, including warranty and guarantee periods. However, the County shall have the right to terminate this Contract sooner if the Contractor is in breach or default or has failed to perform satisfactorily the Work required, as determined by the County in its discretion.

If the County determines that the Contractor has failed to perform satisfactorily, then the County will give the Contractor written notice of such failure(s) and the opportunity to cure such failure(s) within at least fifteen (15) days before termination of the Contract takes effect ("Cure Period"). If the Contractor fails to cure within the Cure Period or as otherwise specified in the notice, the Contract may be terminated for the Contractor's failure to provide satisfactory Contract performance. Upon such termination, the Contractor may apply for compensation for Contract services satisfactorily performed by the Contractor, allocable to the Contract and accepted by the County prior to such termination unless otherwise barred by the Contract ("Termination Costs"). In order to be considered, such request for Termination Costs, with all supporting documentation, must be submitted to the County Project Officer within fifteen (15) days after the expiration of the Cure Period. The County may accept or reject, in whole or in part, the application for Termination Costs and notify the Contractor of same within a reasonable time thereafter.

If the County terminates the Contract for default or breach of any Contract provision or condition, then the termination shall be immediate after notice from the County to the Contractor (unless the County in its discretion provides for an opportunity to cure) and the Contractor shall not be permitted to seek Termination Costs.

Upon any termination pursuant to this section, the Contractor shall be liable to the County for all costs incurred by the County after the effective date of termination, including costs required to be expended by the County to complete the Work covered by the Contract, including costs of delay in completing the Work or the cost of repairing or correcting any unsatisfactory or non-compliant work performed or provided by the Contractor or its subcontractors. Such costs shall be either deducted from any amount due the Contractor or shall be promptly paid by the Contractor to the County upon demand by the County. Additionally, and notwithstanding any provision in this Contract to the contrary, the Contactor is liable to the County, and the County shall be entitled to recover, all damages to which the County is entitled by this Contract or by law, including, and without limitation, direct damages, indirect damages, consequential damages, delay damages, replacement costs, refund of all sums paid by the County to the Contractor under the Contract and all attorney fees and costs incurred by the County to enforce any provision of this Contract.

Except as otherwise directed by the County in the notice, the Contractor shall stop work on the date of receipt of notice of the termination or other date specified in the notice, place no further orders or subcontracts for materials, services, or facilities except as are necessary for the completion of such portion of the Work not terminated, and terminate all vendors and subcontracts and settle all outstanding liabilities and claims. Any purchases after the date of termination contained in the notice shall be the sole responsibility of the Contractor.

In the event any termination for cause, default, or breach shall be found to be improper or invalid by any court of competent jurisdiction then such termination shall be deemed to have been a termination for convenience.

21. TERMINATION FOR THE CONVENIENCE OF THE COUNTY

The performance of work under this Contract may be terminated by the County's Purchasing Agent in whole or in part whenever the Purchasing Agent shall determine that such termination is in the County's best interest. Any such termination shall be effected by the delivery to the Contractor of a written notice of termination at least fifteen (15) days before the date of termination, specifying the extent to which performance of the work under this Contract is terminated and the date upon which such termination becomes effective. The Contractor will be entitled to receive compensation for all Contract services satisfactorily performed by the Contractor and allocable to the Contract and accepted by the County prior to such termination and any other reasonable termination costs as negotiated by the parties, but no amount shall be allowed for anticipatory profits.

After receipt of a notice of termination and except as otherwise directed, the Contractor shall stop all designated work on the date of receipt of the notice of termination or other date specified in the notice; place no further orders or subcontracts for materials, services or facilities except as are necessary for the completion of such portion of the work not terminated; immediately transfer all documentation and paperwork for terminated work to the County; and terminate all vendors and subcontracts and settle all outstanding liabilities and claims.

22. INDEMNIFICATION

The Contractor covenants for itself, its employees, and subcontractors to save, defend, hold harmless and indemnify the County, and all of its elected and appointed officials, officers, current and former employees, agents, departments, agencies, boards, and commissions (collectively the "County" for purposes of this section) from and against any and all claims made by third parties or by the County for any and all losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), charges, liability, demands or exposure, however caused, resulting from, arising out of, or in any way connected with the Contractor's acts or omissions, including the acts or omissions of its employees and/or subcontractors, in performance or nonperformance of the work called for by the Contract Documents. This duty to save, defend, hold harmless and indemnify shall

survive the termination of this Contract. If, after notice by the County, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse the County for any and all expenses, including but not limited to, reasonable attorneys' fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by the County and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.

23. INTELLECTUAL PROPERTY INDEMNIFICATION

The Contractor warrants and guarantees that no intellectual property rights (including, but not limited to, copyright, patent, mask rights and trademark) of third parties are infringed or in any manner involved in or related to the services provided hereunder.

The Contractor further covenants for itself, its employees, and subcontractors to save, defend, hold harmless, and indemnify the County, and all of its officers, officials, departments, agencies, agents, and employees from and against any and all claims (including but not limited to demand letters), losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), charges, liability, or exposure, however caused, for or on account of any trademark, copyright, patented or unpatented invention, process, or article manufactured or used in the performance of this Contract, including its use by the County. If the Contractor, or any of its employees or subcontractors, uses any design, device, work, or materials covered by letters patent or copyright, it is mutually agreed and understood, without exception, that the Contract Amount includes all royalties, licensing fees, and any other costs arising from the use of such design, device, work, or materials in any way involved with the Work. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract. If, after Notice by the County, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse the County for any and all expenses, including but not limited to, reasonable attorney's fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by the County and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.

24. DATA SECURITY AND PROTECTION

The Contractor shall hold County Information in the strictest confidence and comply with all applicable County security and network resources policies as well as all local, state and federal laws or regulatory requirements concerning data privacy and security. The Contractor shall develop, implement, maintain, continually monitor and use appropriate administrative, technical and physical security measures to preserve the confidentiality, privacy, integrity and availability of all electronically maintained or transmitted County Information received from, created or maintained on behalf of the County and strictly control access to County Information. For purposes of this provision, and as more fully described in this Contract and the County's Non-Disclosure and Data Security Agreement (NDA), "County Information" (also referred to as "County Data" or "data")includes, but is

not limited to, electronic information, documents, data, images, and records including, but not limited to, financial records, personally identifiable information, Personal Health Information (PHI), personnel, educational, voting, registration, tax or assessment records, information related to public safety, County networked resources, and County databases, software and security measures which is created, maintained, transmitted or accessed to perform the work under this Contract.

(a) **County's Non-Disclosure and Data Security Agreement (NDA).** The Contractor shall require that an authorized Contractor designee, and all key employees, agents or subcontractors working on-site at County facilities or otherwise performing non-incidental work under this Contract, sign the NDA (attached as an Exhibit E hereto) prior to performing any work or permitting access to County networked resources, application systems or databases under this Contract. A copy of the signed NDAs shall be available to the County Project Officer upon request.

(b) **Use of Data.** The Contractor shall ensure that the use, distribution, disclosure or access ("use") to County Information and County networked resources shall not occur in an unauthorized manner. Use of County Information for other than as specifically outlined in this Contract is strictly prohibited, unless such other use is agreed to in writing by the parties. The Contractor will be solely responsible for any unauthorized use, reuse, distribution, transmission, manipulation, copying, modification, access or disclosure of County Information and any non-compliance with this DATA SECURITY AND PROTECTION provision or any NDA.

(c) **Data Protection.** The Contractor agrees that it will protect the County's Information according to standards established by the National Institute of Standards and Technology, including 201 CMR 17.00, Standards for the Protection of Personal Information of Residents of the Commonwealth and the Payment Card Industry Data Security Standard (PCI DSS), as applicable, and no less rigorously than it protects its own data, proprietary and/or confidential information. The Contractor shall provide to the County a copy of its data security policy and procedures for securing County Information and a copy of its disaster recovery plan/s. The Contractor shall provide, if requested by the County, on an annual basis, results of an internal Information Security Risk Assessment provided by an outside firm.

(d) **Data Sharing.** Except as otherwise specifically provided for in this Contract, the Contractor agrees that it shall not share, disclosure, sell or grant access to County Information to any third party without the express written authorization of the County's Chief Information Security Officer or designee.

(e) **Security Requirements.** The Contractor shall maintain the most up to date anti-virus, industry accepted firewalls and/or other protections on its systems and networking equipment. The Contractor certifies that all systems and networking equipment that support, interact or store County Information meet the above standards and

industry best practices for physical, network and system security requirements. Printers, copiers or fax machines that store County Data into hard drives must provide data at rest encryption. Significant deviation from these standards must be approved by the County's Chief Information Security Officer or designee, The downloading of County information onto laptops or other portable storage medium is prohibited without the express written authorization of the County's Chief Information Security Officer or designee.

(f) **Data Protection Upon Conclusion of Contract**. Upon termination, cancellation, expiration or other conclusion of this Contract, the Contractor shall return all County Information to the County unless the County requests that such data be destroyed. This provision shall also apply to all County Information that is in the possession of subcontractors or agents of the Contractor. The Contractor shall complete such return or destruction not less than thirty (30) days after the conclusion of this Agreement and shall certify completion of this task, in writing, to the County Project Officer.

(g) **Notification of Security Incidents**. The Contractor agrees to notify the County Chief Information Officer and County Project Officer within twenty-four (24) hours of the discovery of any unintended access to, use or disclosure of County Information.

(h) **Subcontractors**. To the extent the use of subcontractors is permitted under this Contract, the requirements of this entire section shall be incorporated into any subcontractor agreement entered into by the Contractor and any data sharing shall be compliant with these security and protection requirements and the NDA. In the event of data sharing, subcontractors shall provide to the Contractor a copy of their data security policy and procedures for securing County Information and a copy of their disaster recovery plan/s.

25. ETHICS IN PUBLIC CONTRACTING

This Contract incorporates by reference Article 9 of the Arlington County Purchasing Resolution, as well as any state or federal law related to ethics, conflicts of interest, or bribery, including by way of illustration and not limitation, the State and Local Government Conflict of Interests Act (Code of Virginia § 2.2-3100 et seq.), the Virginia Governmental Frauds Act (Code of Virginia § 18.2-498.1 et seq.), and Articles 2 and 3 of Chapter 10 of Title 18.2 of the Code of Virginia, as amended (§ 18.2-438 et seq.). The Contractor certifies that its offer was made without collusion or fraud and that it has not offered or received any kickbacks or inducements from any other offeror, supplier, manufacturer, or subcontractor and that it has not conferred on any public employee having official responsibility for this procurement any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised unless consideration of substantially equal or greater value was exchanged.

26. COUNTY EMPLOYEES

No employee of Arlington County, Virginia, shall be admitted to any share in any part of this Contract or to any benefit that may arise therefrom which is not available to the general public.

27. FORCE MAJEURE

The Contractor shall not be held responsible for failure to perform the duties and responsibilities imposed by this Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, or an act of God beyond control of the Contractor, and outside and beyond the scope of the Contractor's then current, by industry standards, disaster plan, that make performance impossible or illegal, unless otherwise specified in the Contract.

The County shall not be held responsible for failure to perform its duties and responsibilities imposed by the Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, or an act of God beyond control of the County that make performance impossible or illegal, unless otherwise specified in the Contract.

28. AUTHORITY TO TRANSACT BUSINESS

The Contractor shall pursuant to Code of Virginia § 2.2-4311.2, be and remain authorized to transact business in the Commonwealth of Virginia during the Initial Term and any Subsequent Contract Term(s) of this Contract. A contract entered into by a Contractor in violation of this requirement is voidable, without any cost or expense, at the sole option of the County.

29. RELATION TO COUNTY

The Contractor is an independent contractor and neither the Contractor nor its employees or subcontractors will, under any circumstances, be considered employees, servants or agents of the County. The County will not be legally responsible for any negligence or other wrongdoing by the Contractor, its employees, servants or agents. The County will not withhold payments to the Contractor for any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the Contractor. Furthermore, the County will not provide to the Contractor any insurance coverage or other benefits, including workers' compensation, normally provided by the County for its employees.

30. ANTITRUST

By entering into this Contract, the Contractor conveys, sells, assigns and transfers to the County all rights, title, and interest in and to all causes of action the Contractor may now have or hereafter acquire under the antitrust laws of the United States or the Commonwealth of Virginia, relating to the goods or services purchased or acquired by the County under this Contract.

31. REPORT STANDARDS

Reports or written material prepared by the Contractor in response to the requirements of this Contract or a request of the Project Officer shall, unless otherwise provided for in the Contract, meet standards of professional writing established for the type of report or written material provided, shall be thoroughly researched for accuracy of content, shall be grammatically correct and not contain spelling errors, shall be submitted in a format approved in advance by the Project Officer, and shall be submitted for advance review and comment by the Project Officer. The cost of correcting grammatical errors, correcting report data, or other revisions required to bring the report or written material into compliance with these requirements shall be borne by the Contractor.

When submitting documents to the County, the Contractor shall comply with the following guidelines:

- All submittals and copies shall be printed on **at least thirty percent (30%) recycled-content** and/or tree-free paper;
- All copies shall be double-sided;
- Report covers or binders shall be recyclable, made from recycled materials, and/or easily removable to allow for recycling of report pages (reports with glued bindings that meet all other requirements are acceptable);
- The use of plastic covers or dividers should be avoided; and
- Unnecessary attachments or documents not specifically asked for should not be submitted, and superfluous use of paper (e.g. separate title sheets or chapter dividers) should be avoided.

32. AUDIT

The Contractor shall secure an annual independent certified public accountant's audit of its finances and program operation and shall forward to the County the findings of such audit in whole, including the management letter or other ancillary audit components, and permit the County to make such review of the records of the Contractor as may be deemed necessary by the County to satisfy audit purposes. In instances where a management letter was not prepared as an audit function, the Contractor must so certify in writing to the County at the time the audit report is submitted. All accounts of the Contractor are subject to such audit, regardless whether the funds are used exclusively for specific program activities or mingled with funds for other agency activities.

The Contractor agrees to retain all books, records and other documents related to this Contract for at least five (5) years after final payment. The County or its authorized agents shall have full access to and the right to examine any of the above documents during this period and during the Initial Contract Term and any Subsequent Contract Term. If the Contractor wishes to destroy or dispose of records (including confidential records to which the County does not have ready access) within five (5) years after final payment, the Contractor shall notify the County at least thirty (30) days prior to such disposal, and if the County objects, shall not dispose of the records.

33. ASSIGNMENT

Neither parties shall not assign, transfer, convey, sublet, or otherwise dispose of any award, or any or all of its rights, obligations, or interests under this Contract, without the prior written consent of the other party.

34. AMENDMENTS

This Contract shall not be amended except by written amendment executed by persons duly authorized to bind the Contractor and the County.

35. ARLINGTON COUNTY PURCHASING RESOLUTION AND COUNTY POLICIES

Notwithstanding any provision to the contrary herein, no provision of the Arlington County Purchasing Resolution or any applicable County policy is waived in whole or in part.

36. DISPUTE RESOLUTION

All disputes arising under this Agreement, or its interpretation, whether involving law or fact, or extra work, or extra compensation or time, and all claims for alleged breach of Contract shall be submitted to the Project Officer for decision at the time of the occurrence or beginning of the work upon which the claim is based, whichever occurs first. Such claims shall state the facts surrounding it in sufficient detail to identify it together with its character and scope. In accordance with the Arlington County Purchasing Resolution, claims denied by the Project Officer may be submitted to the County Manager in writing no later than 60 days after final payment. The time limit for final written decision by the County Manager in the event of a contractual dispute, as that term is defined in the Arlington County Purchasing Resolution, is fifteen (15) days. Procedures for considering contractual claims, disputes, administrative appeals, and protests are contained in the Purchasing Resolution, incorporated herein by reference, and available upon request from the Office of the Purchasing Agent. The Contractor shall not cause a delay in the Work pending a decision of the Project Officer, County Manager, County Board, or a court.

37. APPLICABLE LAW, FORUM, VENUE AND JURISDICTION

This Contract and the work performed hereunder shall be governed in all respects by the laws of the Commonwealth of Virginia and the jurisdiction, forum, and venue for any litigation with respect thereto shall be in the Circuit Court for Arlington County, Virginia, and in no other court. In performing the Work under this Contract, the Contractor shall comply with applicable federal, state, and local laws, ordinances and regulations.

38. ARBITRATION

It is expressly agreed that nothing under the Contract shall be subject to arbitration, and any references to arbitration are expressly deleted from the Contract.

39. NONEXCLUSIVITY OF REMEDIES

All remedies available to the County under this Contract are cumulative, and no such remedy shall be exclusive of any other remedy available to the County at law or in equity.

40. NO WAIVER

The failure of either party to exercise in any respect a right provided for in this Contract shall not be deemed to be a subsequent waiver of the same right or any other right.

41. SEVERABILITY

The sections, paragraphs, sentences, clauses and phrases of this Contract are severable, and if any phrase, clause, sentence, paragraph or section of this Contract shall be declared invalid by a court of competent jurisdiction, such invalidity shall not affect any of the remaining phrases, clauses, sentences, paragraphs and sections of this Contract.

42. NO WAIVER OF SOVEREIGN IMMUNITY

Notwithstanding any other provision of this Contract, nothing in this Contract or any action taken by the County pursuant to this Contract shall constitute or be construed as a waiver of either the sovereign or governmental immunity of the County. The parties intend for this provision to be read as broadly as possible.

43. SURVIVAL OF TERMS

In addition to any numbered section in this Agreement which specifically state that the term or paragraph survives the expiration of termination of this Contract, the following sections if included in this Contract also survive: INDEMNIFICATION; RELATION TO COUNTY; OWNERSHIP AND RETURN OF RECORDS; AUDIT; COPYRIGHT; INTELLECTUAL PROPERTY INDEMNIFICATION; WARRANTY; CONFIDENTIAL INFORMATION; AND DATA SECURITY.

44. HEADINGS

The section headings in this Contract are inserted only for convenience and are not to be construed as part of this Contract or a limitation on the scope of the particular section to which the heading precedes

45. AMBIGUITIES

Each party and its counsel have participated fully in the review and revision of this Agreement. Any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in interpreting this Agreement. The language in this Agreement shall be interpreted as to its fair meaning and not strictly for or against any party.

46. NOTICES

Unless otherwise provided herein, all notices and other communications required by this Contract shall be deemed to have been given when made in writing and either (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, or (c) deposited in the United States mail, postage prepaid, certified or registered, addressed as follows:

TO THE CONTRACTOR:

AETNA LIFE INSURANCE COMPANY
151 FARMINGTON AVENUE
HARTFORD CT 06156

TO THE COUNTY:

AMY ROZIER, Project Officer
ARLINGTON COUNTY
HUMAN RESOURCES DEPARTMENT

AND

Richard D. Warren, Jr., Purchasing Agent
Arlington County, Virginia
2100 Clarendon Boulevard, Suite 500
Arlington, Virginia 22201

47. NON-DISCRIMINATION NOTICE

Arlington County does not discriminate against faith-based organizations.

48. INSURANCE REQUIREMENTS

The Contractor shall provide to the County Purchasing Agent a Certificate of Insurance indicating that the Contractor has in force the coverage below prior to the start of any Work under this Contract and upon any contract extension. The Contractor agrees to maintain such insurance until the completion of this Contract or as otherwise stated in the Contract Documents. All required insurance coverages must be acquired from insurers authorized to do business in the Commonwealth of Virginia, with a rating of "A-" or better and a financial size of "Class VII" or better in the latest edition of the A.M. Best Co. Guides, and acceptable to the County. The minimum insurance coverage shall be:

a. Workers Compensation - Virginia Statutory Workers Compensation (W/C) coverage including Virginia benefits and employers liability with limits of $100,000/100,000/500,000. The County will not accept W/C coverage issued by the Injured Worker's Insurance Fund, Towson, MD.

b. Commercial General Liability - $1,000,000 combined single limit coverage with $2,000,000 general aggregate covering all premises and operations and including Personal Injury, Completed Operations, Contractual Liability, Independent Contractors, and Products Liability. The general aggregate limit shall apply to this Contract. Evidence of Contractual Liability coverage shall be typed on the certificate.

c. Business Automobile Liability - $1,000,000 Combined Single Limit (Owned, non-owned and hired).

d. The Contractor shall carry Errors and Omissions or Professional Liability insurance which will pay for injuries arising out of errors or omissions in the rendering, or failure to render services or perform Work under the contract, in the amount of $1,000,000.

e Crime Policy (Employee Dishonesty) - $500,000 Limit

f. Miscellaneous E&O - $1,000,000 per occurrence/claim

g. Umbrella\Excess Liability - $1,000,000 Bodily Injury, Property Damage and Personal Injury

h. Additional Insured - Additional Insured coverage will be active under Aetna policy.

i. Any insurance coverage that is placed as a "claims made" policy must remain valid and in force, or the Contractor must obtain an extended reporting endorsement consistent with the terms of this Contract, until the applicable statute of limitations has expired, such date as determined to begin running from the date of the Contractor's receipt of final payment.

The Contractor must disclose the amount of any deductible or self insurance component applicable to the General Liability, Automobile Liability, Professional Liability, Intellectual Property or any other policies required herein, if any. The County reserves the right to request additional information to determine if the Contractor has the financial capacity to meet its obligations under a deductible. Thereafter, at its option, the County may request a lower deductible,a certificate of self-insurance, collateral, or other mechanism in the amount of the deductible to ensure protection for the County.

No acceptance or approval of any insurance by the County shall be construed as relieving or excusing the Contractor from any liability or obligation imposed upon the Contractor by the provisions of the Contract Documents.

The Contractor shall be responsible for the work performed under the Contract Documents and every part thereof, and for all materials, tools, equipment, appliances, and property of any description used in connection with the work. The Contractor assumes all risks for direct and indirect damage or injury to the property or persons used or employed on or in connection with the Work contracted for, and of all damage or injury to any person or property wherever located, resulting from any action, omission, commission or operation under the Contract, or in connection with the contracted work.

The Contractor shall be as fully responsible to the County for the acts and omissions of its subcontractors and of persons employed by them as it is for acts and omissions of persons directly employed by it.

Notwithstanding any of the above, the Contractor may satisfy its obligations under this section by means of self insurance for all or any part of the insurance required, provided that the Contractor can demonstrate financial capacity and the alternative coverages are submitted to and acceptable to the County. The Contractor must also provide its most recent actuarial report to the extent one was completed, and to determine the adequacy of the insurance funding.

WITNESS these signatures:

THE COUNTY BOARD OF ARLINGTON COUNTY, VIRGINIA	AETNA LIFE INSURANCE COMPANY
AUTHORIZED SIGNATURE: Antoinette Gonzalez	AUTHORIZED SIGNATURE: Kevin Kearney
NAME AND TITLE: RICHARD D. WARREN, JR. PURCHASING AGENT	NAME AND TITLE: KEVIN KEARNEY GROUP INSURANCE OPS HEAD
DATE: 8/16/12	DATE: 8/10/12

Aetna Life Insurance Company

A

Notice Concerning Coverage Limitations And Exclusions 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 this 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; nor does it 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 guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by an insurer authorized to conduct business in Tennessee. 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 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 insureds 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 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), unless qualified under Section 403(b) of the Internal Revenue Code, except that, even if qualified under Section 403(b), unallocated annuities issued to employee benefit plans protected by the federal Pension Benefit Guaranty Corporation are not covered.

Limits on Amount 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 or contract. Also, for any one insured life, the association will pay a maximum of $ 300,000 no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $ 300,000 limit, the association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in health insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits -- again, regardless of the number of policies and contracts there were with the same company, and no matter how many different types of coverages.

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
1200 First Union Tower 150 4th Avenue
North Nashville, Tennessee 37219-2433

Tennessee Department Of Commerce And Insurance
500 James Robertson Parkway
Nashville, Tennessee 37243

Aetna Life Insurance Company

A

Texas Life, Accident, Health & Hospital Service Insurance Guaranty Association

Important Information About Coverage Under The Texas Life and Health Insurance Guaranty Association (For Insurers Declared Insolvent or Impaired on or After September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association (the "Association") administers this protection system. Only the policyholders of insurance companies which are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association
When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas at the time **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
  1. The policyholder has a policy with a company domiciled in Texas;
  2. The policyholder's state of residence has a similar guaranty association; and
  3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association
Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies; up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue,
Suite 1875
Austin, Texas 78701
800-982-6362 or
www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439
www.tdi.state.tx.us

Aetna Life Insurance Company

A

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

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association (the Association) and the protection it provides for policyholders. This safety net was created under Utah 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 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 Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
$500,000 in death benefits
$200,000 in cash surrender or withdrawal values

Health Insurance
$500,000 in hospital, medical and surgical insurance benefits
$500,000 in long-term care insurance benefits
$500,000 in disability income insurance benefits
$500,000 in other types of health insurance benefits

Annuities
$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion 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. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

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

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 www.utlifega.org or contact:

Utah Life and Health
Insurance Guaranty Corporation
60 East south Temple, Suite 500
Salt Lake City, UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City, UT 84114-6901
(801) 538-3800

Aetna Life Insurance Company

A

Important Information Regarding Your Insurance

To: Policyholders with Group Policies Issued in the State of Virginia

Subject: Insurance Contact Notice

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
1-800-872-3862

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at the following address and telephone number:

Virginia Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
Consumer Service Hotline (Toll Free and Nationwide):
877-310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

Aetna Life Insurance Company

A

Notice Concerning Coverage
Limitations And Exclusions Under The West Virginia
Life And Health Insurance
Guaranty Association Act

Residents of West Virginia 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 West Virginia 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 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 West Virginia 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 West Virginia. You should not rely on coverage by the West Virginia Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy. For a complete description of coverage, consult Article 26A, Chapter 33 of the West Virginia Code.

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.

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 Guaranty Association or the West Virginia Insurance Commission will respond to questions you may have which are not answered by this document. Policyholders with additional questions may contact:

West Virginia Life and Health Insurance Guaranty Association
P.O. Box 816
Huntington, West Virginia 25712

West Virginia Insurance Commissioner
Consumer Services Division
1124 Smith Street, Room 309
P.O. Box 50540
Charleston, West Virginia 25305-0540
(304) 558-3386
Toll Free 1-800-642-9004
TDD 1-800-435-7381

The state law that provides for this safety-net coverage is called the West Virginia Life and Health Insurance Guaranty Association Act. 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 anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

Generally, individuals will be protected by the West Virginia Life and Health Insurance Guaranty Association if they live in West Virginia and hold a life or health insurance contract, annuity contract, unallocated annuity contract, or if they are insured under a group life, health or annuity insurance contract, issued by a member insurer. Member insurer also includes non-profit service corporations and health care corporations. 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 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 at a time when the insurer was not licensed or authorized to do business in the state;
- their policy was issued by an HMO, a fraternal benefit society, mandatory state pooling plan, a mutual protective association or similar plan in which the policyholder is subject to future assessments, an insurance exchange, or an entity similar to the above.

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 or contract holder has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;

- employer or association plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them) or uninsured, including:
  i. multiple employer welfare arrangement;
  ii. minimum premium group insurance plan;
  iii. stop loss group insurance plan; or
  iv. administrative services only contract.
- any unallocated annuity contract issued to an employee benefit plan protected under the federal pension guaranty corporation;
- any portion of any unallocated contract which is not issued to or in connection with a specific employee, union or association's benefit plan or a governmental lottery.

Limits on Amount of Coverage

The act also limits the amount the Guaranty Association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in health insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits --again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

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 $ 150,000 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 $ 1,000,000 applies to each contract holder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

Aetna Life Insurance Company

A

Puerto Rico
Life And Disability Insurance Guaranty
Association

Your benefit is assured

Life and health insurance guaranty associations protect policyholders providing them with a financial safety net. Guaranty Associations are established in all 50 states, the District of Columbia, and Puerto Rico. Life and health insurance guaranty associations include, by law, all insurance companies (with limited exceptions) licensed to write annuities or life and disability insurance or annuities, among their members.

Am I protected?
This protection is **automatically** in place when you purchase a policy or annuity. State law specifies the types of policies that are protected by the Guaranty Associations and the extent of that protection. In case your insurance company experiences severe financial difficulties, the insurer could be taken over by the Office of the Insurance Commissioner and the Insurance Commissioner becomes the "receiver." If the insurer is determined to be insolvent, the court could order liquidation. In such instance, you will be notified by the Insurance Commissioner and/or by the Guaranty Association. The Guaranty Association will work with the receiver to pay covered claims directly or transfer the policies to a financially sound insurance company.

Do I need to keep paying policy premiums?
It is important to remember that if you are paying premiums to your company, you must continue to do so as those premiums go to your Guaranty Association, which is continuing your coverage. If you stop paying premiums, your insurance coverage may be terminated.

Protecting policyholders when most needed:
Like the FDIC, state guaranty associations have maximum benefit limits. In Puerto Rico the overall combined benefit "cap" is $300,000. The specific limits are:

- $300,000 in life insurance death benefits but not more than $100,000 in cash surrender or cash withdrawal values
- $100,000 in disability insurance policy benefits
- $100,000 in the present value of annuities.

If you have questions regarding the guaranty protection, please contact the Puerto Rico Life and Disability Insurance Guaranty Association ***www.agsvipr.com*** or write email to ***info@agsvipr.com***. Also, you can visit the National Organization of Life & Health Insurance Guaranty Associations website at ***www.nolhga.com***. This site offers direct links to the state associations' web sites and information on the guaranty system safety net. Generally, individual or group life and health insurance policies and

Individual annuity contracts issued by the member insurers are covered by the Guaranty Association.

Asociación de Garantía de Seguros de Vida e Incapacidad de Puerto Rico

Su beneficio está asegurado

Las asociaciones de garantía de seguros de vida y salud protegen a los tenedores de póliza brindándoles una red de seguridad. Dichas entidades están establecidas en los 50 estados, el distrito federal de Washington y Puerto Rico. Las asociaciones de garantía de seguros de vida y salud incluyen, por ley, a todos los aseguradores (con limitadas excepciones) con autorización para emitir anualidades o seguros de vida e incapacidad, entre sus miembros.

¿Estoy protegido?

La protección se aplica **automáticamente** cuando usted compra una póliza o anualidad. Las leyes estatales especifican los tipos de pólizas que están protegidos por las asociaciones de garantía, así como el alcance de dicha protección. En el caso de que su asegurador experimente graves dificultades financieras, ésta pasaría a manos del Comisionado de Seguros, quien se convertiría en "síndico". Si éste determina que el asegurador está insolvente, el Tribunal ordenará una liquidación. En ese caso, usted recibiría una notificación de la Oficina del Comisionado y/o de nuestra Asociación de Garantía. La Asociación de Garantía trabajaría con el "síndico" para pagar directamente las reclamaciones cubiertas o transferir las pólizas a otro asegurador con solidez financiera.

¿Tengo que seguir pagando la póliza?

Es importante recordar que si está pagando primas a su asegurador, tiene que continuar haciéndolo. Esas primas van a su Asociación de Garantía, la cual continúa con su cobertura. Si usted deja de pagar las primas, su cubierta de seguro podría cancelarse.

Protegiendo a los asegurados cuando más lo necesitan:

Al igual que la FDIC, las asociaciones de garantía estatales tienen límites de beneficio máximo. En Puerto Rico el tope de beneficios combinado es de $300,000. Los límites específicos son:

- $300,000 en beneficios por muerte bajo seguro de vida pero no más de $100,000 en valores netos de rescate en efectivo o retiro de fondos en efectivo
- $100,000 en beneficios de seguros de incapacidad
- $100,000 en el valor presente de anualidades

Para cualquier pregunta acerca de la protección de garantía, debe comunicarse con la Asociación de Garantía de Seguros de Vida y Salud puede visitar el sitio web de la National Organization of Life & Health Insurance Guaranty Associations (www.nolhga.com). La misma ofrece enlaces directos con los sitios web de las asociaiones estatales y también incluye información adicional sobre la red de seguridad del sistema de garantía. Por lo general, las pólizas de seguro de vida y de salud individuales o grupales y los

contratos de anualidad individuales emitidos por los aseguradores miembros, están cubiertos por la Asociación de Garantía.

A

Group Life and Accident and Health Insurance Policy

This Policy is entered into by and between

Aetna Life Insurance Company
(**Aetna**, We, Us, or Our)

and

Arlington County
(the Policyholder)

Policy Number:	GP-326435
Date of Issue:	June 1, 2012
Effective Date:	July 1, 2012

This Policy shall be effective on the Effective Date and shall continue in force until terminated as provided herein.

In consideration of the mutual promises hereunder and the payment of Premiums and fees when due, We will pay benefits in accordance with the terms, conditions, limitations and exclusions set forth in this Policy. Benefits will be paid in accordance with the reasonable exercise of Our business judgment, consistent with applicable law. The duties and the rights of all persons will be based solely on the terms of this Policy.

Upon receipt of the Policyholder's signed Group Application, and upon receipt of the required initial Premium, this Policy shall be considered to be agreed to by the Policyholder and Us, and is fully enforceable in all respects against the Policyholder and Us.

Term of Policy:	The Initial Term shall be: The 12 consecutive month period beginning on the Effective Date. Thereafter, Subsequent Terms shall be: The 12 consecutive month period beginning on July 1 of each year.
Premium Due Dates:	The Effective Date and the first day of each succeeding calendar month.

This Policy is non-participating.

This Policy is governed by applicable federal law and the laws of the Commonwealth of Virginia.

Signed at **Aetna's** Home Office 151 Farmington Avenue Hartford, Connecticut 06156 on the date of issue.

Mark T. Bertolini
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company
(A Stock Company)

GR-29N
01-01
01 VA

Aetna Life Insurance Company

Index

Cover Page - Group Life and Accident and Health Insurance Policy

Index

Special Notice

Definitions

Policy Contents

Premiums and Fees

Responsibilities of the Policyholder

Termination

General Provisions

Special Notice *(GR-29N-02-01-05 VA)*

Important Information Regarding Your Insurance

Insurance Contact Notice
In the event you need to contact someone about this insurance for any reason please contact your sales agent or broker. If no sales agent or broker was involved in the sale of this insurance, or if you have additional questions you may contact Us at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
1-800-872-3862

If you have been unable to contact or obtain satisfaction from your insurance company or agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Commonwealth of Virginia
State Corporation of Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23216
1-800-552-7945

Written correspondence is preferred so that a record of your inquiry is maintained. When contacting your sales agent, broker or Us, have your policy number available.

Fraud Notice
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Your Life Insurance Beneficiary Designation May Not Apply in the Event of Annulment or Divorce

Under Virginia law (Virginia code section 20-111.1), a revocable beneficiary designation in a policy owned by one spouse that names the other spouse as beneficiary becomes void upon entry of a decree of annulment or divorce, and the death benefit prevented from passing to a former spouse will be paid as if the former spouse had predeceased the decedent. In the event of annulment or divorce proceedings, and if it is the intent of the parties that the beneficiary designation of the former spouse is to continue, you are advised to make certain that one of the following courses of action is taken prior to the entry of a decree of annulment or divorce: (i) change the beneficiary designation to make it irrevocable; (ii) change the ownership of the policy or contract;

(iii) execute a separate written agreement stating the intention of both parties that the beneficiary designation is to remain in effect beyond the date of entry of the decree of annulment or divorce; or (iv) make certain that the decree of annulment or divorce contains a provision stating that the beneficiary designation is not to be revoked pursuant to section 20-111.1. Refer to the *"How the Plan Works - Naming your Beneficiary"* section of your booklet-Certificate for additional information.

Definitions *(GR-29N-03-01-01)*

Defined terms as used throughout this Policy appear in bolded print. Some of the terms are defined in this section while others are defined in the *Glossary* section of the Booklet-Certificate.

Associated Companies. This term means any company which is a subsidiary to or affiliated with the Policyholder for the purpose of providing benefits under This Policy.

Employee. This term is defined in the *Eligibility, Enrollment and Effective Date of Your Coverage* Section of the Certificate.

If the Policyholder is a partnership or proprietorship, each of its natural-person partners, or the proprietor, will be deemed to be an employee.

If an eligible person is covered under any other group health plan issued to the Policyholder by Us, or any other health benefit plan established and maintained by the Policyholder, they will not be considered eligible for health coverage under this Policy.

An employee is eligible only for the coverages shown in the Certificate which applies to his or her class.

Policy Contents

This Policy consists of all provisions set forth in this document as well as the provisions found in the Certificate, including the *Schedule of Benefits*, issued to covered employees under the group plan. Any amendment changing the provisions of the Certificate is also made part of this Policy as of the effective date of the amendment.

Certificate means each certificate included in the Policy as follows:

Identification	**Issue Date**	**Effective Date**	**Eligible Group and/or Type of Coverage**
Cert. Base: 1	June 1, 2012	July 1, 2012	Life and ADPL
SOB: 1A	June 1, 2012	July 1, 2012	Full-time Employees

Premiums and Fees

Premiums Rates. The premium charges will be determined in accordance with the Premium Rates in effect on the Premium Due Date. The initial monthly Premium Rates are set forth in the Schedule of Premiums and Fees.

However, any other method may be used which: (a) yields about the same total amount; and (b) is agreeable to both the Policyholder and Us.

If the Policyholder so agrees, We may determine the Premium Rates:

- On the basis of an examination of the experience of the risk assumed; and
- On reasonable assumptions as to interest, mortality and expense.

The rate is subject to change as provided in this Policy. The Premium Rate is for a period of one month.

Premiums Due - Experience Rating. The Premium due under this policy on any Premium Due Date will be the sum of the premium charges for the coverages provided under this Policy. Covered employees and dependents as of each Premium Due Date will be determined by Us in accordance with Our records. A check does not constitute payment until it is honored by a bank. We may return a check issued against insufficient funds without making a second deposit attempt. We may accept a partial payment of Premium without waiving our right to collect the entire amount due.

If premiums are payable monthly, any insurance becoming effective will be charged for from the first day of the policy month on or right after the date the insurance takes effect. Premium charges for insurance which terminates will cease as of the first day of the policy month on or right after the date the insurance terminates. If premiums are payable less often than monthly, premium charges or credits for a fraction of a premium-paying period will be made on a pro rata basis for the number of policy months between the date premium charges start or cease and the end of the premium-paying period. If this policy is changed to provide more coverage to take effect on a date other than the first day of a premium-paying period, a pro rata premium for the coverage will be due and payable on that date. It will cover the period then starting and ending right before the start of the next premium-paying period.

We may change premiums due to experience or a change in factors bearing on the risk assumed. Each change shall be made by written notice to the Policyholder by Us:

- At any time; or
- Pursuant to *Changes in Premium* section.

Except as otherwise provided in the *Changes in Premium* provision, no experience reduction or increase in Premium Rates shall become effective less than 12 months after the effective date of this Policy.

At the end of a policy year, We may declare an experience credit. We do not have a duty to declare any experience credit. If We declare an experience credit, We will return the amount of that credit to the Policyholder. We may return such credited funds by check, by application against future premium in the current or succeeding policy period, or in any other manner as agreed to by the Policyholder and Us. We may require the Policyholder to share the credit with employees as a condition of Our returning the credited funds to the Policyholder.

If the sum of employee contributions which have been made for group insurance exceeds the sum of premiums which have been paid for group insurance, (after giving effect to any experience credits), the excess will be applied by the Policyholder for the sole benefit of employees. We will not have to see to the use of such excess.

Instead of figuring premiums as described above, premiums may be figured in any way approved by Us that comes up with about the same amount of premiums.

AGREEMENT NO. 638-12

SCOPE OF WORK

EXHIBIT A

PURPOSE/OVERVIEW:
To administer a redesigned basic and supplemental life insurance and accidental death and dismemberment benefits for active employees and their spouses, supplemental life insurance for dependents and basic and supplemental life insurance benefits for retired employees. Continuity of coverage must be maintained for current participants and the actively at work provision must be waived. Supplemental life insurance participants who have been approved for additional coverage by the incumbent contractor should continue with the same level of coverage. All current beneficiary designations, viatical settlements and assignments will also be honored.

To administer newly designed long and/or short term disability plans for active employees that will be implemented after July 1, 2012. If designs or eligibility criteria change from initial rate proposal, rates may be renegotiated.

GENERAL REQUIREMENT:
The Contractor shall provide the following deliverables for administering County benefit programs:

Deliverable 1:	Plan Administration
Deliverable 2:	Enrollment and Underwriting
Deliverable 3:	Claims Administration
Deliverable 4:	Customer Service
Deliverable 5:	Communication
Deliverable 6:	Reports and Recordkeeping
Deliverable 7:	Technology

Deliverable 1: Plan Administration
The Contractor shall provide an online administration manual and access for Human Resources staff, technical guidance regarding compliance with pertinent laws, and a thorough implementation of the program.

The Contractor shall provide the administration of all life and accidental death and dismemberment plan specifics including, but not limited to: locating missing beneficiaries, processing, validating and paying claims accurately and timely, administering accelerated benefits, where applicable, providing hardcopy and electronic copy of plan booklets/certificates, and providing conversion/ported policies.

The Contractor shall provide the administration of all disability plan specifics such as, but not limited to: receiving and processing enrollments, changes and claims, FICA withholding and remittance, breaks in elimination

periods, waiver of premium clauses, W2 statements, coordination with Social Security regarding disability benefits.

The Contractor shall provide the administration of a long-term disability plan available initially to a small subset of new hires that would include management-level employees and rehired retirees.
The Contractor shall administer conversion/portability of life insurance benefits including but not limited to notifying terminating active employees of their rights to convert/port life insurance at no extra administrative charge. The County will provide a bi-weekly file of employees becoming eligible for these conversions.

The Contractor shall attend ten (10) open enrollment meetings in May 2012 as well as subsequent years. Meetings may consist of 5 to 30 people. The Contractor shall present plan information in person at various work sites and respond to employee/retiree inquiries.

The Contractor shall submit performance metrics, measured on a quarterly basis, in the following categories. A total fees at risk with a set dollar amount or percentage of fees and premiums that the County has designated to each metric (as outlined in Exhibit C - Performance Guarantees).

- Life insurance claims administration
- Disability administration
- Medical underwriting
- Complaint Handling/Resolution
- Account management
- Account implementation (year 1 only)

Administration of a one-time open enrollment for active employees (regardless of current supplemental life insurance election) that would allow employees to elect and become insured for amounts up to the guaranteed issue amounts: 2 times salary for themselves, $50,000 for spouses, and $10,000 for each child.

In addition to the statement above, Contractor agrees to perform in accordance with Exhibit C, where applicable, and Exhibit F which are incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

Deliverable 2: Enrollment and Underwriting

The Contractor shall enroll newly eligible employees via a file feed from the County, when applicable. The County will provide a regular file of newly eligible and currently enrolled members at a minimum on a monthly basis. However, if necessary, the file will sent more frequently as agreed upon by the Parties.

The Contractor shall perform medical underwriting services and bear the expense of physical exams or other costs incurred in the process. The Contractor shall inform the applicant and the County of the outcome of all

requests. Results shall be communicated at a minimum of monthly to the County via online access.

The Contractor shall administer the appeals process for any denied applications.

In addition to the statement above, Contractor agrees to perform in accordance with (Exhibit C, where applicable, and Exhibit F which are incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

Deliverable 3: Claims Administration

The Contractor shall process, review, and, if necessary, investigate claims, locate beneficiaries; and pay claims (or advising the County to pay, in the case of short-term disability claims) according to the County's benefit plan specifications. The Contractor shall administer viatical settlements, assignment of benefits and the appeals process for any denied claims. The Contractor shall recover any claims payments made in error.

In addition to the statement above, Contractor agrees to perform in accordance with Exhibit C, where applicable, and Exhibit F which is incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

Deliverable 4: Customer Service

The Contractor shall provide high quality customer service to County staff and employees in accordance with Exhibit C; a toll free number for claims and customer service. Customer service shall be accessible during normal business hours at a minimum, which is 8 am to 5 pm EST and/or a secured email customer service method that shall be available within the same guidelines.

The Contractor shall provide customer service metrics that are measured and reported on a quarterly basis. The metrics are outlined in Exhibit C - Performance Guarantees.

In addition to the statement above, Contractor agrees to perform in accordance with Exhibit C, where applicable, and Exhibit F which are incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

Deliverable 5: Communication

The Contractor shall provide material in hardcopy and electronic format for distribution to active employees and retirees. Such written materials shall include, but are not limited to, examples and worksheets designed to assist employees to make sound decisions and summary plan booklets. The County reserves the right to review, revise and approve all materials prepared by the Contractor for distribution to employees. Any materials distributed shall include a local or toll-free telephone number, and secured email option, if available, for participants to call with questions and/or

concerns. Material shall be clear and understandable to the average employee.

In addition to the statement above, Contractor agrees to perform in accordance with Exhibit C, where applicable, and Exhibit F which are incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

Deliverable 6: Reports and Recordkeeping

The Contractor shall provide administrative, accounting services and reporting on a monthly basis via electronic format to the County Project Officer, or designee. Reports must include but are not limited to quarterly claims experience including loss ratio percentage, enrollment breakout, and ad hoc reports as needed. All data collected by Contractor shall remain confidential and shall not be released without the prior written permission of the County. The Contractor shall randomly audit their processes to ensure accurate processing of enrollments and claims.

In addition to the statement above, Contractor agrees to perform in accordance with Exhibit C, where applicable, and Exhibit F which are incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

Deliverable 7: Technology

The Contractor shall provide online administration services for enrollment and claims inquiries as well as online reporting. The Contractor shall also provide a secure means for transferring data between the County and the Contractor. County data shall be protected as described in Exhibit E - Nondisclosure and Data Security Agreement. The Contractor shall have a disaster recovery plan to avoid/minimize any interruption in service to the County and its employees.

In addition to the statement above, Contractor agrees to perform in accordance with Exhibit C, where applicable, and Exhibit F which are incorporated by reference and more specifically explains the detail of how the Contractor will meet this Deliverable.

PRICING AND FEES

EXHIBIT B

Proposed Term Life Insurance Rates

Basic Term Life	Lives	Volume	Rate Per $1,000 of Volume	Monthly Premium
Active Term Life	3,535	$230,976,000	$0.071	$16,399
Retiree Term Life	1,870	$16,538,000	$2.497	$41,295
Active AD&D Ultra	3,535	$230,976,000	$0.025	$5,774
Monthly Total	5,405	$247,514,000		$63,469
Annual Premium				$761,629

The above rates are subject to verification of lives and volume as appropriate. No demographic threshold will apply during year 1 of the rate guarantee. During years 2-5, if the actual amounts and volume

Employee Supplemental Term	Lives	Volume	Rate Per $1,000 of	Monthly Premium
Non-Tobacco Use				
Under 25	5	$363,000	$0.037	$14
25-29	51	$3,444,000	$0.037	$128
30-34	124	$11,456,000	$0.048	$549
35-39	165	$16,748,000	$0.053	$891
40-44	192	$23,608,000	$0.069	$1,633
45-49	210	$24,741,000	$0.101	$2,501
50-54	206	$24,505,000	$0.181	$4,433
55-59	149	$18,442,000	$0.298	$5,495
60-64	99	$10,324,000	$0.458	$4,724
65-69	37	$3,933,000	$0.878	$3,453
70-74	7	$583,000	$1.421	$828
75+			$1.421	$0
Monthly Total	1,245	$138,147,000	$0.178	$24,649

Tobacco Use Rates				
Under 25	1	$30,000	$0.048	$1
25-29	6	$256,000	$0.048	$12
30-34	4	$199,000	$0.064	$13
35-39	4	$414,000	$0.085	$35
40-44	12	$1,171,000	$0.133	$156
45-49	14	$1,306,000	$0.202	$264
50-54	31	$3,200,000	$0.346	$1,107
55-59	16	$1,283,000	$0.575	$737
60-64	2	$224,000	$0.878	$197
65-69	1	$42,000	$1.692	$71
70-74			$2.746	$0
75+			$2.746	$0
Monthly Total	91	$8,125,000	$0.319	$2,593
Combined Monthly	1,336	$146,272,000	$0.186	$27,242
Combined Annual				$326,909

The proposed rates may be subject to imputed income, under Section 79 of the Internal Revenue Code. Please consult your tax counsel for details.

The above rates are subject to verification of lives and volume as appropriate. No demographic threshold will apply during year 1 of the rate guarantee. During years 2-5, if the actual amounts and volume differ

Retiree Supplemental	Lives	Volume	Rate Per $1,000 of	Monthly Premium
Non-Tobacco Use Rates				
Under 25			$0.101	$0
25-29			$0.101	$0
30-34			$0.129	$0
35-39	2	$105,000	$0.144	$15
40-44	5	$231,000	$0.187	$43
45-49	11	$630,000	$0.273	$172
50-54	20	$1,459,000	$0.489	$713
55-59	62	$3,904,000	$0.807	$3,150
60-64	92	$4,489,000	$1.238	$5,557
65-69	112	$2,726,000	$2.375	$6,473
70-74	86	$860,000	$3.848	$3,310
75+	217	$1,881,000	$4.010	$7,544
Monthly Total	607	$16,285,000		$26,977

Tobacco Use Rates				
Under 25			$0.129	$0
25-29			$0.129	$0
30-34			$0.172	$0
35-39			$0.230	$0
40-44			$0.359	$0
45-49	3	$44,000	$0.547	$24
50-54	3	$162,000	$0.936	$152
55-59	7	$327,000	$1.550	$507
60-64	16	$717,000	$2.375	$1,703
65-69	25	$573,000	$4.578	$2,623
70-74	16	$160,000	$7.425	$1,188
75+	14	$110,000	$7.751	$853
Monthly Total	84	$2,093,000		$7,049
Combined Monthly	691	$18,378,000		$34,026
Combined Annual				$408,309

The proposed rates may be subject to imputed income, under Section 79 of the Internal Revenue Code. Please consult your tax counsel for details.

The above rates are subject to verification of lives and volume as appropriate. No demographic threshold will apply during year 1 of the rate guarantee. During years 2-5, if the actual amounts and volume differ

Spouse Supplemental	Lives	Volume	Rate Per $1,000 of	Monthly Premium
Under 25			$0.051	$0
25-29	6	$140,000	$0.043	$6
30-34	15	$485,000	$0.051	$25
35-39	30	$1,080,000	$0.068	$74
40-44	44	$1,540,000	$0.111	$171
45-49	43	$1,255,000	$0.162	$203
50-54	44	$1,095,000	$0.290	$318
55-59	30	$765,000	$0.478	$365
60-64	12	$315,000	$0.734	$231
65-69	4	$95,000	$1.356	$129
70-74	1	$10,000	$2.244	$22
75+			$3.668	$0
Monthly Total	229	$6,780,000		$1,544
Annual Premium				$18,530

The proposed rates may be subject to imputed income, under Section 79 of the Internal Revenue Code. Please consult your tax counsel for details.

The above rates are subject to verification of lives and volume as appropriate. No demographic threshold will apply during year 1 of the rate guarantee. During years 2-5, if the actual amounts and volume differ

Supplemental AD&D Ultra	Lives	Volume	Rate Per $1,000 of Volume	Monthly Premium
Employee Only	1,336	$146,272,000	$0.025	$3,657
Spouse/Child	480	$9,290,000	$0.025	$232
Monthly Total	1,816	$155,562,000		$3,889
Annual Premium				$46,669

The above rates are subject to verification of lives and volume as appropriate. No demographic threshold will apply during year 1 of the rate guarantee. During years 2-5, if the actual amounts and volume

Dependent Term Life	Lives	Rate Per $10,000 Volume	of Volume	Monthly Premium
Child(ren) Per Unit	251	$2,510,000	$0.510	$128
Monthly Total	251	$2,510,000		$128
Annual Premium				$1,536

The proposed rates may be subject to imputed income, under Section 79 of the Internal Revenue Code. Please consult your tax counsel for details.

The above rates are subject to verification of lives and volume as appropriate. No demographic threshold will apply during year 1 of the rate guarantee. During years 2-5, if the actual amounts and volume differ

Basic Life Portability Rates
Supplemental Life Portability Rates
Death Benefit Only
Monthly Rates per $1,000

Attained Ages	Employee & Spouse Non-smoker Base Rate	Employee & Spouse Smoker Base Rate
15-19	$0.072	$0.123
20-24	$0.072	$0.123
25-29	$0.072	$0.123
30-34	$0.082	$0.140
35-39	$0.113	$0.195
40-44	$0.165	$0.285
45-49	$0.290	$0.500
50-54	$0.464	$0.805
55-59	$0.731	$1.275
60-64	$1.154	$2.025
65-69	$1.998	$3.513
70-74	$3.512	$6.163
75-79	$6.149	$10.788
80-84	$10.764	$18.875
85-89	$18.839	$33.038
90-94	$32.970	$57.810
95+	$57.701	$101.175

Portable Pooled rates are guaranteed for 12 months, on a calendar year basis.

Portable pooled rates will be renewed annually with a January 1st effective date.

Child Rate

Accidental Death
.04/1000

An employee may be eligible to have his or her ported coverage continue on a premium waiver basis if the employee becomes permanently and totally disabled after having ported coverage

AGREEMENT NO. 638-12

PERFORMANCE GUARANTEES

EXHIBIT C

Contractor will place the following at risk in the form of ~~proposed~~ performance categories:

1. 1% of annual life premium (Basic Life, Supplemental Life, and Dependent Life Premium only)and

2. 1% of the annual fully insured long term disability premium.

Guarantees are for the Initial Contract Term and will remain the same percentages and allocations in Subsequent Contract Terms. Changes will be implemented as mutually agreed upon by County and Contractor at renewal.

Performance Category	Minimum Standard	Proposed Penalty
First Year - Life Insurance Implementation		
• Implementation Satisfaction	Average evaluation score of 3 or higher.	15% of the total performance guarantee dollars at risk
LIFE INSURANCE		
Account Management		
Account Management Satisfaction	Average evaluation score of 3.5 or higher	10% of the total performance guarantee dollars at risk
Claims Administration		
• Claim Turnaround Time	90% of claims processed within 5 business days	15% of the total Life performance guarantee dollars at risk
• Claim Turnaround Time	100% of good order claims processed within 10 business days	5% of the total Life performance guarantee dollars at risk
• Payment Accuracy	99% based upon whole dollars	15% of the total Life performance guarantee dollars at risk
• Coding Accuracy	99%	15% of the total Life performance guarantee dollars at risk
•		
Member Services		

• Telephone Response Time (Average Speed of Answer)	30 seconds	10% of the total Life performance guarantee dollars at risk
• Abandonment Rate	3%	5% of the total Life performance guarantee dollars at risk
• Service Center Auto Survey Results	85% overall customer satisfaction	10% of the total Life performance guarantee dollars at risk
	Total	**100% of total Life performance guaranteed dollars at risk**
LONG TERM DISABILITY		
Account Management		
Account Management Satisfaction	Average evaluation score of 3.5 or higher	5% of the total Disability performance guarantee dollars at risk
Claims Administration		
• Claim Turnaround Time	90% of claims processed within 45 calendar days	15% of the total Disability performance guarantee dollars at risk
• Payment Accuracy	98% based upon whole dollars	15% of the total Disability performance guarantee dollars at risk
• Coding Accuracy	97%	15% of the total Disability performance guarantee dollars at risk
• Payment Incidence Accuracy	98%	15% of the total Disability performance guarantee dollars at risk
Social Security Advocacy		
• Facilitation of advocacy services for appropriate cases	98% of eligible claimants will be evaluated for SSD eligibility, for claims aged 24	10% of the total Disability performance guarantee dollars at risk

	months or greater	
• Social Security Advocacy Results	85% of claimants eligible for SSD benefits will be approved for SSD for claims aged 60 months or greater	10% of the total Disability performance guarantee dollars at risk
Member Services		
• Telephone Response Time (Average Speed of Answer)	30 seconds	10% of the total Disability performance guarantee dollars at risk
• Abandonment Rate	3%	5% of the total Disability performance guarantee dollars at risk
	Total	**100% Disability performance guarantee dollars at risk**

AGREEMENT NO. 638-12

Group Policy

EXHIBIT D

YOUR GROUP POLICY

This is your Group Policy. We feel certain that you will be pleased with this new format.

Your Group Policy consists of:

a policy "shell" containing general provisions relating to policyholder/insurance company matters, and

a certificate (including the Schedule of Benefits) containing the complete plan of benefits.

As changes in the plan occur, new or replacement pages will be issued and, when necessary a new or replacement certificate, Schedule of Benefits (SOB) or amendment which will be attached to a cover rider to the policy.

Aetna Life Insurance Company

A

Limitations and Exclusions under the Arkansas Life and Health Insurance Guaranty Association Act

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain 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 policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member 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 insurance companies that are well-managed and financially stable.

Disclaimer
The Arkansas Life and Health Insurance Guaranty Association ("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 the state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with 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 Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not

cover all provisions of the Act; nor does it 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 Guaranty Association if they live in this state and hold a life, annuity, or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons owning such policies are NOT protected by the Guaranty 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;
- their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the individual has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- 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); unallocated annuity contracts (which give rights to group contractholders, not individuals); unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;

- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

Limits on Amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the Association will not pay more than $ 300,000 in health insurance benefits, $ 300,000 in present value of annuity benefits, or $ 300,000 in life insurance death benefits or net cash surrender values--again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $ 1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

NOTICE TO EMPLOYERS

Important Information to Employees
The Arkansas Insurance Department requires that employees located in Arkansas be furnished with a notice advising them who to contact in the event of a question about group insurance. The form that follows entitled "Important Information" is provided to you in compliance with the requirement.

All employees located in Arkansas who are or become covered by your group plan insured by Aetna, should be provided a copy of the form. The form can be distributed in the manner you deem most appropriate.

Important Information
In the event you need to contact someone about your insurance coverage, you may contact Aetna Life Insurance Company at the following address and telephone number:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
(860) 273-0123

If you have been unable to contact or obtain satisfaction from Aetna, you may contact the Arkansas Insurance Department at:

Arkansas Insurance Department
Consumer Services Division
400 University Tower Building
1123 South University Avenue
Little Rock, AR 72204
(501) 686-2945

Aetna Life Insurance Company

A

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 April 1, 2011, is $470,125. 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.

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

A

Colorado Notice
Summary of The Life And Health Insurance Protection Association Act And Notice
Concerning Coverage
Limitations And Exclusions

Introduction
Residents of Colorado 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 Life and Health Insurance Protection 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 Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Colorado and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. 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.

Important Disclaimer
The Life and Health Insurance Protection Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require residency in Colorado. You should not rely on coverage by the Life and Health Insurance Protection 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.

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 Association to induce you to purchase any kind of insurance policy.

Summary
The state law that provides for this safety-net coverage is called the Life and Health Insurance Protection Association Act. 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 anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage

Generally, individuals will be protected by the Life and Health Protection Association if they live in this state and hold a life or health insurance contract, or annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees, or assignees of insured persons are protected as well, even if they live in another state. Certain parties to structured settlement annuity contracts may be entitled to coverage benefits as well based on defined circumstances.

Exclusions from Coverage
Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Colorado, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Colorado at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation, 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 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;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rates yields, crediting rate yields or other factors employed in calculating returns, including but not limited to indexes or other external references stated in the policy or contract, that exceed an average rate specified in the Association Act;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- any unallocated annuity;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- policies or contracts issued by an insurer which was insolvent or unable to fulfill its contractual obligations as of July 1, 1991, except for annuity contracts issued by a member insurer which was placed into liquidation between July 1, 1991 and August 31, 1991;
- policies or contracts covering persons who are not citizens of the United States;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits on Amount 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 or contract. Also, for any one 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, basic hospital, medical and surgical, or major medical insurance, including any net cash surrender and net cash withdrawal values: $ 300,000 for disability insurance; or $ 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 values; or
- with respect to each payee of a structured settlement annuity, $ 250,000 in present value annuity benefits in the aggregate, including net cash surrender and net cash withdrawal values; or
- $300,000 for long term care benefits.

The Association shall not be liable to expend more than $ 300,000 in the aggregate, with respect to any one life except that with respect to benefits for basic hospital, medical and surgical and major medical insurance, the aggregate liability of the association shall not exceed $ 500,000 with respect to any one individual.

This Information is Provided By:

Life and Health Insurance Protection Association
P.O. Box 36009
Denver, CO 80236
(303) 292-5022

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
(303) 894-7499

Aetna Life Insurance Company

A

District of Columbia
Life & Health Insurance Guaranty
Association Act of 1992

Summary of General Purposes And
Current Limitations of Coverage

Residents of the District of Columbia who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in the District of Columbia to write these types of insurance are members of the District of Columbia Life and Health Insurance Guaranty Association. The purpose of this Guaranty 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 District of Columbia and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is limited, however, as noted below.

Disclaimer
The District of Columbia 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 generally conditioned on residence in the District of Columbia. Other conditions may also preclude coverage.

The District of Columbia Life and Health Insurance Guaranty Association or the District of Columbia Insurance Commissioner 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 Act of 1992 when selecting an insurer.

Policyholders with additional questions may contact:

Mr. Robert M. Willis
Executive Director
District of Columbia Life and Health
Insurance Guaranty Association
1200 G Street, N.W.
Washington, D.C. 20005
(202) 434-8771
Fax: (202) 347-2990

Ms. Gennet Purcell
Commissioner
District of Columbia Department
of Insurance Securities and Banking
810 First Street, N.E.
Suite 701
Washington, D.C. 20002
(202) 727-8000

The District of Columbia law that provides for this safety-net coverage is called the Life and Health Insurance Guaranty Association Act of 1992. 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 anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

Coverage

Generally, individuals will be protected by the District of Columbia Life and Health Insurance Guaranty Association if they live in the District of Columbia and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are 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 in another state.

Exclusions from Coverage

However, persons holding such policies are not protected by this Guaranty 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 of that state of incorporation);
- their insurer was not authorized to do business in the District of Columbia; or
- their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty 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;
- any policy of reinsurance (unless an assumption certificate was issued);
- any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- interest rate guarantees which exceed certain statutory limitations;
- dividends, experience rating credits or fees for services in connection with a policy;
- credits given in connection with the administration of a policy by a group contract holder; or for
- unallocated annuity contracts.

Limits on Amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer; or,
- with respect to any one life, regardless of the number of policies, contracts, or certificates;
- $ 300,000 in life insurance death benefits but not more than $ 100,000 in net cash surrender or net cash withdrawal values for life insurance; or
- $ 100,000 in health insurance benefits, including net cash surrender or net cash withdrawal values; or
- $ 300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values.

Finally, in no event is the Guaranty Association liable for more than $ 300,000 with respect to any one individual.

Aetna Life Insurance Company

A

Policyholder Notice:

To: Policyholders with Group Policies Issued in the State of Georgia

Subject: Breast Cancer Patient Care Act

The Georgia legislature has passed HB 604. This law requires us to inform you that:

- Your medical plan provides coverage for inpatient confinements following a mastectomy or a lymph node dissection;
- The length of such confinement will be determined by the attending physician in consultation with the patient; and
- The number of visits required for follow-up care after such surgery will be determined by the attending physician in consultation with the patient.

If you have any questions regarding this notice, please contact your Aetna account representative.

Aetna Life Insurance Company

A

Notice Concerning Coverage
Limitations And Exclusions Under The Hawaii
Life And Disability Insurance
Guaranty Association Act

Residents of Hawaii who purchase life insurance, annuities or disability insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Hawaii Life and Disability 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 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.

Disclaimer
The Hawaii Life and Disability 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 Hawaii. You should not rely on coverage by the Hawaii Life and Disability 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 Hawaii Life and Disability Insurance Guaranty Association
P.O. Box 4068
Honolulu, Hawaii 96812

Department of Commerce & Consumer Affairs
Insurance Division
P.O. Box 3614
Honolulu, Hawaii 96811

The state law that provides for this safety-net coverage is called the Hawaii Life and Disability Insurance Guaranty Association Act. 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

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 Hawaii Life and Disability Insurance Guaranty Association if they live in this state and hold a life or disability insurance contract, or an annuity, or if they are 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 in another state.

Exclusions from Coverage
However, persons holding such policies are not protected by the Guaranty 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); or
- the insurer was not a member insurer of the Guaranty Association. A nonprofit hospital or medical service organization (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 an insurance exchange are examples of nonmember insurers.

The Guaranty 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;
- 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);
- 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. Also, for any one insured life, the Guaranty Association will pay a maximum of $ 300,000--no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $ 300,000 limit, the Association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in disability insurance benefits, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits --again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Aetna Life Insurance Company

A

Illinois
Life And Health Insurance Guaranty
Association Law

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty 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 covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) 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, as noted below.

Illinois Life And Health Insurance Guaranty Association

Disclaimer
The Illinois 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 substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(312) 714-8050

Illinois Department of Insurance
320 West Washington Street 4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions and limits. This summary does not cover all provisions; nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

A) **Coverage:**
The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:

1) life insurance, health insurance, and annuity contracts;
2) life, health or annuity certificates under direct group policies or contracts;
3) unallocated annuity contracts; and
4) contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.

B) **Exclusions from Coverage:**

1) The Guaranty association does not provide coverage for:
   a) any policy or portion of a policy for which the individual has assumed the risk;
   b) any policy of reinsurance (unless an assumption certificate was issued);
   c) interest rate guarantees which exceed certain statutory limitations;
   d) certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or government lottery;
   e) any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
   f) any stop loss insurance.

2. In addition, persons are not protected by the Guaranty Association if:
   a) the Illinois Director of insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
   b) their policy was issued by an organization which is not a member insurer of the Association.

C) **Limits on Amount of Coverage:**

1. The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. The Guaranty Association's liability is limited to the lesser of either:
   a) the contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
   b) with respect to any one life, regardless of the number of policies, contracts, or certificates:
      i) in the case of life insurance, $ 300,000 in death benefits but not more than $ 100,000 in net cash surrender or withdrawal values;
      ii) in the case of health insurance, $ 300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
      iii) with respect to annuities, $ 100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and $ 100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is $ 5,000,000 in benefits per contract holder, regardless of the number of contracts.

However, in no extent is the Guaranty Association liable for more than $ 300,000 with respect to any one individual.

Aetna Life Insurance Company

A

General Purposes And
Limitations of The Kansas
Life And Health Insurance
Guaranty Association
K.S.A. 40-3001, et. Seq.

Disclaimer
The Kansas Life and Health Insurance Guaranty Association may not provide coverage for all or a portion of this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and is dependent upon continued residence in Kansas. Therefore, you should not rely upon coverage by the Kansas Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Insurance companies and their agents are prohibited by law from using the existence of the Kansas Life and Health Insurance Guaranty Association in selling you any form of an insurance policy, or to induce you to purchase any form of an insurance policy. Either the Kansas Life and Health Insurance Guaranty Association or the Kansas Insurance Department will respond to any questions you have regarding this document.

The Kansas Life and Health Insurance Guaranty Association
2909 SW Maupin Lane
Topeka, KS 66614-5335

The Kansas Insurance Department
420 Southwest 9th Street
Topeka, KS 66612-1678

This is a summary of the basic provisions of the Kansas Life and Health Insurance Guaranty Association Act. It is only a summary, and does not provide an in depth analysis of that act. Nothing in this summary modifies the rights of persons who are protected by the act, or the rights or duties of the association.

The purpose of the Kansas Life and Health Insurance Guaranty Association Act is to protect certain individuals who purchase life insurance, annuities or health insurance in Kansas. The act provides for the establishment of a funding mechanism to pay benefits or provide insurance coverage to individuals when a life or health insurance company is unable to meet its obligations by reason of insolvency or financial impairment. However, not all individuals with a right to recover under life or health insurance policies are protected by the act. An individual is only provided protection when:

1. the individual, regardless of where they reside, except for nonresident certificate holders under group policies or contracts, is the beneficiary, assignee or payee of a covered policy or contract holder,
2. the individual policy or contract holder is a resident of the state of Kansas,
3. the individual is not a resident of the state of Kansas, but only with respect to an annuity contract which has been awarded pursuant to a judgment or settlement agreement in a medical malpractice liability action,
4. the individual is not a resident of the state of Kansas, but only under all of the following conditions:
   a. the impaired or insolvent insurer was a Kansas domestic insurer; and
   b. the insurer never had a license to do business in the state in which the individual resides; and
   c. the state in which the individual resides has an association similar to this state's; and
   d. the individual is not eligible for coverage by the association of the state in which the individual resides.

Additionally, the association may not provide coverage for the entire amount the individual expects to receive from the policy. The association does not provide coverage for any portion of the policy where the individual has assumed the risk, for any policy of reinsurance, for interest rates that exceed a specified average rate, for employers' plans that are self funded, for parts of plans that provide dividends or credits in connection with the administration of the policy, for policies sold by companies not authorized to do business in Kansas, or for any unallocated annuity contract or for policies or contracts that provide benefits under Medicare Part C or Part D. Also, the association will not provide coverage where any guaranty protection is provided to the individual under the laws of the insolvent or impaired insurer's state of domicile.

The act also limits the amount the association is obligated to pay individuals on various policies to those limits in effect on the date the association became liable for that impaired or insolvent insurer. The association does not pay more than the amount of the contractual obligation of the insurance company. Regardless of the number of policies or contracts the association is not obligated to pay amounts over $ 300,000 in life insurance death benefits; $ 100,000 in net cash surrender and net cash withdrawal values for life insurance, $ 100,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $ 250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values, unless the annuity contract is awarded pursuant to a judgment or settlement agreement in a medical

Aetna will not have to refund any premium, even if the Policyholder paid the premium in error, for a period prior to:

- The first day of the policy year in which **Aetna** receives proof that the refund should be made; or
- The date 3 months before **Aetna** receives proof that the refund should be made, if this produces a larger refund.

Fees and Assessments. In addition to the Premium, We may charge the following fees and require the Policyholder to pay or reimburse Us for the following assessments. Any such fees and assessments are due on the Premium Due Date as determined by Us:

- We may charge an installation fee upon initial installation of coverage or any significant change in installation (e.g., a significant change in the number of employees or a change in the method of reporting employee eligibility to Us). A fee may also be charged upon initial installation for any custom plan set-ups.
- We may charge a billing fee to each monthly Premium bill. The billing fee may include a fee for the recovery of any surcharges for amounts paid through credit card, debit card or other similar means.
- We may charge a reinstatement fee pursuant to the Termination provision.
- We may charge a conversion fee in connection with each employee or dependent electing conversion coverage. The conversion fee may be charged monthly, based upon the number of covered persons electing conversion coverage during the previous month.
- We may charge a fee in connection with a check returned due to insufficient funds.
- We may require the Policyholder to pay or reimburse Us for fees and special assessments required for high risk pools and other state programs.

Grace Period. The "Grace Period" means the 45 consecutive day period immediately following the Premium Due Date. The Policy will remain in force during the Grace Period. If We have not received all Premiums and fees due by the end of the Grace Period, this Policy will automatically terminate at the end of the Grace Period.

We will mail a written notice to the Policyholder at least 10 days prior to the end of the Grace Period informing the Policyholder that the premium was not received and that the Policy will be terminated as of the premium due date if the premium is not received by the end of the 45 day Grace Period.

Payment of Premiums and Fees. The Policyholder will pay premiums and fees by the Premium Due Date. Payment occurs when we receive good funds. They must be paid at Our home office or its authorized agent.

If We do not receive payment by the Premium Due Date, the Policyholder shall pay Us interest on the total premium amount and any fees overdue after the Premium Due Date including the premiums due for the Grace Period. The interest rate will be up to 1 1/2% per month for each month; or partial month; the balance remains unpaid. We may recover from the Policyholder: costs of collecting any unpaid premiums or fees, including reasonable attorney's fees; and costs of suit.

Premium Waiver

Payment of Premiums

Notwithstanding any provision in the Policy to the contrary, We may waive up to one month's billed premium during any policy term. If, after that month's premium has been billed, employees are added to or removed from plan coverage for that month of coverage, the premium waiver will not apply for those employees and additional premium will be due or credited, as applicable.

Termination

If the Policy is terminated within 12 months of the Policyholder's original Policy Effective Date, then We may require Policyholder to pay back the premium so waived. In that event, We will notify Policyholder on at least 10 days prior notice of the Premium Due Date for such premium.

(GR-29N-05-03-04 VA)

Changes in Premium. We may also change the Premium rates and fees effective as of any Premium Due Date upon 30 days prior written notice to the Policyholder or upon 60 days prior written notice to the Policyholder if the rate of increase is more than 35%. However, no such adjustment will be made during the Initial Term except:

- when there is significant change in factors bearing a material impact on the risk assumed by **Aetna**; or
- to reflect changes in any law or regulation that applies or a judicial decision having a material impact on the cost of providing Coverage.

Retroactive Adjustments. We may, at Our discretion, make retroactive adjustments to the Policyholder's billings for the coverage termination of persons not posted to previous billings. However, the Policyholder may only receive a maximum of 2 month's credit for terminations that occurred more than 60 days before the date the Policyholder notified Us of the termination. We may reduce any such credits by the amount of any payments We may have made on behalf of such persons before We were informed their coverage had been terminated. Retroactive additions will be made at Our discretion based upon eligibility guidelines stated in the Certificate, and are subject to the payment of all premiums that apply.

Notwithstanding the foregoing, We will not make a retroactive adjustment for any covered person who has paid the required premium contribution. When retroactive terminations are submitted by the Policyholder, or on the Policyholder's behalf, We will regard the submission as proof that the required Premium contribution was not paid by the person(s) for that period

(GR-29N-05-03-03 VA)

Premium Rate Reduction For Failure to Meet Performance Guarantees. We may reduce the Policyholder's premium due to Our failure to provide the agreed upon levels of service. Such service levels are guaranteed by Us and agreed to in writing by Us and the Policyholder.

The reduction is based upon a percentage of the projected annual premium which is due over the term of the period for which service levels are guaranteed. The reduction amount will be paid by check at the end of the policy year.

The reduction will apply only to the Life and Accidental Death and Personal Loss Coverage issued under this policy.

The terms of the Performance Guarantees are set forth in the Service Agreement.

Premiums and Fees (Continued)

Schedule of Premiums and Fees. The initial monthly Premium Rates are as follows:

Life Insurance	Unit Benefit	
Basic	Per $1,000 Of Insurance	$0.071
Retiree	Per $1,000 Of Insurance	$2.497

Premiums and Fees (Continued)

Schedule of Premiums and Fees. The initial monthly Premium Rates are as follows:

Accidental Death and Personal Loss	Per $1,000 of Coverage	$0.025

Premiums and Fees (Continued)

Employee Non-Smoker Supplemental Life Insurance - Table of Premium Rates

Age Last Birthday	Monthly Premium Per $1,000 of Insurance
Under 25	$0.037
25-29	$0.037
30-34	$0.048
35-39	$0.053
40-44	$0.069
45-49	$0.101
50-54	$0.181
55-59	$0.298
60-64	$0.458
65-69	$0.878
70-74	$1.421
75+	$1.421

Employee Smoker Supplemental Life Insurance - Table of Premium Rates

Age Last Birthday	Monthly Premium Per $1,000 of Insurance
Under 25	$0.048
25-29	$0.048
30-34	$0.064
35-39	$0.085
40-44	$0.133
45-49	$0.202
50-54	$0.346
55-59	$0.575
60-64	$0.878
65-69	$1.692
70-74	$2.746
75+	$2.746

Retiree Non-Smoker Supplemental Life Insurance - Table of Premium Rates

Age Last Birthday	Monthly Premium Per $1,000 of Insurance
Under 25	$0.101
25-29	$0.101
30-34	$0.129
35-39	$0.144
40-44	$0.187
45-49	$0.273

50-54	$0.489
55-59	$0.807
60-64	$1.238
65-69	$2.375
70-74	$3.848
75+	$4.010

Retiree Smoker Supplemental Life Insurance - Table of Premium Rates

Age Last Birthday	Monthly Premium Per $1,000 of Insurance
Under 25	$0.129
25-29	$0.129
30-34	$0.172
35-39	$0.230
40-44	$0.359
45-49	$0.547
50-54	$0.936
55-59	$1.550
60-64	$2.375
65-69	$4.578
70-74	$7.425
75+	$7.751

Dependent Spouse Supplemental Life Insurance - Table of Premium Rates

Age Last Birthday	Monthly Premium Per $1,000 of Insurance
Under 25	$0.051
25-29	$0.043
30-34	$0.051
35-39	$0.068
40-44	$0.111
45-49	$0.162
50-54	$0.290
55-59	$0.478
60-64	$0.734
65-69	$1.356
70-74	$2.244
75+	$3.668

Dependent Child Supplemental Life Insurance:
Premium per $10,000 Unit of Life Insurance - $0.510

Employee Supplemental Accidental Death and Personal Loss Coverage:
Premium per $1,000 of Life Insurance - $0.025

Spouse/Child Supplemental Accidental Death and Personal Loss Coverage:
Premium per $1,000 of Life Insurance - $0.025

Responsibilities of the Policyholder *(GR-29N-06-003-01 VA)*

Records. The Policyholder will furnish to Us such information as We may reasonably require to administer this Policy. This will occur on a monthly basis or as otherwise required. This data may be on our form or by fax. It may also be on such other form or means as We may reasonably approve. This includes, but is not limited to:

- Data needed to enroll the Policyholder's covered persons and their dependents;
- Process terminations;
- Effect changes in family status; and
- Transfer of employment of covered persons.

The Policyholder represents that all enrollment and eligibility information that has been; or will be; supplied to Us is correct. The Policyholder acknowledges that We can; and will; rely on such enrollment and eligibility data to determine whether a person is eligible for coverage under this Policy. To the extent such data is supplied to Us by the Policyholder (in electronic or hard copy format), the Policyholder agrees to:

- Maintain a reasonably complete record of such data in the same format. This includes:
  - Evidence of coverage elections;
  - Evidence of eligibility;
  - Changes to such elections; and
  - Terminations.

  Records must be kept for at least seven years or until the final rights and duties under this Policy have been resolved.
- Make such data available to Us upon request.
- If it applies, obtain from all covered persons and their dependents a "*Disclosure of Healthcare Information*" authorization in the form currently being used by Us in the enrollment process (or such other form as We may reasonably approve).

We will not be liable to covered persons for the fulfillment of any obligation prior to information being received in a form which We will accept. For the purpose of termination of coverage under this Policy, the Policyholder must notify Us of the date in which:

- a covered person's status, or employment, ceases; or
- a dependent loses eligibility under the Plan;

within 15 business days of the event. Subject to any law that applies, unless otherwise provided in the Certificate, We will

consider a covered person's employment to continue until stopped by the Policyholder.

The Policyholder must notify persons of the termination of the Policy in compliance with all laws that apply. However, We reserve the right to notify covered persons of termination of the Policy for any reason. This includes non-payment of premium. The Policyholder shall provide written notice to covered persons of their rights when coverage stops.

The Policyholder must notify Us when a request for retroactive termination is a result of a covered person:

- performing an act; practice; or omission that constitutes fraud; or
- making an intentional misrepresentation of material fact as prohibited by the Certificate.

Access. Make payroll and other records directly related to a covered person's coverage under this Policy available to Us for inspection. This will occur:

- upon reasonable advance request;
- at Our expense;
- at the Policyholder's office; and
- during regular business hours.

This provision shall survive termination of this Policy.

Forms. Distribute materials to persons regarding enrollment and coverage features. This includes Certificates as described in the Certificates provision of the Policy Section 7; *General Provisions*.

Policies and Procedures; Compliance Verification. Comply with all policies and procedures established by Us in administering and interpreting this Policy. The Policyholder shall, upon request, provide a certification of its compliance with Our participation and contribution requirements. The Policyholder shall, upon request, submit proof that it continues to meet the definition of an eligible group as provided under any law or regulation that applies.

Continuation and Conversion Rights. We shall notify all eligible covered persons in writing of their right to continue their coverage pursuant to the continuation provisions, procedures, and timeframes for obtaining such coverage that are described in the Certificate and any applicable law. The notice shall be provided to each covered person within 14 days of the Policyholder's knowledge of the covered person's loss of eligibility under this Policy.

Termination

Termination by Policyholder. This Policy, or any coverage included may be terminated by the Policyholder. The Policyholder may terminate this Policy as to all or any class of its employees. **Aetna** must be given written notice. The notice must state when such termination shall occur. It must be a date after the notice. It shall not be effective during a period for which a premium has been paid to Us for the coverage.

Termination by Us. This Policy will terminate as of the last day of the Grace Period if the Premium remains unpaid at the end of the Grace Period as described in the *Grace Period* provision under the *Premiums and Fees* section and is subject to the terms of any laws or regulations.

In addition, We may terminate this Policy as to any or all coverage, other than the Health Expense Coverage, of all or any class of employees or dependents of any one or more member employers by giving prior written notice to the Policyholder of when it will terminate. The date shall not be earlier than 31days after the date of the notice unless it is agreed to by the Policyholder and Us.

As used in this section: "Health Expense Coverage" means:

- Comprehensive Medical Plan;
- Major Medical Plan;
- Prescription Drug Plan;
- Basic Hospital Plan;
- Basic Medical Plan;
- Limited Medical Plan; and
- Comprehensive Hearing Benefits

But does not include:

- Basic Dental Plan;
- Comprehensive Dental Plan;
- Comprehensive Vision Benefits; and
- DMO Dental

This Policy may also be terminated by Us as follows:

- Immediately upon notice to Policyholder if the Policyholder has performed any act or practice that constitutes fraud or made any intentional misrepresentation of a material fact relevant to the coverage provided under this Policy;
- Upon 30 days written notice to the Policyholder if the Policyholder breaches a provision of this Policy and such breach remains uncured at the end of the notice period;

- Upon 30 days written notice to the Policyholder if the Policyholder ceases to meet Our requirements for an employer group as defined under applicable state law or regulation;
- Upon 30 days written notice to the Policyholder if the Policyholder: (i) fails to meet Our contribution or participation requirements applicable to this Policy (which contribution and participation requirements are available upon request); (ii) fails to provide the certification required by the Policies and Procedures; *Compliance Verification* provision under Section 4 within a reasonable period of time specified by Us; or (iii) changes its eligibility or participation requirements without Our consent;
- Upon 90 days written notice to the Policyholder (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if We cease to offer the product line to which the Policy relates;

Certificate, the Policyholder shall provide written notice to employees of their rights upon termination of coverage.

Life Insurance Portability. Unless otherwise stated: Termination of this Policy by the Policyholder or Us will not terminate Life Insurance then in force for any covered person under the terms of the Group Life Insurance Portability section in the Certificate. This Policy will be deemed to remain in force solely for the purpose of continuing such Life Insurance, but without further obligation of the Policyholder hereunder. Any Life Insurance continued by the terms of this paragraph will remain in force until terminated under the terms of the Group Life Insurance Portability section in the Certificate. A person may only elect coverage according to the terms of the Group Life Insurance Portability section in the Certificate on or after the date of termination by the Policyholder or Us.

Termination By Us. (Continued)

- Upon 180 days written notice to the Policyholder (or such shorter notice as may be permitted by applicable law, but in no event less than 30 days) if We cease to offer coverage in a market in which persons covered under this Policy reside; or

If the Policy terminates for any reason, the Policyholder will continue to be held liable for all Premiums and fees due and unpaid before the termination, including, but not limited to, Premium payments for any period of time Policy is in force during the Grace Period. Covered persons shall also remain liable for their cost sharing and other required contributions to coverage for any period of time Policy is in force during the Grace Period. We may recover from the Policyholder Our costs of collecting any unpaid Premiums or fees, including reasonable attorneys' fees and costs of suit.

Non-Renewal. We may request from the Policyholder, a written indication of their intention to renew or non-renew a Policy at any time during the final three months of any policy year. If the Policyholder fails to reply to such request within two weeks of their receipt of the request; or 15 days prior to the renewal date, whichever is later; then upon **Aetna's** written notice to the Policyholder, all or a part of the Policy shall be deemed to terminate automatically as of the end of the policy year. Similarly, upon Our written confirmation to the Policyholder, We may accept an oral indication by the Policyholder; or its agent or broker of intent to non-renew as the Policyholder's notice of termination of all or a part of the Policy effective as of the end of the policy year.

Effect of Termination. No termination of this Policy will relieve either party from any obligation incurred before the date of termination. When terminated, this Policy and all coverage provided hereunder will end at 12:00 midnight on the effective date of termination. Upon termination, We will provide employees and their dependents with Certificates of Creditable Coverage which will show evidence of their prior health coverage under this Policy for a period of up to 18 months prior to the loss of coverage.

We may, at Our sole discretion, reinstate terminated coverage provided any past due premium and reinstatement fees are paid.

Notice to employees. It is the responsibility of the Policyholder to notify employees of the termination of the Policy in compliance with all applicable laws. However, We reserve the right to notify employees of termination of the Policy for any reason, including non-payment of Premium. In accordance with the

General Provisions *(GR-29N-09-01-01)*

Policy. The entire Policy consists of:

- This Policy;
- The application, copy attached;
- The current rates on file with the Policyholder;
- The attached Certificate(s); and
- Any riders, endorsements, insert attachments or amendments to this Policy or Certificate.

Certificates. Our method of providing the Policyholder with Certificates will be electronic. But We will provide a supply of paper copies to the Policyholder upon request. The Policyholder shall make available or distribute the Certificates to each insured employee. The insurance in force will be set forth in the Certificate. Statements as to whom benefits are payable will appear. Any applicable Conversion Privilege will also be described.

Policies and Procedures. We have the right to adopt reasonable policies, procedures, rules, and interpretations of this Policy and the Certificate in order to promote orderly and efficient administration.

Policy Changes. This Policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations. This Policy may also be amended by Us:

- By written agreement between Us and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Us are signed by an authorized executive officer of **Aetna**. No one other than an authorized officer of **Aetna** may change or waive any of the Policy terms or make any agreement binding Us.

The Policyholder will not have to give written agreement of a change in the Policy if:

- The Policyholder has asked for the change and We have agreed to it.
- The change is needed to correct an error in the Policy, including any Certificate issued to anyone.
- The change is needed so that the Policy will conform to any law, regulation or ruling of a jurisdiction that affects a person covered under this Policy; or the federal government.
- The change has been initiated by Us and is not resulting in either: a reduction or elimination in benefits or coverage; or an increase in premium

The Policyholder will have to give written agreement of a change in the 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 the Policyholder's written agreement of those changes on behalf of all persons covered under this Policy.

(GR-29N-09-02-01)
Delegation and Subcontracting. The Policyholder acknowledges and agrees that We may enter into arrangements with third parties to delegate functions hereunder such as utilization management, quality assurance and provider credentialing, as We deem appropriate in Our sole discretion and as consistent with applicable laws and regulations. The Policyholder also acknowledges that Our arrangements with third party vendors (e.g. pharmacy, behavioral health) are subject to change in accordance with applicable laws and regulations.

Prior Agreements; Severability. As of the Effective Date, this Policy replaces and supersedes all other prior agreements between the Parties as well as any other prior written or oral understandings, negotiations, discussions or arrangements between the Parties related to matters covered by this Policy or the documents incorporated herein. If any provision of this Policy is deemed to be invalid or illegal, that provision shall be fully severable and the remaining provisions of this Policy shall continue in full force and effect.

Clerical Errors. A clerical error in keeping records; or a delay in making an entry; will not alone decide if insurance is valid. An equitable adjustment in premiums will be made when the error or delay is found. If the clerical error affects the existence or amount of insurance, the facts as determined by Us will be used to decide if insurance is in force and its amount. We may also modify or replace a Policy, Certificate or other document issued in error.

malpractice liability action; or more than $ 300,000 in the aggregate for the above coverage's with respect to any one life.

Aetna Life Insurance Company

A

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. 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 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.

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
$300,000 in health insurance benefits, including net cash surrenders and net cash withdrawal values

Annuities
$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, are the amounts listed above.

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 and agents 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. 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 www.mdlifega.org or contact:

The Maryland Life and Health
Insurance Guaranty Corporation
9199 Reisterstown Road
P.O. Box 671, Suite 216C
Owings Mills, Maryland 21117
(410) 998-3907

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
1-800-492-6116, ext. 2170

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
A

Notice Concerning Policyholder Rights In An Insolvency Under The Minnesota Life And Health Insurance Guaranty Association Law

If the insurer that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer.

In addition, residents of Minnesota who purchase life insurance, annuities, or health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITS AND EXCLUSIONS, in the event the insurer becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

MINNESOTA LIFE AND
HEALTH INSURANCE GUARANTY ASSOCIATION
4640 West 77th Street, Suite 342
Edina, Minnesota 55435
(612) 831-1908

The maximum amount the guaranty association will pay for all policies issued on one life by the same insurer is limited to $ 300,000. Subject to this $ 300,000 limit, the guaranty association will pay up to $ 300,000 in life insurance death benefits, $ 100,000 in net cash surrender and net cash withdrawal values for life insurance, $ 300,000 in health insurance benefits, including any net cash surrender and net cash withdrawal values, $ 100,000 in annuity net cash surrender and net cash withdrawal values, $ 300,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities in regard to which periodic annuity benefits, for a period of not less than the annuitant's lifetime or for a period certain of not less than ten years, have begun to be paid on or before the date of impairment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $ 300,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, [FN1] as amended through December 31, 1992, are covered up to $ 100,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the association shall not be responsible for more than $ 7,500,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $ 7,500,000, the $ 7,500,000 shall be prorated among all claimants. These are the maximum claim amounts. Coverage by the guaranty association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the guaranty association's limits, you may still recover a part or all of that amount from the proceeds of the liquidation of the insolvent insurer, if any exist. Funds to pay claims may not be immediately available. The guaranty association assesses insurers licensed to sell life and health

insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE POLICIES OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE POLICIES ARE REQUIRED TO PROVIDE THIS NOTICE.

NOTICE TO POLICYHOLDER CONCERNING AVAILABILITY OF "QUALIFIED PLANS"

The accident and health insurance included in this policy does not constitute a "qualified plan" as defined by Minnesota statute. Aetna does offer insurance plans that are qualified plans. Qualified plans provide coverage for major medical expense, as defined by Minnesota statute. Information is available upon request.

Aetna Life Insurance Company

A

Missouri Notice Concerning Coverage Limitations And Exclusions Under The Life And Health Insurance Guaranty Association Act

Residents of this state 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 Missouri 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 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 Missouri 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 Missouri. You should not rely on coverage by the Missouri 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 insurance producers are required by law to give or send you this notice. However, insurance companies and their insurance producers are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy. **You May Contact Either The Association or The Missouri Department of Insurance At The Following Addresses Should You Have Any Questions Regarding This Notice.**

The Missouri Life and Health Insurance Guaranty Association
520 Dix Road, Suite D
Jefferson City, MO 65109

Missouri Insurance Department
P.O. Box 690
Jefferson City, MO 65109

The state law that provides for this safety-net is called the Missouri Life and Health Insurance Guaranty Association Act. 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 anyone's rights or obligations under the Act or the rights or obligations of the guaranty association.

Generally, persons will be covered if they live in this state, and hold a life or health insurance contract or annuity, or a certificate under a group policy or contract. However, not all individuals with a right to recover under life or health insurance policies or annuities are protected by the Act. A person is not protected when:

1. The person is eligible for protection under the laws of another state;
2. The person purchased the insurance from a company that was not authorized to do business in this state;
3. The policy is issued by an organization which is not a member insurer of the association; or
4. The person does not live in this state, except under limited circumstances.

Additionally, the Association may not provide coverage for the entire amount a person expects to receive from the policy. The Association does not provide coverage for any portion of the policy where the person has assumed the risk, for any policy of reinsurance (unless an assumption certificate was issued), for interest rates that exceed a specified average rate, for employers' plans that are self-funded, for parts of plans that provide dividends or credits in connection with the administration of policy, or for unallocated annuity contracts (which are generally issued to pension plan trustees). The Act also limits the amount the Association is obligated to pay persons on various policies. The Association does not pay more than the amount of the contractual obligation of the insurance company. The Association does not have to pay more than three hundred thousand dollars ($ 300,000) in death benefits for any one life regardless of the number of policies that insure that life. The Association does not have to pay amounts over one hundred thousand dollars ($ 100,000) in cash surrender or withdrawal benefits on one life regardless of the number of policies insuring that individual. For health insurance benefits, the Association is not obligated to pay over one hundred thousand dollars ($ 100,000) including net cash surrender and withdrawal benefits. On an annuity contract, the Association is not liable for over one hundred thousand dollars ($ 100,000) in present value. Finally, the Association is never obligated to pay more than a total of three hundred thousand dollars ($ 300,000) for any one insured for any combination of insurance benefits.

Aetna Life Insurance Company

A

Summary of Mississippi Life And Health Insurance Guaranty Association Act And Notice Concerning Coverage

Limitations and Exclusions

Residents of this state who purchase life insurance, health insurance, or annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners 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 policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member 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 insurance companies that are well-managed and financially stable.

Disclaimer

The Mississippi Life and Health Insurance Guaranty Association (the "Guaranty Association") may not provide coverage for this policy. If coverage is provided, it will be subject to substantial limitations and exclusions, and require continued residency in this state. You should not rely on coverage by the Guaranty Association when selecting an insurer.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. You may contact either the Guaranty Association or the Mississippi Insurance Department at the following addresses if you should have any questions regarding this notice.

The Mississippi Life and Health Insurance Guaranty Association
300 North Mart Plaza, Suite 2
Jackson, Mississippi 39206

Mississippi Insurance Department
1804 Walter Sillers Building
Jackson, Mississippi 39205

The state law that provides for this safety-net coverage is called the Mississippi Life and Health Insurance Guaranty Association Act (the "Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it 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 Guaranty Association if they live in this state and hold a life, or health insurance contract or policy, or an annuity contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons owning such policies are NOT protected by the Guaranty 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;
- their policy or contract was issued by a hospital or medical service organization whether profit or nonprofit, a health maintenance organization (HMO), a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or other person that operates on an assessment basis, an insurance exchange, or any similar entity.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy or contract of reinsurance, unless an assumption certificates were issued pursuant to the reinsurance policy or contract;
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits or payment of any fees or allowances to any person in connection with this service to or administration of the policy or contract;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts issued to or in connection with benefit plans protected under federal Pension Benefit Guaranty Corporation ("PBGC") regardless of whether the PBGC has yet become liable to make any payments with respect to the benefit plan;
- Portions of any unallocated annuity contract not issued to or in connection with a specific employee, union or association of natural persons benefit plan, or a government lottery;
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association with respect to the policy or contract are preempted by State or Federal law;

- Obligations that do not arise under the express written terms of the policy or contract, including claims based on marketing materials, side letters, riders or other documents that were issued by the insurer without meeting applicable policy form filing or approval requirements, or claims for policy misrepresentations, or extra-contractual or penalty or consequential or incidental damages claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

Limits on Amount of Coverage

The Act also limits the amount the Guaranty Association is obligated to cover. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, with respect to any one life, regardless of the number of policies or contracts, the maximum obligation of the Guaranty Association is $ 300,000 in benefits except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance in which case the aggregate liability of the Guaranty Association is $ 500,000. Within these overall limits, the Guaranty Association will not pay more than $ 300,000 in life insurance death benefits, $ 100,000 in net cash surrender and net cash withdrawal values, $ 300,000 for disability insurance benefits, $ 500,000 for basic hospital, medical and surgical insurance or major medical insurance benefits, $ 100,000 in present value of annuity benefits, including net cash surrender and net cash withdrawal values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $ 5,000,000 limit with respect to any contract owner for unallocated annuity benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or to the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

Aetna Life Insurance Company

A

Notice Concerning Coverage
Limitations And Exclusions Under The North Carolina
Life And Health Insurance Guaranty Association Act

Residents of this state 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 North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholder 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 the insured persons who live in this 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 North Carolina 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 North Carolina. You should not rely on coverage by the North Carolina Life and Health 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 North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Services Division
1201 Mail Service center
Raleigh, North Carolina 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page 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.

Coverage
Generally, individuals will be protected by the life and health guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are 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 in another state.

Exclusions from Coverage
However, persons owning such policies are not protected by the 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 insured who live outside that state);
- The insurer was not authorized to do business in this state;
- 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 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 the average rate specified in the law;
- Dividends;
- Experience or other 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);
- Unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

Limits on Amount of Coverage
The act also limits the amount the association is obligated to pay out as follows:
(1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
(2) Except as provided in (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
(3) Except as provided in (4) and (5) below, the guaranty association will pay an aggregate maximum of $500,000 with respect to any one individual affected by multiple insolvencies.
(4) The guaranty association will pay a maximum of $1,000,000 with respect to any one structured settlement annuity contract holder.

(5) The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

Aetna Life Insurance Company

A
Summary of The 1996 New Hampshire Life And Health Insurance Guaranty Association Act (RSA 408-B)
And
Notice Concerning Coverage Limitations And Exclusions

Residents of New Hampshire who purchase life insurance, health insurance, and annuities should know that the insurance companies licensed in New Hampshire to write these types of insurance are members of the New Hampshire 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 Association will assess its other member insurance companies for the money to pay the claims of policyholders who live in New Hampshire and, in some cases, to keep coverage in force. This protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

Important Disclaimer
The New Hampshire 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 Hampshire. Other conditions may preclude coverage.

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 provide you with this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy.**

This information is provided by:

New Hampshire Life and Health Insurance Guaranty Association
47 Hall Street, Suite 2
Concord, NH 03301
(603) 226-9114

New Hampshire Department of Insurance
10 Chestnut Drive, Unit B
Bedford, NH 03110
(603) 472-3734
Fax (603) 472-3741

Summary:
The 1996 state law that provides for this safety-net coverage is called the New Hampshire Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, 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 Association.

Coverage:
Generally, individuals will be protected by the New Hampshire Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance policy or an annuity contract, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, assignees or payees of insured persons are protected as well, even if they live in another state.

Coverage provided under this Act may be different from coverage provided prior to 1996, as coverage is determined by the governing Act in effect on the date that the Association becomes obligated.

Exclusions from Coverage:
Persons holding such policies or contracts are NOT protected by this Association if:

- they are not residents of the state of New Hampshire, except under certain very specific circumstances;
- they are eligible for protection under the laws of another state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or an entity that operates on an assessment basis, an insurance exchange, or any entity similar to any of the above.

The Association also does NOT provide coverage for:

- any policy or portion of a policy or contract not guaranteed by the insurer or under which the risk is borne by the policy holder or contract holder;
- any policy or contract of reinsurance, unless assumption certificates have been issued;
- interest rate guarantees that exceed certain statutory limitations;
- any plan or program of an employer, association, or similar entity to provide life, health, or annuity benefits to its employees or members to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association, or similar entity;
- dividends, experience rating credits, or fees for services in connection with this policy;
- any policy or contract issued in this state by an insurer at a time when it was not licensed or authorized to do business in New Hampshire;

- any unallocated annuity contract issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- any portion of any unallocated annuity contract which is not issued to or in connection with a specific employee, union, or 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.

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.

With respect to any one life, regardless of the number of policies or contracts, the Association will pay a maximum of $ 300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance, $100,000 in health insurance benefits, except long-term care insurance benefits, including any net surrender and net cash withdrawal values; $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; $300,000 in long-term care insurance benefits.

With respect to any one contract holder of an unallocated annuity contract, not including a governmental retirement plan established under Section 401, 403(b) or 457 of the U.S. Internal Revenue code, the Association will pay a maximum of $ 5,000,000 in benefits, irrespective of the number of such contracts held by that contract holder.

Additional Information:
Policyholders should contact the New Hampshire Insurance Department with questions they may have with regard to concerns about their rights under the Act and procedures for filing a complaint to allege a violation of the Act.

Policyholders may contact the New Hampshire Insurance Department for sources of information about the financial condition of insurers.

Aetna Life Insurance Company

A

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 extra 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
One Gateway Center
9th Floor
Newark, NJ 07102

State of New Jersey
Department of Insurance
20 West State Street
CN-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 insurance or long-term care insurance contract, or if they are 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 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 or contract.

With respect to any one insured individual, regardless of the number of policies or contracts, the Association will pay not more than $ 500,000 in life insurance death benefits and present value annuity benefits, including net cash surrender and net cash withdrawal values. Within this overall limit, the Association will not pay more than $ 100,000 in cash surrender

values for annuity benefits, $ 500,000 in life insurance death benefits or $ 500,000 in present value of annuities--again no matter how many policies and contracts there 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 contractholder 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

A

Nevada Life And Health Insurance
Guaranty Association Act Summary Document

Residents of Nevada 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 Nevada Life and Health Insurance Guaranty Association (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 assesses 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 extra 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.

The Nevada Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations and exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Nevada Life and Health Insurance Guaranty Association when selecting an insurance company or when 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 the policyholder has assumed the risk, such as a variable contract sold by prospectus.

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

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverage, 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. **Anyone may obtain additional information or file a complaint with the Commissioner of Insurance, at the address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.**

The Nevada Life and Health Insurance Guaranty Association
P.O. Box 3302
Reno, Nevada 89505

Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance

788 Fairview Drive, Suite 300
Carson City, Nevada 89701-5491

Coverage
Generally, individuals will be protected by the Nevada Life and Health Insurance Guaranty Association if they live in this state and **hold a life or health insurance contract, or an annuity, or if they are 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 in another state.

Exclusions from Coverage
However, persons holding 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 the state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), a health maintenance organization, 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 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;
- interest rate yields that exceed an average rate;
- 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);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

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 any one insured life, the Association will pay a maximum of $ 300,000, regardless of how many policies and contracts there were with the same company, and even if they provided different types of coverage. Within this overall $ 300,000 limit, the Association will not pay more than $ 100,000 in cash surrender values, $ 100,000 in present value of annuities, or $ 300,000 in life insurance death benefits. Again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverage.

With respect to health insurance for any one natural person, the Association will not pay more than: 1) $ 100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash surrender or withdrawal; 2) $ 300,000 for disability insurance; or 3) $ 500,000 for basic hospital, medical and surgical insurance or major medical insurance.

With respect to each payee of a structured settlement annuity, or beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $ 100,000 in present value of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to any one life or person, in no event will the Association be obligated to cover more than: 1) an aggregate of $ 300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance; or 2) an aggregate of $ 500,000 in benefits, including benefits for basic hospital, medical and surgical insurance or major medical insurance.

With respect to one owner of several nongroup policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $ 5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

Aetna Life Insurance Company

A

Ohio Life And Health Insurance
Guaranty Association
Disclaimer And Not Covered Form

The Ohio 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 Ohio. You should not rely on coverage by the Ohio 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. You should check with your insurance company representative to determine if you are only covered in part or not covered at all.

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.

Ohio Life and Health Insurance Guaranty Association
1840 Mackenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
50 West Town Street, Third Floor - Suite 300
Columbus, Ohio 43215

Aetna Life Insurance Company

A

Notice Of Protection Provided By
Oklahoma Life And Health Insurance
Guaranty Association Act

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma 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 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 association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

Life Insurance
$300,000 in death benefits
$100,000 in cash surrender or withdrawal values
Health Insurance
$500,000 in hospital, medical and surgical insurance benefits
$300.000 in disability income insurance benefits
$300,000 in long-term care insurance benefits
$100,000 in other types of health insurance benefits
Annuities
$300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid 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 various residency requirements and other limitations under Oklahoma law.

Insurance companies and agents are not allowed by Oklahoma 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, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

To learn more about the above protections, please visit the Association's website at www.oklifega.org or contact:

Oklahoma Life and Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, Oklahoma 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, Oklahoma 73112
Phone: 1-800-522-0071 or (405) 521-2828

Aetna Life Insurance Company

A

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 administrators 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.

Administrative Matters. We have complete discretionary authority to review all denied claims for benefits under this Policy. This includes, but is not limited to, the denial of certification of the **medical necessity** of hospital or medical treatment. In performing its review, We shall have discretionary authority to determine whether and to what extent employees and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this Policy.

We shall be deemed to have properly exercised such authority unless We abuse our discretion by acting arbitrarily and capriciously. We have the right to adopt reasonable policies, procedures, rules; and interpretations of this Policy to promote orderly and efficient administration.

The Policyholder shall be responsible for making reports and disclosures required by law or regulation. This includes the distribution of Certificates and disclosures prepared by Us.

Misstatements. If any fact as to the Policyholder or any employee or dependent is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or an employee shall be deemed representations and not warranties. No written statement made by an employee shall be used by Us in a contest unless a copy of the statement is or has been furnished to the employee or his beneficiary, his personal representative or the person making the claim.

Our failure to implement or insist upon compliance with any provision of this Policy at any given time or times, shall not constitute a waiver of Our right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

Incontestability. *(GR-29N-09-03-01)*
As to Life Insurance. The validity of this Policy shall not be contested, except for non-payment of premiums, after it has been in force for 2 years. No statement made by an employee about his insurability shall be used by Us in contesting the validity of the insurance as to which such statement was made if the insurance has been in force prior to the contest for 2 years during the employee's lifetime; or if the insurance under the Policy may be increased upon the application of the employee and the production of evidence of good health if the increase have been in force prior to the contest for 2 years during the employee's lifetime; nor unless such statement is contained in a written form signed by him or her.

As to Accident and Health Benefits. Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or any employee or dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by an eligible employee or dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Assignability. No rights or benefits under this Policy are assignable by the Policyholder to any other party unless approved by Us.

Waiver. Our failure to implement, or insist upon compliance with, any provision of this Policy or the terms of the Certificate incorporated hereunder, at any given time or times, shall not constitute a waiver of Our right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of Premiums or benefits. This applies whether or not the circumstances are the same.

Notices. Any notice required or permitted under this Policy shall be in writing and shall be deemed to have been given on the date when delivered in person; or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid, and properly addressed to the address set forth in the face page of the Policy, or to any more recent address of which the sending party has received written notice or, if delivered by facsimile or other electronic means, on the date sent by facsimile or other electronic means.

Third Parties. This Policy shall not confer any rights or obligations on third parties except as specifically provided herein.

Non-Discrimination. In the management of this Policy, the Policyholder and the Member Employers:

- Will make no attempt, whether through differential contributions or otherwise, to encourage or discourage enrollment in the coverages provided by the Policy based on health status or health risk; and
- Will act so as not to discriminate unfairly between persons in like situations at the time of the action.

We can rely on such action and will not have to probe into the details.

Use of Our Name and all Symbols, Trademarks, and Service Marks. We reserve the right to control the use of Our name and all symbols, trademarks, and service marks presently existing or subsequently established. The Policyholder agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without Our prior written consent and will cease any and all usage immediately upon Our request or upon termination of this Policy.

Workers' Compensation. The Policyholder is responsible for protecting Our interests in any Workers' Compensation claims or settlements with any eligible individual. We shall be reimbursed for all paid medical expenses which have occurred as a result of any work related **injury** that is compensable or settled in any manner.

On or before the Effective Date of this Policy and upon renewal, the Policyholder shall submit proof of their Workers' Compensation coverage or an exclusion form which has been accepted by the applicable regulatory authority governing Workers' Compensation. Upon Our request, the Policyholder shall also submit a monthly report to Us listing all Workers' Compensation cases. Such list will contain the name, social security number, date of loss and diagnosis of all applicable eligible individuals.

AGREEMENT NO. 638-12

NONDISCLOSURE AND DATA SECURITY AGREEMENT

EXHIBIT E

NONDISCLOSURE AND DATA SECURITY AGREEMENT (CONTRACTOR)

The undersigned, an authorized agent of the Contractor and on behalf of Aetna Life Insurance Company (Contractor) hereby agree that the Contractor will hold County provided information, documents, data, images, records and the like (hereafter "information") confidential and secure and to protect it against loss, misuse, alteration, destruction or disclosure. This includes but is not limited to the information of the County, its employees, contractors, residents, clients, patients, taxpayers and property as well as information that the County shares with Contractor for testing, support, conversion or other services provided under Arlington County Agreement No. 638-12 (the "Project" or "County Agreement" as applicable) or which may be accessed through other County owned or controlled databases (all of the above collectively referred to herein as "information" or "County information").

In addition to the DATA SECURITY obligations set in the County Agreement, the Contractor agrees that it will maintain the privacy and security of the County information, control and limit internal access and authorization for access to such information and not divulge or allow or facilitate access to County information for any purpose or by anyone unless expressly authorized. This includes but is not limited to information that in any manner describes, locates or indexes anything about an individual including, but not limited to, his/her (hereinafter

"his") Personal Health Information, treatment, disability , services eligibility, services provided, investigations, real or personal property holdings, and his education, financial transactions, medical history, ancestry, religion, political ideology, criminal or employment record, social security number, tax status or payments, date of birth, address, phone number or that affords a basis of inferring personal characteristics, such as finger and voice prints, photographs, or things done by or to such individual, and the record of his presence, registration, or membership in an organization or activity, or admission to an institution (also collectively referred to herein as "information" or "County information").

Contractor also agree that it will not directly or indirectly use or facilitate the use or dissemination of information (whether intentionally or by inadvertence, negligence or omission verbally, electronically, through paper transmission or otherwise) for any purpose other than that directly associated with its work under the Project. Contractor acknowledges that any unauthorized use, dissemination or disclosure of information is prohibited and may also constitute a violation of Virginia or federal laws, subjecting it or its employees to civil and/or criminal penalties.

The Contractor agrees that it will not divulge or otherwise facilitate the disclosure, dissemination or access to or by any unauthorized person, for any purpose, of any information obtained directly, or indirectly, as a result of its work on the Project. Contractor shall coordinate closely with the County Project Officer to ensure that its authorization to its employees or approved subcontractors is appropriate, tightly controlled and that such person/s also maintain the security and privacy of information and the integrity of County networked resources.

Contractor agrees to take strict security measures to ensure that information is kept secure, properly stored, that if stored that it is encrypted as appropriate, stored in accordance with industry best practices and otherwise protected from retrieval or access by unauthorized persons or unauthorized purpose. Any device or media on which information is stored, even temporarily, will have strict security and access control. Any information that is accessible will not leave the Contractor's work site or the County's physical facility, if working onsite, without written authorization of the County Project Officer. If remote access or other media storage is authorized, Contractor is responsible for the security of such storage device or paper files.

Contractor will ensure that any laptops, PDAs, netbooks, tablets, thumb drives or other media storage devices, as approved by the County, and connected to the County network are secure and free of all computer viruses, or running the latest version of an

industry standard virus protection program. Contractor will ensure that all passwords used by its employees or subcontractors are robust, protected and not shared. No information may be downloaded expect as agreed to by the parties and then only onto a County approved device. Downloading onto a personally owned device is prohibited. Contractor agrees that it will notify the County Project Officer immediately upon discovery, becoming aware or suspicious of any unauthorized disclosure of information, security breach, hacking or other breach of this Agreement, the County Contract, County policy, Contractor's security policies, or any other breach of Project protocols. The Contractor will fully cooperate with the County to regain possession of any information and to prevent its further disclosure, use or dissemination. The Contractor also agrees, if requested, to promptly notify others of a suspected or actual breach.

Contractor agrees that all duties and obligations enumerated in this agreement also extend to its employees, agents or subcontractors who are given access to County information. Breach of any of the above conditions by Contractor's employees, agents or subcontractors shall be treated as a breach by Contractor. Contractor agrees that it shall take all reasonable measures to ensure its employees, agents and subcontractors are aware of and abide by the terms and conditions of this Agreement and related data security provisions in the County Agreement.

It is the intent of this *NonDisclosure and Data Security Agreement* to ensure that the Contractor has the highest level of administrative safeguards, disaster recovery and best practices are in place to ensure confidentiality, protection, privacy and security of County information and County networked resources and to ensure compliance with all applicable local, state and federal law or regulatory requirements. Therefore, to the extent that this *NonDisclosure and Data Security Agreement* conflicts with the County Agreement or with any applicable local, state, or federal law, regulation or provision, the more stringent County Contract requirement, law, regulation or provision shall control.

At the conclusion of the Project, Contractor agrees to return all County information to the County Project Officer. These obligations remain in full force and effect throughout the Project and shall survive any termination of the County Agreement.

Authorized Signature: _____

Printed Name and Title:

James D. Juliano, Director or Business Development

Date: August 16, 2012

AGREEMENT NO. 638-12

EXCERPTS FROM INITIAL WRITTEN PROPOSAL

EXHIBIT F

I. Excerpts from Initial Written Proposal

Section 3 - Experience of Firm and Team

C. Each Offeror shall verify that a dedicated, knowledgeable account representative will be accessible to County Benefit Staff as a resource. Provide the names, experience, and primary responsibilities of the individuals who will be the County's primary contacts during the agreement/policy term. Please include an organizational chart that demonstrates the roles, responsibilities and interrelationships between proposed staff members.

The County's primary contacts will be Kim Thielemann Patrick, Dawn Fairhurst, and Nancy LaRoche.

Kim Thielemann Patrick
Vice President, Client Management for the Public and Labor Division
509 Progress Drive, Linthicum, Maryland 21090. Phone: 443-285-1710.

Kim has 5 years of service with Aetna, and 25 years of service in this industry. Kim is the assigned Executive Sponsor for Arlington County. Kim will work closely with Arlington County and their consultants to analyze county's goals and objectives and develop innovative solutions and strategic action plans to achieve them.

Dawn Fairhurst
Account Executive for the Public and Labor Division
2010 Corporate Ridge, Suite 300, McLean, VA 22102

Dawn has 17 years of service with Aetna. Dawn is the assigned Account Executive for Arlington County and will be responsible for the overall administration of the plan and the primary contact to the customer. Dawn will work closely with Kim Patrick on innovation solutions and strategic planning.

Nancy LaRoche
Account Manager for the Public and Labor Division
509 Progress Drive, Linthicum, Maryland 21090. Phone: 410-487-2769

Nancy has 2 years of service with Aetna, and 26 years of service in the industry. Nancy is the Assigned Account Manager for Arlington County. Nancy will work on a day to day basis with Arlington County and their consultants to provide ongoing support and collaborate with the County to support their goals and objectives.

Please refer to the Samples and Brochures section of this proposal for an Organizational Chart for the County's Account team.

F. The location(s) of the office(s) that will be servicing this account (i.e. handling claimant/customer service and handling general administration). If more than one location, please identify all locations.

Life claim management and customer service will be handled from our Hartford, CT location. Our Portland, Maine Disability Claim Service Center will be responsible for management/service of the County's STD and LTD claims.

Section 4: Basic Administration

A. The County will require an Administration Manual for adminstering the plan(s). Please confirm you will be able to provide this online and in hardcopy, if requested.

We provide electronic plan administration manuals through our Employer Secure Website (they can be downloaded and printed if requested). The "Plan Information" section of the website houses the administration manual as well as plan documents and additional information about Aetna's value added services.

B. Describe the type and frequency of technical guidance regarding compliance with pertinent laws, rules and regulations you provide to clients.

We monitor and identify newly enacted and adopted laws and regulations that impact our client's products, operations, and/or business practices. We also proactively identify

compliance risks, and foster compliance as a core competency, so that we can provide a best-in-class service experience for our clients and to ensure compliance with federal and state laws and regulations.

C. How are your account managers and claims processors evaluated? Identify the relative importance of quantity vs. quality for claims processors. Is compensation linked to job performance?

Performance management at Aetna is a dynamic process aimed at achieving business results through the superior performance of our people.

Organizations work most effectively when you link the goals and objectives of the organization, those of smaller work units and the job responsibilities of each employee. When people in the organization understand how their work contributes to the success of the company, morale and productivity improve. We use a scorecard approach to ensure we align individual and organizational goals. We communicate business objectives through an enterprise-wide scorecard, segment or business unit scorecards and individual employee scorecards.

By setting clear goals, participating in performance discussions with management and determining appropriate training and development activities to improve skills, each employee better understands how their contributions link to the achievement of their business organization, as well as Aetna's overall success. Employees and management use the Individual Scorecard to discuss those goals, development needs and to monitor performance results.
We encourage managers to address performance problems swiftly and appropriately. Through the Performance Improvement Action Process, we inform employees of performance problems and give them an opportunity to correct those problems before they become severe enough to result in termination.

The following describes the components of the Performance Improvement Action process.

- Employee and manager meet to discuss the performance problem

Performance deficiencies and desired performance identified and discussed

Discussion is formally documented in a Performance Improvement Action Plan

- Employee and manager meet periodically during the performance improvement period to monitor and discuss progress against goals

- Employee and manager meet at the end of the Performance Improvement Action timeframe to discuss results

There are three possible outcomes:

- If the desired results outlined in the Performance Improvement Action Plan are met, the employee will be removed from this status, and expected to maintain satisfactory performance in the future.

- If the employee fails to meet the objectives outlined in the Performance Improvement Action Plan by the end of the period, employment may be terminated.

- If the employee has made significant improvement in all areas and met most, but not all of the performance goals, the manager may choose to extend the Performance Improvement Action period to allow more time for improvement.

D. At the County's request, will you be able to attend 10 open enrollment meetings in May 2012 and in subsequent years a minimum of 10 open enrollment meeting.

Confirmed.

E. Provide a detailed outline of the implementation schedule. Be sure to include key dates and deadlines, a description of tasks and whom is responsible for each task. Open enrollment is held in May for a July 1 effective date.

The goal of our implementation process is to deliver a quality and timely implementation of your employee benefit program. We anticipate and identify issues critical to a successful implementation and smooth transition.

We use a project-scheduling plan as a standard to ensure we meet key deliverable dates. We base these dates on the mutually agreed upon implementation plan. We prefer to engage with a customer 90 - 120 days prior to the effective date of any changes or additional set up. This allows enough time to fully understand all possible impacts and deliver flawlessly.

The County's ability to deliver specific information and sign-off is the basis of completing many milestones.

An implementation project manager assembles an experienced implementation team and prepares a detailed implementation Decisions and Issues document (i.e. a functional area set up checklist) to outline the criteria needed for a successful implementation. The Decisions and Issues document addresses objectives and guidelines for the entire process across all functional areas. The covered topics include a list of specific needed, detailed, and clarifying information including:

- Billing
- Taxation
- Plan design verification

We encourage the County to coordinate a team representing:

- Financial
- Payroll
- Benefits
- Data processing
- Human resources

Together, we will coordinate and finalize the implementation priorities and identify potentially sensitive areas. Our implementation project manager will revise the implementation documents based on the periodic conference calls between the teams.

Our extensive implementation experience has shown that careful planning, concise documentation and open communication between our two organizations, promotes a seamless transition.

Please refer to the Samples and Brochures section of this proposal for a detailed Implementation Schedule.

F. Describe all limitations and exclusions applicable to your offer.

Life Exclusions

Supplemental and Dependent Life coverage includes suicide exclusion.

The exclusion applies during the first two years of the person's coverage. The exclusion also applies to increased Supplemental and Dependent Life coverage amounts elected at annual benefit election time (or at the time of a family status change) for the two-year period immediately following the buy-up.

AD&D Exclusions

Benefits would not be paid under the following circumstances:

- Air or space travel. The exception is if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo.)
- Bodily or mental infirmity.*
- Commission of or attempting to commit a criminal act.
- Illness, ptomaine or bacterial infection.*
- Inhalation of poisonous gases.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Ligature strangulation resulting from auto-erotic asphyxiation.
- Intentionally self-inflicted injury.
- Medical or surgical treatment*.
- 3rd degree burns resulting from sunburn.
- Use of alcohol.
- Use of drugs, except as prescribed by a physician.

- Use of intoxicants.

- Use of alcohol or intoxicants or drugs while operating any form of a **motor vehicle** whether or not registered for land, air or water use. A **motor vehicle accident** will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the **accident** you or your covered dependent were:

  Operating the **motor vehicle** while under the influence of alcohol as a level which meets or exceeds the level at which intoxication would be presumed under the laws of the state where the **accident** occurred. If the **accident** occurs outside of the United states, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or

  Operating the **motor vehicle** while under the influence of an intoxicant or illegal drug; or

  Operating the **motor vehicle** while under the influence of a **prescription drug** in excess of the amount prescribed by the **physician**; or

  Operating the motor vehicle while under the influence of an over the counter medication taken in an amount above the dosage instructions.

- Suicide or attempted suicide (while sane or insane).

- Use of drugs, except as prescribed by a physician.

- War or any act of war (declared or not declared).

* These do not apply if the loss is caused by:

- An infection which results directly from the injury.

- Surgery needed because of the **injury** ***STD Exclusions***

Short term disability coverage does not cover any disability on any day that you are confined in a penal or correctional institution for conviction of a criminal act or other public offense. You will not be considered to be disabled, and no benefits will be payable.
Short term disability coverage also does not cover any disability that:

- Is due to an occupational illness or occupational injury except in the case of sole proprietors or partners who can not be covered by workers' compensation.
- Is due to insurrection, rebellion, or taking part in a riot or civil commotion.
- Is due to intentionally self-inflicted injury (while sane or insane).
- Is due to war or any act of war (declared or not declared).

- Results from your commission of, or attempting to commit a criminal act.
- Results from a motor vehicle accident caused by operating the vehicle while you are under the influence of alcohol. A motor vehicle accident will be deemed to be caused by the use of alcohol if it is determined that at the time of the accident you were:

  - Operating the motor vehicle while under the influence of alcohol at a level which meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred.) If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter.

LTD Exclusions

Long Term Disability (LTD) coverage does not cover any disability that:

- Is due to intentionally self-inflicted injury (while sane or insane).

- Results from your commission of, or attempting to commit, a criminal act.

- Results from:

  - Driving a motor vehicle while intoxicated. (We define intoxicated as the blood alcohol level of the driver that meets or exceeds the intoxication level under state law.)

  - Operating a motor vehicle while under the influence of an intoxicant or illegal drug.

- Operating a motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician.

- Operating a motor vehicle while under the influence of an over-the-counter medication taken in an amount above the dosage instructions.

- Is due to voluntarily taking poison, voluntary inhalation of poisonous gases, or taking a drug or chemical not administered by a physician.

- Is due to war or any act of war (declared or not declared).

- Is due to insurrection, rebellion, or taking part in a riot or civil commotion.

- Starts during the first 12 months (this timeframe is variable) of the current LTD coverage if it is caused or contributed to by a pre-existing condition. A disease or injury is a pre-existing condition if, during the three months (this timeframe is variable) before the date the member last became covered:

  - It was diagnosed or treated.

  - Services were received for diagnosis or treatment of the disease or injury.

  - Drugs or medicines were taken by the member that a physician prescribed or recommended for that condition.

On any day during a period of disability that a person is confined in a penal or correctional institution for conviction of a criminal or other public offense:

- The person will not be deemed to be totally disabled
- No benefits will be payable

Also, a period of total disability will end after 24 monthly benefits (variable) are payable if we determine the disability is at that time caused to any extent by a mental condition (including conditions related to alcoholism or drug abuse) described in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

There are two exceptions to this rule. These apply if the member is confined as an inpatient in a hospital or treatment facility for treatment of that condition at the end of such 24 months:

- If the inpatient confinement lasts less than 30 days, the period of total disability will cease when the member is no longer confined.
- If the inpatient confinement lasts 30 days or more, the period of total disability may continue until the date the member has not been so confined for that condition for a total of 90 days during any 12-month period.

G. Describe any participation requirements associated with your offer. Keep in mind the proposed design options described in Exhibit B.

We require a minimum of 20% participation for employee paid life coverages and 25% participation for employee paid disability coverages.

H. Describe your Waiver of Premium provisions.

We can write Basic Term Life and Supplemental Term with an optional premium waiver feature.

Premium waiver is a Life disability provision which states that if an employee becomes permanently and totally disabled, the insurance will remain in force and we will waive the premiums while they remain permanently and totally disabled. Coverage will continue without premium until the earlier of:

- Date of retirement,
- Date the employee reaches a specified age,
- Employee is well enough to work at any reasonable job,
- Employee works at any job for pay/profit, or
- Employee fails to submit requested proof of continued permanent and total disability.

I. Currently, the County does not personalize the life insurance certificates. Do you require personalized certificates? If so, the County will require the insurer to be responsible for personalizing and distributing the certificates. How do you propose to distribute new certificates to the current participants as well as those who enroll in the future?

We do not require certificates to be personalized. It is the responsibility of the County to distribute insurance certificates to its employees. We send electronic documents to the County for distribution to employees. We can send documents web-ready to post on internal websites for immediate employee access. Printed documents are available for customers who do not have electronic capabilities; however, additional charges may apply.

J. The County is requiring that employees and retirees be able to maintain their current level of supplemental life insurance coverage without undergoing medical underwriting. Can you accommodate this requirement? Please describe any limitations.

We can accommodate this requirement.

K. Currently, the County increases premiums for supplemental life participants who are **active employees** the first day of the month following their birthday which moves them from one age band to another. Explain your standard procedure for increasing premiums as participants experience a birthday which moves them from one age band to another (include your definition of attained age, if attained age is used). If our approach differs from your standard, can you accommodate the County's current process? How does the County continuing our current process impact the rates quoted?

We are able to administer this with no rate impact.

L. Currently, the County increases premiums for supplemental life participants who are **retired employees** on April 1st the year following their change to a new age bracket.

Explain your standard procedure for increasing premiums as participants experience a birthday which moves them from one age band to another (include your definition of attained age, if attained age is used) If our approach differs from your standard, can you accommodate the County's current process? How does the County continuing our current process impact the rates quoted?

We are able to administer this with no rate impact.

M. Please describe coverage limits, guaranteed issue amounts, application process, medical underwriting requirements, and rates for coverage for spouses and children.

The applicant completes the evidence of insurability statement when he or she:

- Fails to enroll in the plan within 31 days of the eligibility date,
- Fails to enroll in the disability plan within 90 days after the eligibility date or 60 days after a qualifying event,
- Requests an amount over the guaranteed issue limit,
- Requests an increase in coverage by more than one increment, or
- Requests reinstatement of coverage previously discontinued.

Completed evidence of insurability statements are:

- Forwarded to our imaging service,
- Keyed into our database,
- Auto-adjudicated for online applications, and/or
- Underwritten by an experienced medical underwriter.

A medical underwriter reviews the evidence form and accepts or declines coverage, or requests additional information. They may review the application with our clinical consultant staff to interpret medical records.

If we need additional information, we may request a statement from an attending physician, a paramedical examination, or information relating to a specific health condition or laboratory test. The applicant pays any costs

associated with these requirements if they are requesting coverage outside the initial 31 day eligibility period.

We send a reminder/follow-up letter to the applicant. If we do not receive the requested medical information within the 30 day time allowed, the EOI file will close and we notify the customer.

We mail approval letters to the attention of a customer representative (i.e., Benefits/Insurance Administrator, Human Resources personnel) and/or employee based on customer requirements. We process work by date order, with the oldest date first. The medical underwriter reviews the evidence form within our standard 20 business days of receipt.

If additional medical information is necessary, such as examination or medical records, the underwriter sends a letter to the employee requesting the additional medical information, as well as a letter to the customer advising of the request for additional information. Exam forms and an Attending Physician Report form are included, as well as return self-addressed envelopes.

We pend the file for the standard of 30 business days for medical requests or 15 business days for administrative requests. The time frame can be customer specific. If we do not receive a response within that time, we close the file and send a closure letter to the applicant and the County. Once we close a file, medical underwriting requires a current EOI for further consideration. When we receive the information within the timeframe and make a final decision, we notify the County of the decision through the ESW or EOI reports. We send the reports monthly, weekly or bi-weekly. If we approve coverage, we determine the effective date and send a Notice of Approval to the County who then notifies the employee. We can send the approval letter to the employee based on customer requirements. We send a letter to the employee if we deny coverage. The employee's denial letter explains the reason(s) for the denial of coverage and when he or she may reapply.

Online Evidence of Insurability Processing Capabilities
Upon receipt of an electronic eligibility file from the County, we will manage the enrollment and eligibility process. We will determine which employees require evidence of insurability and will manage that fulfillment process (mailing of the EOI package). We will provide the customer with both enrollment activity reports and EOI status reports. In addition, we will perform follow-up activities on EOI forms not returned to Aetna.

The guaranteed issue limit for spouses is $50,000. Child coverage is all guaranteed issue.

The rates for dependent coverage are shown on the provided rate exhibits.

N. The County has a number of military reservists on staff. Currently, there is no war exclusion in the existing life insurance policy and the County intends to maintain this feature. Explain your ability to accommodate the County and include in your cost proposal. The County also has a repatriation benefit in our current plan. Describe the repatriation benefit included in your quote.

Or life insurance plans do not include a war exclusion, however, one is included in our AD&D plans. A repatriation benefit is included in our AD&D plans. We offer a maximum of $5,000 for remains located outside a 200 mile radius from the principal place of residence.

O. The County prefers that both the basic life and the supplemental life insurance be both portable and convertible. Can you accommodate this? If not, why not? Describe any pros/cons associated with this request.

Portability on both basic and supplemental coverage is include in our life insurance programs.

P. Please explain the conversion privilege available under the group life insurance contract and the conversion process. What is your current conversion charge per $1000? Is it a flat charge or does it vary based on factors such as age? If the charge can vary, please describe in detail. What is

the maximum conversion amount? How do you inform employees of this option?

We can convert Basic Term, Supplemental Term, Dependent Term and AD&D coverage.

A member may convert coverage to a whole life individual policy issued by our company during the 31 days following:

- Termination of employment
- Termination of membership in an eligible class
- Reduction of life insurance due to age or retirement
- Policy discontinuance in whole or part

The individual policy amount can be up to the current coverage unless the policy discontinues. If the policy discontinues the member can convert only a limited amount of coverage. We will issue the conversion policy without a medical examination at our standard rates. Some states may require additional options.

If a member dies within 31 days following the termination of group life coverage, the amount of group term life insurance that could have been converted will be paid to the beneficiary under the group policy.

The conversion process begins when an eligible member requests a conversion application, which must be done within 31 days following the loss of coverage. One side of the conversion application is a statement that must be completed by the plan sponsor. The member completes the application for insurance on the reverse side of the form.

We require the applicant to submit the first premium payment with the conversion application. Once received, we review the application and if approved, we issue a new policy. If the correct premium is not included, coverage is not effective until we receive payment.

Premium rates are based on the applicant's sex and age at the time of application.

We will assess the conversion charge against the plan as a recorded claim charge at the time of conversion. We currently assess a flat charge of $195 per $1,000 of non-pooled life insurance converted to individual life contracts. We do not make a separate conversion charge for pooled insurance because it is included in the rate level for pooled insurance. Once the conversion process is

complete, we make no further accounting of premium or claim experience for that individual under the group contract.

Q. Describe in detail your portability feature (if offered). How are premiums adjusted for employees to access this option? What experience (if any) is charged to the group? How do you inform employees of this option?

The portability provision allows members to take their coverage with them if they terminate employment or if they remain employed, but the life insurance coverage ends for the class the employee belongs. Members may be able to keep their coverage subject to certain limits until they reach the age limit specified in the plan by simply paying the portable term pool rates we bill them.

For customers requesting portability maximums in excess of $500,000 for an employee and $250,000 for a spouse, we may require evidence of good health. Portability also applies to children to a maximum of $5,000. If an employee dies or divorces their spouse, we can only convert dependent coverage. We cannot port it.

Benefit provisions include:

- Members must be actively at work prior to employment termination.

- Members and Spouses are eligible up to age 98. Children are eligible if they were covered while the member was an active plan participant. This is generally age 18 for non-students and age 22 if a full-time student or up to age 25 for groups where the child definition has changed to match new health care reform standards.

- Portability ends on the first anniversary of the portability date that next follows age 99 for former group members and spouses. For dependent children the age that is one year after the plan's limiting age, which is generally age 23 or 26 if health care reform standards are being matched.

- Dependents are only eligible for portable coverage if the member is participating.

- Current coverage amounts are available for portability up to the amounts described below. Members may not increase or decrease their insurance coverage or add new dependents once elected.

  - The minimum and maximum portable coverage amounts are:
    - Members: $5,000/$500,000
    - Spouses: $1,000/$100,000
    - Children: $1,000/$5,000

  - Coverage amounts for members will be reduced by 35 percent at age 65. Thereafter, the amount of life insurance will be reduced by 60 percent at age 70, and by 75 percent at age 75.

- Portability pool rates (not the current group rates) are presented on a non-smoker/smoker basis in five-year age bands.

- Premium notices include a direct-billing administration charge of $2.00 per direct bill.

- Premium waiver (for employees) and accidental death may be included in the portable coverage.

- Portable premium and claim experiences are not applied to the customer's active plan.

  It will be the County's responsibility to let employees know their portability rights.

R. Describe any ancillary benefits included as part of your life insurance policies. Indicate if there is an extra charge for any of these and if so, what are the charges?

AD&D Ultra® with Enhanced Personal Protection
AD&D Ultra® with Enhanced Personal Protection is Aetna's response to the needs of today's employees for enhanced accident protection. This package provides your employees with our AD&D Ultra® package of 14 family-created benefits ***plus*** additional features that are designed to help an employee return to his or her usual lifestyle after a disabling accident, or help protect the family and their health coverage in the event the accident causes death.

The **AD&D Ultra® with Enhanced Personal Protection** package would be added to the Basic ***or*** Supplemental AD&D Ultra® product, but not both. It includes the following benefits:

- Medical Coverage Funding Benefit - Provides up to $300 per month/$3,600 per year, for up to 36 months to help pay for out-of-pocket expenses that are incurred by surviving dependents who elect to continue medical coverage under the employer's COBRA option.

- Adaptive Home and Vehicle Benefit - Provides up to $10,000 for out-of-pocket expenses that are incurred by a member for necessary home and vehicle modifications to make their principal residence and/or personal motor vehicle accessible and usable following an accident that results in severance or paralysis.

- Monthly Hospital Benefit - Provides a $2,500 monthly income benefit to employees who become confined to a hospital or convalescent facility for more than 30 days following an accident. The benefit is payable for each 30-day period of continuous confinement for up to a maximum of 12 months/$30,000.

- Rehabilitation Training Benefit - Provides up to $2,500 for out-of-pocket expenses that are incurred by a member for rehabilitation training which is designed to help the employee return to work.

The cost for AD&D Ultra® with Enhanced Personal Protection is $.005 for each $1,000 of AD&D Ultra® Principal Sum coverage.

Optional AD&D Ultra® or AD&D Ultra® with Enhanced Personal Protection Features

Two features are available as options with AD&D Ultra® or AD&D Ultra® with Enhanced Personal Protection to offer even more comprehensive coverage:

- Double Indemnity on Common Carrier - Doubles the employee's or Spouse's Principal Sum to a maximum of $250,000 in the event the covered person suffers a loss of life while boarding, alighting from or traveling in a vehicle licensed for public transportation.

- Spouse **Common Accident** - Pays a benefit equal to the difference between the covered spouse's Principal Sum and the employee's Principal Sum to a maximum of $200,000 in

the event the employee and spouse die within 30 days of each other.

S. If the County wants to unbundle Supplemental Life from Supplemental AD&D, can you administer this? If so, describe the options available for employees to elect. Describe the AD&D options available for spouses and dependent child(ren).

We are able to administer this.

Coverage options are a multiple of salary or a specific dollar increment, e.g. increments of $25,000. Coverage for spouses and children is typically a percentage of the employee's coverage. For example, spouse coverage might be 56% of the employees supplemental AD&D if no children are covered, 50% if children are covered. Child coverage might be 15% of the employee's supplemental AD&D coverage if no spouse is covered or 10% if spousal coverage is provided.

T. Provide an overall description of your disability management services for Long Term Disability (LTD) and Short Term Disability (STD).

We offer a variety of convenient intake methods:

- Paper claim form (mail or fax)
- Telephonic (via a toll free number)
- Web (when an employer eligibility file is provided)

As part of our intake, we:

- Educate the employee about the claim process
- Verify their eligibility
- Begin the return to work (RTW) discussion
- Set expectations
- Attempt to gather all the necessary information needed to make an initial claim determination

When we identify an employee as having both Aetna medical and Aetna disability coverage, we perform a HIPPA compliant telephonic consent process. Secure Voice Authorization allows us to coordinate in obtaining clinical information and providing our unique integrated health and disability (IHD) benefits.

Within 2 business days from creation of the STD claim we mail the employee an Introductory Letter, which again explains the claim process and may include a:

- W-4 or W-4S Tax Form
- Medical Authorization Form
- Reimbursement Form

Next, our trained and experienced intake staff conduct a three-point contact. Three-point contact includes outreach to:

- The employee (by telephone) -- if needed, to obtain any missing information not included/gathered in the initial claim submission.
- The employer (by e-mail) -- to verify eligibility and confirm information about the employee's job duties and alert them to the claim.
- The attending physician (by telephone and/or fax) -- to obtain relative disability related medical information.

Following the intake and based on initial diagnosis, our senior nurse reviewer (SNR) immediately reviews claims identified as needing an intensive assessment. In these cases, the SNR:

- Performs an initial triage review
- Assigns the claim to an appropriate disability benefits manager
- Makes initial recommendations regarding additional clinical resources that may be advisable and/or potential accommodated RTW opportunities that may be present

The SNR remains engaged on these claims until claim resolution. SNRs determine the need and level of clinical oversight and claim staff necessary, assessing information such as:

- Age
- Past medical history
- Job description
- Diagnosis
- Disability duration
- Past disability history
- Treatment and clinical information
- RTW accommodations
- Modified duty

Our experienced short term disability benefits managers are responsible for making all claim certification decisions and managing the employee's claim, working with them to pursue a productive and safe return-to-work. If extended claim certifications are required, the disability benefits manager will work with the employee and their provider to obtain additional medical information to support a continued disability and may refer the claim to other disability resources including clinical and vocational rehabilitation consultants for additional review and communication with the treating provider and customer with focus on return to work planning and coordination as appropriate.

At the ninth week prior to the Short Term Disability end of benefit date, a system diary flags the benefits managers for LTD consideration. It has prompts to ensure all appropriate areas are addressed, including:

- Thorough claim history summary
- Return-to-work efforts
- Current clinical status
- Specific current information that supports payment of claim
- Assessment of what is anticipated regarding timeframe from 18-26 weeks

Once this process begins, we will consider the member for transition into LTD. When appropriate, an STD clinical resource will review the claim and make recommendations for case movement and assess appropriateness of management and an action plan.

To ensure a smooth transition from STD to LTD, our claim administration system is designed to automatically create an LTD consideration task on a newly created STD claim with a task due date that can be determined on the benefit duration of the STD claim. As applicable, we conduct eligibility and pre-existing investigation and request payroll or enrollment documentation and medical records.

If the STD claim transitions into LTD, it is sent to a Benefits Liaison (BL) where the claim is assessed and possibly placed in a round table discussion to ensure the claim is appropriately transitioned and managed.

When the task is complete, it automatically creates and pre-populates the LTD claim with as much data as possible from the STD claim. The newly created LTD claim will also

contain all of the necessary tasks for claim assignment, triage, initial decision, and communication. We send an LTD introductory packet to the member, requesting additional form completion and advising what is required for transition to LTD.

Once we receive the LTD packet, we enter the claim into our system and place it in "pending" status until we make an LTD claim decision. The LTD Benefits Manager checks all forms for signatures and dates once the claim is assigned.

U. The County will require the selected vendor to calculate and properly withhold FICA from applicable payments as well as remitting the FICA to the Federal government. Describe how your organization will meet this requirement.

FICA match is available only for employer paid coverage.

We will withhold and deposit federal withholding, FICA, for the employee.

Handling FICA for the County is also an option. The County's portion of FICA will be included in the rates with insured programs and invoiced for reimbursement for self-insured programs.

Please note, if the plan is contributory, then a separate bill must be sent to collect the needed premium associated with this service.

V. The following questions pertain to a fully-insured short-term disability contract:
   a. Please explain how you track and properly withhold taxes from benefits received under the plan.
   b. Will W-2 statements be provided for claimants if applicable? Is this part of your core services? If not, please detail the cost associated with providing this service.
   c. What other tax related services can you offer for the STD plan (e.g. withholding and remittance of employee's and employer's portion of FICA). Please detail costs associated with these services.
   d. How would you handle the recovery of an overpayment?

---

a. We have the ability to automatically deduct FICA, however; Federal and State taxes are voluntary deductions on Insured STD/LTD. Claimants must submit the appropriate

W-4s and State W-4s to have us deduct those taxes from their benefits.

b. We will issue W-2 forms if the County completes and authorizes the agency agreement form. If we issue W-2 forms, we report them under our name and tax identification number and mail them directly to the member; we do not provide copies to the customer if we are mailing directly to the member. We will send the County a report (Third Party Sick Pay Recap) that reflects the W-2 financial information for each W-2 form sent. This report is sent at the end of the year.

c. When appropriate, we have the ability to withhold Federal Income Tax (FIT), State Income Tax (SIT) and Social Security tax (FICA) from disability payments. We do not withhold FUTA (Federal Unemployment) or SUTA (State Unemployment) taxes.

d. For a current year repayment, we collect the net pay back from the member and reverse the applicable taxes to obtain the gross payment. We post all current year repayments as manual checks, negating the net, taxes and gross pay from the current year's W-2 form. We only amend current year W-2 data when the overpayment is paid back in the same year.

   For prior year repayments, we collect the gross amount back. The member may have already received a refund of withholdings. We post the repayments as a prior year repayment, which does not apply to the current year's W-2 form.

Section 5: Enrollment and Underwriting

A. Can you accommodate the County if we elect to have a 90 day enrollment period after hire date or 60 day enrollment period after a qualifying event with no underwriting for disability? If your standard enrollment period is less than 90 days, describe how the County's request impacts the rates quoted (i.e. X% higher, etc.).

We are able to accommodate this request.

B. The County captures enrollment via Oracle and employee self service. Do you require a data feed of enrollments and changes in elections? If so, please describe the process

and provide sample file layout(s). Will you accept a full file or changes only or both?

We accept eligibility feeds from customers participating in our BMS program, which is available for an additional fee. Our preferred frequency for receiving eligibility update feeds is weekly; however, we will accept feeds monthly or every other week, or at the County's request.

Our Beneficiary Management services team provides life administration support to customers that include:

- Claim preparation
- Beneficiary record keeping
- Benefit confirmation

There is an additional cost for BMS.

We prefer a weekly eligibility file to ensure the most accurate and up-to-date information is being applied to the claim. Common updates can include:

- Address changes,
- Maiden to married name changes,
- Promotions,
- Hours worked,
- Salary changes, and
- Plan enrollment.

We are able to verify much of the data during the claims process; however, we believe that having one record of source from the County is the best practice.

We accept full eligibility or change only files. We will work directly with the County to determine the best option by doing a thorough review of the data elements to identify any gaps in one format vs. the other.

Please refer to the Samples and Brochures section of this proposal for sample file layouts.

C. How do you communicate enrollment issues to the plan sponsor: fax, e-mail, telephone? What is your standard timeframe for resolving enrollment issues?

We can provide a Beneficiary Management Services (BMS) eligibility file error report to the County after we process each BMS file. Normally, we would post the error report to an FTP folder on our site for the County to retrieve, review, and make any needed corrections for their next BMS file. The error reports list each employee record that has encountered an edit along with the related error message. We will review the first few reports with the County so the County understands the reports and what corrections they need to resolve.

It is our best practice to reach out to the applicable the County representative as soon as possible to discuss any eligibility dispute and provide resolution.

During the initial investigation of a new claim, the Disability Benefits Manager (DBM) obtains the employer statement of claim and a copy of the enrollment card for the year the claim was incurred and the prior year. This validates whether the team member was a late enrollee and subject to evidence of insurability (EOI) or the pre-existing conditions limitation. The DBM also obtains payroll documentation from the County to validate wages/salary and premium deductions prior to the incurred claim.

If we require EOI and the claim is incurred within the first two years of coverage, the DBM will obtain a copy of the medical underwriting file and a medical history supplemental statement from the claimant. The claim investigation includes comparing medical and pharmacy records against the medical history disclosed on the EOI. If there are material misrepresentations on the EOI, we may rescind the coverage and deny the claim.

We advise the claimant of appeal and claim perfection rights on any adverse determination.

D. Do you need to receive notifications of terminated employees? In what format (i.e. electronic, paper, fax, etc.) will you receive these notifications?

Life

If the County choses to participate in our Beneficiary Management Program, we accept 600 byte file feed or excel format for electronic eligibility information and 900 byte

file feed for electronic beneficiary information. There are also several additional file layouts available depending on the services we will provide which could include Conversion/Portability support and On Line Evidence of Insurability. These layouts are available in Excel and TXT.

Disability

We prefer a weekly eligibility file to ensure the most accurate and up-to-date information is being applied to the claim. Common updates can include:

- Address changes,
- Maiden to married name changes,
- Promotions,
- Hours worked,
- Salary changes, and
- Plan enrollment.

We are able to verify much of the data during the claims process; however, we believe that having one record of source from the County is the best practice.

E. When is medical underwriting necessary? When an employee must undergo medical underwriting, who bears the expense of physical exams or other costs incurred in the process?

The applicant completes the evidence of insurability statement when he or she:

- Fails to enroll in the life plan within 31 days of the eligibility date,
- Fails to enroll in the disability plan within 90 days after the eligibility date or 60 days after a qualifying event,
- Requests an amount over the guaranteed issue limit,
- Requests an increase in coverage by more than one increment, or
- Requests reinstatement of coverage previously discontinued.

We request additional information needed for late entrants, such as an attending physician's report or paramedical exam, at the applicant's expense.

We request additional information needed for timely entrants (i.e., new hires or new groups within the initial 60 days) at our expense up to a specified amount.

F. Describe in detail your medical underwriting process.

a. Which diagnoses would typically preclude an individual from obtaining or, in the case of supplemental life insurance, increasing coverage?
b. What are the qualifications of the individuals who are making decisions on whether to approve or deny coverage?
c. Who accepts and processes the necessary forms and other supporting documents?
d. What tracking system exists to ensure all requests are reviewed and processed?
e. How do you inform the participant and the County of the participant's medical underwriting status?

---

a. We use the body mass index method of determining overweight and obesity in adults and may automatically decline when an applicant's body mass index exceeds the allowed threshold.

The proprietary nature of the information contained within Aetna's Medical Underwriting Guidelines precludes us from releasing the highest mortality/morbidity rating to be accepted for medical evidence of insurability to anyone outside of Aetna. This includes the "debit" threshold at which declination is reached. We can, however, provide information related to approval and declination percentages as it relates to total volume of applications.

Aetna's Medical Underwriting Department evaluates each Evidence of Insurability Statement (EOI) per pre-determined guidelines. This ensures standards are met to objectively evaluate the level of insurance risk presented by build, tobacco use and certain health impairments. The goal is to underwrite as efficiently as possible making as many determinations as possibly directly from EOI. However often more information may be necessary and further information may be sought from medical providers. The returned information is evaluated in Medical Underwriting Manuals. These manuals are risk selection tools designed to assist underwriters in identifying and assessing the level of insurance risk imposed by health impairments.

The level of risk is measured in numerical "debits" that represent excess morbidity or mortality above "standard". "Standard" is the equivalent of "0" risk for incurring claims in excess of the pricing loss ratio for the benefit (health, short term disability, long term disability or life) being underwritten. Each benefit has a certain "debit" threshold at which a denial of coverage is determined for that coverage.

b. The underwriting department includes RNs and LPNs with combined medical underwriting experience of 17 years.

c. A medical underwriter reviews the evidence form and accepts or declines coverage, or requests additional information. They may review the application with our clinical consultant staff to interpret medical records.

d. Completed evidence of insurability statements are:

- Forwarded to our imaging service,
- Keyed into our database,
- Auto-adjudicated for online applications

We process work by date order, with the oldest date first. The medical underwriter reviews the evidence form within our standard 20 business days of receipt.

e. The County will have access to the Employer Secure Website to gather status of approved, pending or closed participants that required EOI. We can also send to the customer our EOI reports through secure FTP. We mail approval letters to the attention of a customer representative (i.e., Benefits/Insurance Administrator, Human Resources personnel) and/or employee based on customer requirements.

G. What appeal process exists for an employee who was denied coverage through medical underwriting?

Within the denial letter, we inform the employee of the right for appeal, and/or the release of the medical information. If we receive an appeal letter, we send the underwriting file to the appeal consultant for review. We advise the employee of our decision. We also advise the County by letter of any decision change.

H. Cite and explain your incontestability clause.

The validity of this policy shall not be contested, except for non-payment of premiums, after it has been in force for 2 years. No statement made by an employee about his insurability shall be used by Aetna in contesting the validity of the insurance as to which such statement was made if the insurance has been in force prior to the contest for 2 years during the employee's lifetime nor unless such statement is contained in a written form signed by him.

I. Describe the functions you can administer online (i.e. applications for enrollment, medical underwriting, billing and administration, etc.).

Aetna Group Insurance has several approaches by which we can either integrate with, or provide tools and services to the County, to support their requirement for Online Administration and Enrollment for the Aetna Group Insurance products under consideration.

We believe our approach allows the County to consider whether they would prefer to leverage their existing technologies already in place at the County, or to allow Aetna to provide solutions for the County that may allow for significant cost savings from what otherwise would be invested in the Oracle systems to satisfy the online enrollment needs.

Option 1: Leverage Existing Oracle Tools and Systems

Aetna would work with the County's Oracle administrators to ensure that our plans, products, rates, eligibility criteria, waiting periods, communications materials, content, and evidence of insurability rules are all configured in the Oracle system to meet the needs of properly determining an individual's ability to enroll in the various Aetna coverages selected. This would include being able to properly display the products and coverage amounts for which each person would be eligible, what amount would be considered as "Guaranteed Issue", and what amounts may be subject to Evidence of Insurability (EOI) processing.

Aetna would work with the County's Oracle administrators to determine what is needed to support both the employees themselves and the County's administrators to log into the

Oracle system and make their own enrollment choices themselves, online.

Aetna would work with the County's Oracle administrators to determine what data files, and at what frequency they would need to be sent to Aetna for such "functional file" processing as determining the medical underwriting needs, any beneficiary data requested or needed by Aetna, or any other data files to enable such capabilities as our telephonic claim intake function for the Aetna Disability products.

Aetna would work with the County's Oracle administrators to determine the EOI Status Updates and Approvals file needs, so that correct reporting and payroll deductions for newly-approved coverages could be produced, and reporting from within the Oracle system correctly handled.

With the Aetna tools and systems functional, we would provide access and training to the Aetna Employer Secure Website for such items as the ability to file claims online, access reports for EOI status, Paid / Pending Claim status reports, and more.

Option 2: Leverage Aetna Tools And Solutions Instead of Oracle

Aetna would provide an online, web-based benefits administration and enrollment tool directly to the County's employees and administrators, so employees could each access their own personal data, see what they are each eligible for, and make enrollment transactions themselves. Administrators would have access to employee data, as they may perform tasks on the employee's behalf, but Aetna can restrict the administrator access to "only" their particular department's employees or bargaining or non-bargaining entities, depending on the County's preference. The Aetna tool could save the County significant direct expenses associated with Oracle consulting, programming and usage fees needed to customize the Oracle system to support the Aetna plans and products.

The Aetna solution would provide the direct ability for employees to make their own enrollment elections, online, and immediately complete any EOI paperwork, if so determined by the Aetna system. Upon the employee completing the EOI, decisions in most cases can be rendered on-the-spot and proper payroll authorization delivered back to the County on a weekly, bi-weekly, or monthly basis. Additional systems and tools at Aetna would be automatically updated, such as the Aetna Employer Secure Website for such items as the ability to file claims online, access reports for EOI status, Paid / Pending Claim status reports, and more.

The time and cost savings to the County could be greater, with enhanced workflow, automated processing, data file connectivity, already having been established and factored into the delivery of the Aetna tools and solutions. The dollar savings would be directly commensurate with the anticipated costs by the County to pursue the activities in Option 1 identified above, and would require further discussion between Aetna technical consultants, the County, and your Oracle administrators on how best to proceed. We look forward to further discussions with the County regarding the option they may be interested in. Additional fees may apply based on the level of service established.

Section 6: Claims

A. Describe in detail the claim adjudication process typically followed upon notification of a claim. Include what documentation is required from the beneficiary/claimant, a copy of all correspondence that is used throughout the process, the functional areas involved and the elapsed time.

Life Claim Process

The County will submit claims directly to us on behalf of employees and beneficiaries. A life claim submission includes:

- Proof of death form
- Death certificate
- Beneficiary documents
- Enrollment form
- Other pertinent information (police reports, assignments of benefits, etc.)

We scan claims at our imaging center and enter them into our claim system within 24 hours of receipt. We then electronically assign the claim to a claim analyst, who handles on a first-in/first-out basis. The claim analyst will refer to life claim consultants for complex or questionable claims.

Aetna accepts claim documentation via fax or mail (e.g. Death Certificate, beneficiary card, funeral home assignment, etc). We do not require a claimant's statement or anything signed by the claimant prior to adjudicating the claim.

We also offer the ability for customers to create, save and submit life claims online through our online claim submission tool. The tool is available on our group insurance Employer Secure Website. The tool allows the attachment of any ancillary documents (e.g. attending physician statement, enrollment form) to the online claim. The claim will be in our imaging system within three hours of receipt.

The following outlines our claim process:

- We enter the claim into our life claim system.
- We deliver mail electronically each day to the claim analysts by account assignment.
- The claim analyst:
    - Reviews the claim for completeness and requests any necessary information from the County or the beneficiary
    - Requests police reports, coroner reports, etc. as needed
    - Reviews contractual requirements, legislative requirements and internal standards applicable to each claim
    - Processes the claim in received date order
- We produce drafts overnight and send them out the next day. We can also produce a draft on the same day we process a claim, if necessary.

The online system provides audit controls during processing. For example, each claim analyst has a specific draft authority. The system will not allow the claim analyst to pay a claim above that authority level.

We process clean claims within five business days. A clean claim is one we can process without the need for additional information. We process complex claims or claims that delay pending the receipt of further information within five business days from the date of receipt of the final required paperwork.

Once we have all the information to make a benefit determination, the analyst enters the claim decision into

the life claim system. We distribute benefits as specified in the policy.

Life Claim Process with Beneficiary Management Services

The Beneficiary Management (BMS) and Claim Eligibility Services programs allow employers to out-source the handling of employees/retirees' life insurance beneficiary designation documents, claim establishment, and the servicing of employee/retiree inquiries and requests regarding their current group life benefit profile.

When we provide BMS, the notice of death can be reported directly to the Life Insurance Service Center through the toll-free customer service line or electronically. BMS representatives will verify coverage and initiate the claim filing process. We can also make arrangements to supply the notice of death and beneficiary information back to the employer to satisfy their particular reporting requirements.

The BMS representative will pursue collection of the death certificate and other pertinent information before releasing the claim to the life claims unit. Once the life claims analyst has all the information to make a benefit determination, the analyst enters the claim decision into the life claim system. The analyst then distributes the benefit amount to the appropriate beneficiary/beneficiaries.

Disability Claim Process

We offer a variety of convenient intake methods:

- Paper claim form (mail or fax)
- Telephonic (via a toll free number)
- Web (when an employer eligibility file is provided)

As part of our intake, we:

- Educate the employee about the claim process
- Verify their eligibility
- Begin the return to work (RTW) discussion
- Set expectations
- Attempt to gather all the necessary information needed to make an initial claim determination

When we identify an employee as having both Aetna medical and Aetna disability coverage, we perform a HIPPA compliant

telephonic consent process. Secure Voice Authorization allows us to coordinate in obtaining clinical information and providing our unique integrated health and disability (IHD) benefits.

Within 2 business days from creation of the STD claim we mail the employee an Introductory Letter, which again explains the claim process and may include a:

- W-4 or W-4S Tax Form
- Medical Authorization Form
- Reimbursement Form

Next, our trained and experienced intake staff conducts a three-point contact. Three-point contact includes outreach to:

- The employee (by telephone) -- if needed, to obtain any missing information not included/gathered in the initial claim submission.
- The employer (by e-mail) -- to verify eligibility and confirm information about the employee's job duties and alert them to the claim.
- The attending physician (by telephone and/or fax) -- to obtain relative disability related medical information.

Following the intake and based on initial diagnosis, our senior nurse reviewer (SNR) immediately reviews claims identified as needing an intensive assessment. In these cases, the SNR:

- Performs an initial triage review
- Assigns the claim to an appropriate disability benefits manager

Makes initial recommendations regarding additional clinical resources that may be advisable and/or potential accommodated RTW opportunities that may be present

The SNR remains engaged on these claims until claim resolution. SNRs determine the need and level of clinical oversight and claim staff necessary, assessing information such as:

Age
Past medical history
Job description
Diagnosis
Disability duration
Past disability history
Treatment and clinical information
RTW accommodations
Modified duty

Our experienced short term disability benefits managers are responsible for making all claim certification decisions and managing the employee's claim, working with them to pursue a productive and safe return-to-work. If extended claim certifications are required, the disability benefits manager will work with the employee and their provider to obtain additional medical information to support a continued disability and may refer the claim to other disability resources including clinical and vocational rehabilitation consultants for additional review and communication with the treating provider and customer with focus on return to work planning and coordination as appropriate.

At the ninth week prior to the Short Term Disability end of benefit date, a system diary flags the benefits managers for LTD consideration. It has prompts to ensure all appropriate areas are addressed, including:

- Thorough claim history summary
- Return-to-work efforts
- Current clinical status

- Specific current information that supports payment of claim
- Assessment of what is anticipated regarding timeframe from 18-26 weeks

Once this process begins, we will consider the member for transition into LTD. When appropriate, an STD clinical resource will review the claim and make recommendations for case movement and assess appropriateness of management and an action plan.

To ensure a smooth transition from STD to LTD, our claim administration system is designed to automatically create an LTD consideration task on a newly created STD claim with a task due date that can be determined on the benefit duration of the STD claim. As applicable, we conduct eligibility and pre-existing investigation and request payroll or enrollment documentation and medical records.

If the STD claim transitions into LTD, it is sent to a Benefits Liaison (BL) where the claim is assessed and possibly placed in a round table discussion to ensure the claim is appropriately transitioned and managed.

When the task is complete, it automatically creates and pre-populates the LTD claim with as much data as possible from the STD claim. The newly created LTD claim will also contain all of the necessary tasks for claim assignment, triage, initial decision, and communication. We send an LTD introductory packet to the member, requesting additional form completion and advising what is required for transition to LTD.

Once we receive the LTD packet, we enter the claim into our system and place it in "pending" status until we make an LTD claim decision. The LTD Benefits Manager checks all forms for signatures and dates once the claim is assigned.

Please refer to the Samples and Brochures section of this proposal for a copy of claim forms and correspondence.

B. What are your procedures for notifying the County of claims that are contested or denied? Please also describe procedures for notifying the County of claims in appeals and claims that may have potential problems.

Life Claim Denials & Appeals

We will notify the County before denying a benefit by sending you a written notice of the denial and an explanation of the denial to the beneficiary. We process denial letters within two business days of claim decision.

When we receive an appeal for a denied or disputed claim, wholly or in part, we send written notice explaining why we denied the claim.

The notice addresses the following issues:

- Reason for the denial
- Plan provision on which we based the denial
- Information the claimant can produce that might reverse the denial
- Steps to take to appeal the denial

The claimant has 60 days from receipt of the denial to submit a written request for review. We send the claimant a written decision with an explanation within 60 days of receiving the appeal. If we need more time because of special circumstances, ERISA provides an extension of the review period of up to 60 additional days.

We provide for one level of review for appeal of life and AD&D claims.

Disability Denials

We make several attempts to gather the clinical information needed to support disability. During the process, we keep the member updated and engaged on what information is missing to support the claim review. We may deny a claim if we do not receive the clinical information on time from the physician or if the clinical information we receive is not enough to support the disability. The member can help to prevent a denial by assisting us in obtaining the clinical information from the physician in a timely manner.

When we process a claim, the claims management system generates a notification. We mail or e-mail the notification denial to the member and e-mail the decision to the designated contact at the County.

We also call the member to notify them of the claim determination.

The employee, employer managers and HR representatives can call the Disability Service Center 24/7 to obtain claim status through our IVR system. Employers also have access to claim system reporting and can review current claim status 24/7.

Disability Appeals

When we deny or terminate a claim, we issue a letter detailing the basis for the determination, including:

- Citing the contractual provision in support of the determination
- Detailing the explanation including key information sources and documents
- Explaining the member's right to review

We also send a letter to the customer. If the member chooses to appeal the decision, either with or without additional information, our centralized appeals unit reviews the file and makes a decision to either uphold or overturn the prior adverse decision, or to request additional information.

We perform a telephonic interview with the member or the legal representative and send a written acknowledgement of the appeal. When we make an appeal determination, we send a letter to the member or their legal representative informing them of the decision with complete details of the decision rationale.

If we overturn the original adverse decision, our appeals specialist will let the disability benefits manager know and provide the rationale. The disability benefits manager will send a reinstatement letter to the member or the member's representative or, will send a letter explaining that we overturned the original decision and that we need additional information.

C. What are your quality control standards for processing claims payments accurately (frequency and dollar amount)? How is performance monitored? How would you report performance to the County? Include turnaround time from receipt of claim to payment of claim, dollar accuracy, and error frequency (actual vs. goal) for prior three years, if available. Please provide a copy of your audit results and your SAS70 report for general operations.

Life Audits

Quality consultants perform a daily audit on a random sample of processed life, premium waiver and AD&D claims. Our quality consultants also review the analyst's claim handling procedures, including:

- Correct coding
- Payment determinations
- Following settlement authority guidelines

- Obtaining proper claim documentation (e.g., proof of death, beneficiary designation, guardianship papers, etc.)
- Determination of beneficiary, including prompt handling of adverse claim situations
- Identification and handling of claims with possible AD&D benefits
- Honoring assignment of proceeds
- Compliance with State fair claims practices requirements
- Targeted audits of claims where specific gaps have been detected during the course of the normal random audits

In addition, our corporate office randomly audits the service center once a year to see that we are following procedures and to evaluate statistical and payment accuracy. Upon request, we will provide the County with the overall office quality results.

Claim Turnaround Time
We process clean claims within five business days. A clean claim is one we can process without reference to any additional information.

We process pended or complex claims within five business days of the date of receipt of the final required paperwork.

Performance results

- In 2008, we processed 91.80 percent of claims within 5 business days.
- In 2008, our Coding Accuracy was 99.55 percent.
- In 2008, our Payment Accuracy was 99.92 percent.

- In 2009, we processed 92.10 percent of claims within 5 business days.
- In 2009, our Coding Accuracy was 99.68 percent.
- In 2009, our Payment Accuracy was 99.99 percent.

- In 2010, we processed 92.6 percent of claims within 5 business days.
- In 2010, Our 2010 Coding Accuracy was 99.46 percent
- In 2010, Our 2010 Financial Accuracy was 99.97 percent

Disability Audits

We audit a random sample of short-term disability and long-term disability claims at any time during the life of the claim. We base the statistically valid sample size on three

percent of claims. This sample size allows for a 90 percent confidence level with a 5 percent margin of error.

Our auditors continuously monitor quality. They measure the accuracy of our claim management staff and perform workflow and procedural analyses of all aspects of claim administration. The auditors issue monthly, quarterly and annual reports which document the results at the individual, unit and department level. We share these internal reports with the disability and absence management training department who provide training to employees whose results reflect that need.

Claim Turnaround Time

Our standard process is to make a STD claim decision (pay, deny or pend) within five business days. In the event we are still missing information on the fifth business day, we will pend the claim and make a final determination by the tenth business day.

Our standard is to make a claim determination within 45 calendar days from the receipt of a complete claim (employee, employer and attending physician statements.) If there is missing information, ERISA allows 45 days with two 30-day extensions to make an appropriate determination.

When we have both STD and LTD, we start the transition nine weeks prior to the LTD claim effective date, with the goal of having the decision made on or before the effective date. Our goal of 90 percent allows for the fact that we may re-open STD claims after reconsideration or appeal. The transition to LTD may be late due to those circumstances.

We strive to make all of our long-term disability claim determinations as prompt as possible, while maintaining a thorough and fair evaluation. In all cases, we strive to meet the ERISA standards governing claim decisions.

Performance Results

- For year end 2011 our STD turnaround time was 98.3 percent.
- For year end 2011 our LTD turnaround time was 74.1 percent.
- Our 2010 Claim Payment Accuracy was 98.5 percent.
- Our 2011 Financial Accuracy was 99.5 percent.

- For year end 2010 our STD turnaround time was 98.12 percent
- Our year end 2010 LTD turnaround time is not available.
- Our 2010 Claim Payment Accuracy was 98.7 percent.
- Our 2010 Financial Accuracy was 98.9 percent.

- For year end 2009 our STD turnaround time was 97.48 percent.
- For year end 2009 our LTD turnaround time was 88 percent.
- Our 2009 Claim Payment Accuracy was 97.3 percent.
- Our 2009 Financial Accuracy was 98.7 percent.

Due to the proprietary nature of information contained within a SAS 70 report and our contractual obligations with KPMG, we cannot release this during the proposal phase.

D. Indicate the ceiling amount of claims that can be considered and approved for payment at various staff levels within your organization.

Life claim ceiling amounts are as follows:

- Claim Analysts have authority to pay up to $100,000. New analysts must have all claims reviewed during training.
- Senior Claim Analysts have the authority to pay up to $400,000.
- Team leads have the authority to pay up to $750,000.
- Our consultants have the authority to pay up to $1 million.
- Department Manager will authorize up to $1.2 million.
- Head of Life Operations will authorize up to $2 million.
- Anything over $2 million will be referred to the head of Group Insurance, Dental and Vision.

E. Please explain your method for handling absolute assignments and your method for handling future assignments.

We accept absolute assignments of group life insurance on our forms made as a gift or in connection with a third party transaction.

We allow members to assign their ownership rights as a gift. The member can also assign their life coverage to a viatical company. Assignments are absolute and are for all benefits under the policy with the exception of the dismemberment benefit.

Assignments must be:

Approved by the County and Aetna
Accepted by the assignee
Made on forms acceptable to us

F. Please explain your method for handling existing viatical settlements and your method for handling future viatical settlements.

Existing Assignments

When we transfer a group life plan to Aetna, existing assignments do not apply to the Aetna policy for our purposes unless we accept the assignments.

Assignments that a prior carrier plan completes may be anticipatory or non-anticipatory.

- Anticipatory assignments make the assignment also applicable to substitute policies issued by a succeeding carrier.

- Non-anticipatory assignments do not contain language making the assignment applicable to substitute policies issued by a succeeding carrier.

When an employee with an existing assignment requests us to apply that assignment to the new Aetna policy and we agree, the insured and the assignee complete, sign and date the Notice of Assignment and Request for Acceptance. They then submit the completed forms to us, along with a copy of existing assignment form from the prior insurance carrier.

Future Assignments

The member can assign their life coverage to a viatical company. Assignments are absolute and are for all benefits under the policy with the exception of the dismemberment benefit.

Assignments must be:

Approved by the County and Aetna
Accepted by the assignee
Made on forms acceptable to us

G. Describe your procedure for handling claims that are received where there is no beneficiary information on file for the participant. Describe your legal process for handling beneficiary designations, assignments and claims distributions that are challenged.

The County has the option of choosing from two contractual provisions pertaining to preferential beneficiary designations. The first provision pays life benefits to the employee's estate or to living relatives if there is no estate. The second provision, known as the Next of Kin provision, pays benefits to blood relatives who are living in the order described below:

- Surviving spouse or domestic partner
- Surviving children
- Surviving parents
- Surviving brothers and sisters

If there are no survivors, payment will be made to the estate.

Our obligation under the policy is to pay the named beneficiary, or to an alternate beneficiary when there is no named beneficiary. When issues arise making it unclear who is entitled to the benefits, we attempt to get the adverse claimants to reach an agreement. If this does not happen, we may deny the claim of one of the adverse claimants or initiate an interpleader action in court under which the court would decide who receives the benefits.

H. Describe the interest rate paid from the date of death to the date the claim is paid and how the interest is calculated.

We calculate interest based on the state interest requirement (if any), of the:

- Contract state
- Residence state of the member
- Residence state of the beneficiary

We apply a corporate interest rate if the state does not specifically indicate a higher rate.

States timeframes for when interest is payable varies to the date we pay benefits.
Some examples are date of death and receipt of proof.

I. Describe in detail the death benefit settlement options available to beneficiaries and how these are communicated to beneficiaries. Is direct deposit to beneficiary's bank account possible?

We issue benefit amounts under $5,000 in one lump sum payment and mail to the beneficiary.

We automatically deposit benefits of $5,000 or more into an Aetna Benefits Checkbook account in the beneficiary's name. While the beneficiary decides how to best use the proceeds, the account balance earns interest. The money is always accessible. At their convenience, the beneficiary can withdraw a minimum of $250 up to the entire balance at any time simply by writing a check from the personalized checkbook. There are no withdrawal penalties, per check charges or service fees. Interest compounds daily at a competitive rate and is a credit monthly to the account.

The checkbook and reorders are free. There are no fees or charges for service other than the usual charges for stop payments, check copies and returned checks. Each month, your beneficiary will receive a statement showing interest earned, account balance and account activity for the previous month.

The account will continue to earn interest as long as there is a balance of $2,000. Once the balance drops below that level, we automatically close the account at the end of the month and send the beneficiary a check for the balance.

The Aetna Benefits Checkbook service does not affect the usual life insurance claim process in any way. As soon as a

claim is processed, we open a checking account in the beneficiary's name.

We mail the checkbook directly to the beneficiary who can start writing checks as soon as the checkbook arrives. A customer service representative calls the beneficiary within ten days of the account opening to make sure the checkbook arrived and to answer any questions the beneficiary may have regarding the checkbook program.

We have a toll-free information line to answer questions about the checkbook program. This toll-free information line is off shored by our checkbook vendor.

The checkbook program is not used in the following states: Alaska, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Indiana, Kansas, Kentucky, Louisiana, Maryland, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Rhode Island and West Virginia.

If the contract or beneficiary resides in one of these states, a check will be issued instead.

We do not offer direct deposit into beneficiaries bank accounts at this time. Our beneficiaries can deposit one single check into their account from the Aetna Retained Asset Account.

J. Describe your processes to recover overpayments and payments to incorrect beneficiaries?

In those rare instances when an overpayment or incorrect beneficiary payment occurs, we will contact the beneficiary in an effort to resolve the error. If our efforts are unsuccessful, we will consider other measures such as using an outside vendor who specializes in the recovery of overpayments. Our analysts work closely with your benefits representatives and include them in the problem resolution process.

K. Describe your Accelerated Death Benefit including any eligibility requirements, exclusions and limitations.

In the event of a terminal illness or if a person is suffering from a serious medical condition, our accelerated death benefit provision allows for the early payment of a portion of the life insurance benefits. We do not treat the benefit as a loan and we place no lien on future death benefits. Also, no interest accrues on the benefit amount.

The following provisions apply:

Eligible insureds - This provision is available to employees. It is also available to the employee's spouse or domestic partner when dependent life insurance is part of the plan design (but not dependent children). There are no age restrictions on this benefit.

- Terminal illness - We consider terminal illness when an individual suffers from an incurable, progressive disease or condition and, based on reasonable medical probability, will not survive more than a specified number of months.

- Maximum amount payable - The County elects the maximum amount payable under this provision. The maximum cannot exceed the lesser of $500,000 or the applicable benefit percentage available under the plan times the plan's life insurance maximum.

- Minimum amount payable - The minimum amount payable is $5,000.

- Upon payment of the ADB, we would reduce the person's life insurance amount by the amount of the ADB payment. Thereafter, premium payments are only required on the reduced benefit amount.

- Assignments - This provision is not available to employees who have assigned their life insurance benefits unless the person to whom the coverage has been assigned the coverage gives their written consent re-assigning coverage back to the employee. Upon doing so, the member can then file for ADB coverage.

- Tax consequences for the customer - The inclusion of this benefit in The County's plan should not affect the tax status of the plan (i.e., the premium should remain deductible as a business expense). The County should rely on tax counsel for advice on such matters.

- Tax consequences for the employee - The benefit amount paid should not result in taxable income to the individual. The employee should rely on tax counsel for advice on such matters.

We usually reflect the cost of the benefit through an interest-based reduction to the amount paid, although a plan-wide charge structure is available.

Employees and spouses may request an ADB if they are suffering from one of the following medical conditions that is expected to result in a drastically limited life span. If the person is suffering from one of the following, we will not apply the life expectancy period as one of the criteria for being eligible:

- Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)
- End stage heart, kidney, liver and/or pancreatic organ failure and the person is not a transplant candidate
- A medical condition requiring artificial life support, without which the person would die
- A permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury which are both expected to result in life-long confinement in a hospital or skilled nursing facility

---

L. What steps do you proactively take to locate missing beneficiaries?

In situations where we need to locate a beneficiary in order to make a claim payment, we use a system called Accurint®. Accurint is a people locator that uses information such as someone's name, social security number, date of birth, city, etc. to determine that person's location. Accurint is very reliable and used on a regular basis in our claim operations area.

M. Describe in detail the claim adjudication process typically followed upon notification of a claim. Include what documentation is required from the beneficiary/claimant, a copy of all correspondence that is used throughout the

process, the functional areas involved and the elapsed time.

Life Claim Process

The County will submit claims directly to us on behalf of employees and beneficiaries. A life claim submission includes:

- Proof of death form
- Death certificate
- Beneficiary documents
- Enrollment form
- Other pertinent information (police reports, assignments of benefits, etc.)

We scan claims at our imaging center and enter them into our claim system within 24 hours of receipt. We then electronically assign the claim to a claim analyst, who handles on a first-in/first-out basis. The claim analyst will refer to life claim consultants for complex or questionable claims.

Aetna accepts claim documentation via fax or mail (e.g. Death Certificate, beneficiary card, funeral home assignment, etc). We do not require a claimant's statement or anything signed by the claimant prior to adjudicating the claim.

We also offer the ability for customers to create, save and submit life claims online through our online claim submission tool. The tool is available on our group insurance Employer Secure Website. The tool allows the attachment of any ancillary documents (e.g. attending physician statement, enrollment form) to the online claim. The claim will be in our imaging system within three hours of receipt.

The following outlines our claim process:

- We enter the claim into our life claim system.

- We deliver mail electronically each day to the claim analysts by account assignment.

- The claim analyst:

- Reviews the claim for completeness and requests any necessary information from the County or the beneficiary

- Requests police reports, coroner reports, etc. as needed

- Reviews contractual requirements, legislative requirements and internal standards applicable to each claim

- Processes the claim in received date order

- We produce drafts overnight and send them out the next day. We can also produce a draft on the same day we process a claim, if necessary.

The online system provides audit controls during processing. For example, each claim analyst has a specific draft authority. The system will not allow the claim analyst to pay a claim above that authority level.

We process clean claims within five business days. A clean claim is one we can process without the need for additional information. We process complex claims or claims that delay pending the receipt of further information within five business days from the date of receipt of the final required paperwork.

Once we have all the information to make a benefit determination, the analyst enters the claim decision into the life claim system. We distribute benefits as specified in the policy.

Life Claim Process with Beneficiary Management Services

The Beneficiary Management (BMS) and Claim Eligibility Services programs allow employers to out-source the handling of employees/retirees' life insurance beneficiary designation documents, claim establishment, and the servicing of employee/retiree inquiries and requests regarding their current group life benefit profile.

When we provide BMS, the notice of death can be reported directly to the Life Insurance Service Center through the toll-free customer service line or electronically. BMS representatives will verify coverage and initiate the claim filing process. We can also make arrangements to supply the notice of death and beneficiary information back to the

employer to satisfy their particular reporting requirements.

The BMS representative will pursue collection of the death certificate and other pertinent information before releasing the claim to the life claims unit. Once the life claims analyst has all the information to make a benefit determination, the analyst enters the claim decision into the life claim system. The analyst then distributes the benefit amount to the appropriate beneficiary/beneficiaries.

Disability Claim Process

We offer a variety of convenient intake methods:

Paper claim form (mail or fax)
Telephonic (via a toll free number)
Web (when an employer eligibility file is provided)

As part of our intake, we:

Educate the employee about the claim process
Verify their eligibility
Begin the return to work (RTW) discussion
Set expectations
Attempt to gather all the necessary information needed to make an initial claim determination

When we identify an employee as having both Aetna medical and Aetna disability coverage, we perform a HIPPA compliant telephonic consent process. Secure Voice Authorization allows us to coordinate in obtaining clinical information and providing our unique integrated health and disability (IHD) benefits.

Within 2 business days from creation of the STD claim we mail the employee an Introductory Letter, which again explains the claim process and may include a:

W-4 or W-4S Tax Form
Medical Authorization Form
Reimbursement Form

Next, our trained and experienced intake staff conducts a three-point contact. Three-point contact includes outreach to:

The employee (by telephone) -- if needed, to obtain any missing information not included/gathered in the initial claim submission.
The employer (by e-mail) -- to verify eligibility and confirm information about the employee's job duties and alert them to the claim.
The attending physician (by telephone and/or fax) -- to obtain relative disability related medical information.

Following the intake and based on initial diagnosis, our senior nurse reviewer (SNR) immediately reviews claims identified as needing an intensive assessment. In these cases, the SNR:

Performs an initial triage review
Assigns the claim to an appropriate disability benefits manager
Makes initial recommendations regarding additional clinical resources that may be advisable and/or potential accommodated RTW opportunities that may be present

The SNR remains engaged on these claims until claim resolution. SNRs determine the need and level of clinical oversight and claim staff necessary, assessing information such as:

Age
Past medical history
Job description
Diagnosis
Disability duration
Past disability history
Treatment and clinical information
RTW accommodations
Modified duty

Our experienced short term disability benefits managers are responsible for making all claim certification decisions and managing the employee's claim, working with them to pursue a productive and safe return-to-work. If extended claim certifications are required, the disability benefits manager will work with the employee and their provider to obtain additional medical information to support a continued disability and may refer the claim to other disability resources including clinical and vocational rehabilitation consultants for additional review and communication with the treating provider and customer with focus on return to work planning and coordination as appropriate.

At the ninth week prior to the Short Term Disability end of benefit date, a system diary flags the benefits managers for LTD consideration. It has prompts to ensure all appropriate areas are addressed, including:

- Thorough claim history summary
- Return-to-work efforts
- Current clinical status
- Specific current information that supports payment of claim
- Assessment of what is anticipated regarding timeframe from 18-26 weeks

Once this process begins, we will consider the member for transition into LTD. When appropriate, an STD clinical resource will review the claim and make recommendations for case movement and assess appropriateness of management and an action plan.

To ensure a smooth transition from STD to LTD, our claim administration system is designed to automatically create an LTD consideration task on a newly created STD claim with a task due date that can be determined on the benefit duration of the STD claim. As applicable, we conduct eligibility and pre-existing investigation and request payroll or enrollment documentation and medical records.

If the STD claim transitions into LTD, it is sent to a Benefits Liaison (BL) where the claim is assessed and possibly placed in a round table discussion to ensure the claim is appropriately transitioned and managed.

When the task is complete, it automatically creates and pre-populates the LTD claim with as much data as possible from the STD claim. The newly created LTD claim will also contain all of the necessary tasks for claim assignment, triage, initial decision, and communication. We send an LTD introductory packet to the member, requesting additional form completion and advising what is required for transition to LTD.

Once we receive the LTD packet, we enter the claim into our system and place it in "pending" status until we make an LTD claim decision. The LTD Benefits Manager checks all forms for signatures and dates once the claim is assigned.

N. What are your procedures for notifying the County of claims that are contested or denied? Please also describe procedures for notifying the County of claims in appeals and claims that may have potential problems.

We will notify the County before denying a benefit by sending you a written notice of the denial and an explanation of the denial to the beneficiary. We process denial letters within two business days of claim decision.

When we receive an appeal for a denied or disputed claim, wholly or in part, we send written notice explaining why we denied the claim. The notice addresses the following issues:

- Reason for the denial
- Plan provision on which we based the denial
- Information the claimant can produce that might reverse the denial
- Steps to take to appeal the denial

The claimant has 60 days from receipt of the denial to submit a written request for review. We send the claimant a written decision with an explanation within 60 days of receiving the appeal. If we need more time because of special circumstances, ERISA provides an extension of the review period of up to 60 additional days.

We provide for one level of review for appeal of life and AD&D claims.

O. What are your quality control standards for processing claims payments accurately (frequency and dollar amount)? How is performance monitored? How would you report performance to the County? Include turnaround time from receipt of claim to payment of claim, dollar accuracy, and error frequency (actual vs. goal) for prior three years, if available.

Life Audits

Quality consultants perform a daily audit on a random sample of processed life, premium waiver and AD&D claims. Our quality consultants also review the analyst's claim handling procedures, including:

- Correct coding
- Payment determinations
- Following settlement authority guidelines
- Obtaining proper claim documentation (e.g., proof of death, beneficiary designation, guardianship papers, etc.)
- Determination of beneficiary, including prompt handling of adverse claim situations
- Identification and handling of claims with possible AD&D benefits
- Honoring assignment of proceeds
- Compliance with State fair claims practices requirements
- Targeted audits of claims where specific gaps have been detected during the course of the normal random audits

In addition, our corporate office randomly audits the service center once a year to see that we are following procedures and to evaluate statistical and payment accuracy. Upon request, we will provide the County with the overall office quality results.

Claim Turnaround Time
We process clean claims within five business days. A clean claim is one we can process without reference to any additional information.

We process pended or complex claims within five business days of the date of receipt of the final required paperwork.

Performance results

- In 2008, we processed 91.80 percent of claims within 5 business days.
- In 2008, our Coding Accuracy was 99.55 percent.
- In 2008, our Payment Accuracy was 99.92 percent.

- In 2009, we processed 92.10 percent of claims within 5 business days.
- In 2009, our Coding Accuracy was 99.68 percent.
- In 2009, our Payment Accuracy was 99.99 percent.

- In 2010, we processed 92.6 percent of claims within 5 business days.
- In 2010, Our 2010 Coding Accuracy was 99.46 percent
- In 2010, Our 2010 Financial Accuracy was 99.97 percent

Disability Audits

We audit a random sample of short-term disability and long-term disability claims at any time during the life of the claim. We base the statistically valid sample size on three percent of claims. This sample size allows for a 90 percent confidence level with a 5 percent margin of error.

Our auditors continuously monitor quality. They measure the accuracy of our claim management staff and perform workflow and procedural analyses of all aspects of claim administration. The auditors issue monthly, quarterly and annual reports which document the results at the individual, unit and department level. We share these internal reports with the disability and absence management training department who provide training to employees whose results reflect that need.

Claim Turnaround Time

Our standard process is to make a STD claim decision (pay, deny or pend) within five business days. In the event we are still missing information on the fifth business day, we will pend the claim and make a final determination by the tenth business day.

Our standard is to make a claim determination within 45 calendar days from the receipt of a complete claim (employee, employer and attending physician statements.) If there is missing information, ERISA allows 45 days with two 30-day extensions to make an appropriate determination. When we have both STD and LTD, we start the transition nine weeks prior to the LTD claim effective date, with the goal of having the decision made on or before the effective date. Our goal of 90 percent allows for the fact that we may re-open STD claims after reconsideration or appeal. The transition to LTD may be late due to those circumstances.

We strive to make all of our long-term disability claim determinations as prompt as possible, while maintaining a thorough and fair evaluation. In all cases, we strive to meet the ERISA standards governing claim decisions.

Performance Results

- For year end 2011 our STD turnaround time was 98.3 percent.
- For year end 2011 our LTD turnaround time was 74.1 percent.
- Our 2010 Claim Payment Accuracy was 98.5 percent.
- Our 2011 Financial Accuracy was 99.5 percent.

- For year end 2010 our STD turnaround time was 98.12 percent
- Our year end 2010 LTD turnaround time is not available.
- Our 2010 Claim Payment Accuracy was 98.7 percent.
- Our 2010 Financial Accuracy was 98.9 percent.

- For year end 2009 our STD turnaround time was 97.48 percent.
- For year end 2009 our LTD turnaround time was 88 percent.
- Our 2009 Claim Payment Accuracy was 97.3 percent.
- Our 2009 Financial Accuracy was 98.7 percent.

P. Describe how would you handle the recovery of an overpayment that results when a claimant has been receiving LTD benefits for a period of time (6 months or longer) and they receive a retroactive Social Security award that is more than the LTD benefits that the claimant has received?

We offer a convenient method for members to repay an LTD overpayment resulting from a retroactive SSDI award. Our social security vendor representatives explain how a disability plan overpayment happens. They reiterate throughout the representation process the member's obligation to repay an overpayment should they receive SSDI benefits retroactively. The member signs a preauthorized withdrawal consent form allowing the vendor to withdraw the overpayment amount from their personal bank account.

The vendor provides benefit information to the benefits manager when they grant a retroactive SSDI award. The manager calculates the overpayment amount owed by the member. When a deposit is made of the retroactive SSDI benefits into the member's personal bank account, our vendor will execute an electronic funds transfer of the overpayment amount and forward the amount to Aetna.

Section 7: Communication Materials

A. Communication Materials such as copies of any forms, brochures, enrollment materials, statements and any other pertinent written documentation which would be provided to eligible employees and retirees and/or plan participants.

Please refer to the Samples and Brochures section of this proposal for copies of communication materials sent to eligible employees and plan participants.

B. Describe, and provide samples of written materials (i.e. SPDs, forms, form letters, etc.) that will be used to communicate to eligible employees and retirees. Specify which communications materials are included in the overall price quote and which would be billed separately.

Aetna drafts booklet/certificates which we provide to the County's employees. We do not create Summary Plan Descriptions (SPDs).

Booklet/certificates are not intended for use on their own to satisfy legal obligations of the County under ERISA to provide an SPD. We have sample language the County can choose to attach to the insurance booklet certificate drafted to comply with the SPD regulations, but the County must rely on the review and advice of its own legal counsel to determine if that sample language satisfies the legal obligations of a customer regarding SPDs under ERISA.

Our communications material provides a multifaceted communications strategy based on a common understanding between Aetna and the County of how to effectively communicate to your employees. We design our standard materials to be "account specific" which usually eliminates the need for customization.

If the customer's needs require customization, Aetna Customized Communications Group (CCG) is available to partner with customers to develop and deliver customized materials. CCG, our strategic communications consulting group, has more than 25 years of experience in customized benefit communications and offers a broad range of products and services to meet customer needs.
To support a multi-faceted communications strategy, our Workplan Marketing and Enrollment Services has developed different types of communication materials and tools used to educate and inform the County's employees about new insurance benefits. We designed our standard materials so that we can make them specific to your plan design and eliminate the need for significant customization. An Aetna Marketing Consultant will work closely with you to provide a menu of marketing materials from which to choose.

Please refer to the Samples and Brochures section of this proposal for copies of our standard communication materials.

C. Describe how you keep abreast of Health Care Reform. The County expects that you will provide understandable benefit summaries to the County and its employees; can you meet this requirement?

We are well positioned to meet the diverse needs of the new health care marketplace. For several years, we have been working with doctors and hospitals, employers, consumers, public officials and others to build a stronger, more effective health care system. Our goal is to make quality health care more affordable and more accessible for all Americans.

To achieve this goal, we continue to evolve our business model to:

- Consistently deliver innovative products and services to help employers maintain a healthy and productive workforce
- Empower consumers to better manage their health and health care dollars
- Work with providers to help them increase efficiency, improve quality and lower costs

We support these efforts by:

- Building on our core capabilities of benefits design, disease and care management, network management and customer service
- Investing heavily in health information technology to provide tools and information to help people get and stay healthy
- Integrating information and services to support clinical excellence and evidence-based care that achieves the right outcomes

To that end, we view health care reform as a catalyst for change:

- We are focused on effective implementation of the law and fostering compliance. We continue to advocate for workable regulations to avoid unintended negative consequences of the new law; thereby protecting our customers and our members.

- We are advocating for changes that add value for consumers. We remain a constructive advocate for a regulatory and policy environment that encourages competition, choice and flexibility for consumers.

- We play a unique role in driving positive changes in health care:

  Paying for quality and not just quantity of services delivered
  Collaborating with providers to build a better system of care
  Offering innovative products in a post-reform environment

One of the biggest challenges we face in the short term is having the rules written in a way that is best for the American consumer -- and that we focus on avoiding unintended consequences of the legislation or the rulemaking process as we try to deliver more affordable coverage for millions more Americans.

To accomplish this, we have continued to offer the benefit of our experience to the rulemaking phase of reform implementation, to help ensure that the new law is implemented in a workable fashion and to encourage additional measures, such as a renewed focus on health care cost drivers to attain reform across our system. We know that the biggest concern all our customers, employer and individuals face is the rising cost of health care, and we must continue to focus on this issue to help deliver better value in the future.

We also are preparing for the marketplace evolution that will occur by 2014 (i.e., with the implementation of the health insurance Exchanges). Recognizing that we have a strong brand, our mission continues to be to deliver value for our customers, whom we put at the center of everything we do. As such, we will be increasingly involved in the discussions around the appropriate design of health insurance Exchanges, because we know that Exchanges are likely to impact the health care purchasing system, particularly for individuals and small group employers (2 to 50 employees). We are committed to the individual and

small group markets where we can maintain viable and affordable product offerings.

We support insurance exchanges that help consumers navigate a competitive insurance market and choose the plan that best suits their needs:

- Exchanges should provide convenience and transparency so the consumer can choose a plan that addresses specific needs.

- Exchanges should empower consumers by involving them more directly in health-related economic decision making, and choosing plans and providers.

- Exchanges should be designed to avoid adding cost to consumers and cost of insurance.

Consumers are demanding more transparency for cost and quality, and we provide multiple tools and resources, including providing payment estimators in those markets where we can release information. We are also responding to the need for better integration and information exchange across the health care system. We have invested billions of dollars in companies and technologies that are making a difference in the lives of consumers and their physicians. We know that our investments in health information exchange technology, such as through our acquisition of Medicity, can deliver a better-connected health care system for consumers. We know that our investments in the our portable personal health record systems and programs such as our CareEngine are delivering actionable information to providers at the point of service to help improve the quality of care and drive down costs in the system.

The key to making health care reform work in the future is to ensure that the individual mandate is adequately enforced, even as we change the rating systems, which could cause some individuals to choose not to be covered and just pay the limited $95 fine for the first year. If only those individuals who need health care services immediately joined up for coverage in 2014, the resulting system of coverage in the Exchanges would be unaffordable because prices within the market would increase at a rapid pace with no balance in the risk pool of consumers.

There is more to do beyond the single new law. Health care reform is an evolutionary effort, and we intend to be involved every step of the way.

Going forward, we will continue to leverage our advocacy position for several key areas of focus, all necessary to ensure the effectiveness of health care reform. Specific examples include:

- Working with our employer partners to address their major concerns with the new law so that it is implemented in the best possible manner for their employees

- Addressing the true drivers of medical costs, which are largely responsible for rising health care premiums, including hospital and drug costs, which continue to rise every year

- Reforming the medical payment system to pay for quality and not just the quantity of services delivered

- Harnessing the power of health information technology to improve connectivity and quality while driving down costs Improving the quality of health care outcomes through targeted, population-based programs that help consumers live healthier lives and manage chronic conditions better

---

Section 8: Customer Service

A. The County desires a toll-free number for claims and/or customer service. The minimum expectation is that customer service should be available from 8:00 am to 5:00 pm, Monday through Friday EST, with a procedure for handling after-hours calls and returning them the next business day. Describe your customer service hours, other avenues for contact (i.e. email, fax, online chat) and procedures for answering and responding to inquiries.

Life

Life customer service representatives are available through our toll-free number weekdays from 8 a.m. to 7 p.m., ET. We return voice mail messages we receive after hours within one business day.

Our customer service representatives (CSRs) are here to help our members and customers get the information they need and answer any and all questions they may have.

It's extremely important to us that members can get the information they need whether it's related to their health coverage, the care of a loved one, or help with facing an emotionally stressful and draining period. If a member has questions, he or she can reach us through:

- Email - through the "Contact Us" feature on Aetna.com
- Fax
- Our toll-free telephone number

At this time, we do not have the capability for members to use instant messaging.

We have also given our CSRs rigorous training to help members navigate our website step by step to find the information they need. While our CSRs are knowledgeable of our website's inner-workings, they do not have the ability to view a member's own secure site.

Disability

Our South Portland, Maine Disability Service Center will be responsible for disability claim management. Customer service is available 8 a.m. to 8 p.m. ET Monday through Friday, excluding holidays. We have designated toll-free numbers for our customers and their employees to use. Customer service representatives (CSRs) provide centralized customer service support for the disability service center after the initial claim set up.
If our customer service center receives calls after hours, the caller will hear a message that we are currently closed, and they may call back during regular business hours. The message then gives our business hours to the caller. We also provide each claimant the ability to email to a secure monitored email address with questions. Our experienced Customer Service Representatives ensure all emails are answered and/or directed to the appropriate case manager.

B. If your customer service standards are different in responding to customer service calls from employees versus calls from County benefit staff to your account manager, please describe availability of the account manager and the claims processor and response standards.

If the County has questions they can contact their Account Team, who will make every reasonable attempt to return the

call that same day. Customer Service Representatives return voice mail messages we receive after hours within one business day.

C. The County wants a dedicated Account Representative and Claims Processor, are you able to accommodate?
We will provide the County with designated account management and claim teams. We have found designated teams provide our customers with greater bench strength and flexibility.

Section 9: Reports and Recordkeeping

A. How will participant data be maintained in your system? How is data updated? How will you protect the confidentiality of information for the County, employees, retirees, and beneficiaries? What type of controls do you have in place to ensure the security of the information?

Our claim system is an online, real-time mainframe system that we developed internally with assistance from full-time, on-site IBM personnel. The software is a modified package purchased from XYBERNET.

The system maintains an electronic file for each claim. A coverage record for each of the employee's life-based coverage's identifies the:

- Type of coverage
- Effective date of the coverage
- Benefit amount

We can add a series of action records to the file to identify incoming and outgoing mail, document events that affect the status of the claim, and document payments.

We maintain the confidentiality of member information using various security levels within our systems. Our claims system monitors and reports system use by all personnel. Only supervisors can change the access level of claims personnel.

B. How long do you retain claim forms or other documentation sent by those claiming benefits under the plan? How is the information kept (i.e., imaging system, microfiche, hard copy, etc.)?

We maintain claim records online in our disability systems for a minimum of 20 years or as contractually defined if another agreement or plan provision requires a separate retention period. We archive claim and financial records for at least seven years.

C. Provide copies of standard reports that are provided to your clients. At a minimum, sample reports should be submitted which provide detail on claims experience and premiums received, as well as a sample for how you will track your performance for compliance with the proposed performance guarantees. Indicate which reports are available online.

Life Reports

Our standard life reports are available online. Our standard reports include:

- Life Claim Activity Report - This report presents claim information on each employee and summarizes each claim. We can issue it monthly, quarterly, semiannually, or annually. An electronic copy is available via an e.Port secure website upon request from the County. Customers can view the report on the first or second business day of the month. This option requires a specific request from the County and a modest lead time to establish the appropriate connections within the system. Along with an electronic copy via the e.Port secure website, we also mail a paper copy of the report to the County.

- Life Disability Approval Report - This report presents Premium Waiver/Death Benefit Only-Aetna Investigates Death claim information on each employee and a summary of all claims. We can issue it monthly, quarterly, semiannually, or annually.

- Evidence of Insurability Detail Report - Upon request, the County may receive medical underwriting reports which show applications submitted for evidence of insurability. This report contains:
  - The insured's name and social security number
  - The date the application was received
  - Coverage amount requested

- The status of coverage
- Approval dates

Disability Reports

We provide real-time access to claim data through online disability claim reports. A large number of data fields are available for review including, but not limited to, the following:

- Employee social security number and/or employee ID
- Employee date of birth (day, month, year)
- Gender (male/female)
- Job code
- Supervisor name
- Date of disability (day, month, year)
- Nature of illness/injury
- Benefit commencement date
- Monthly or weekly rate of pay
- Social Security benefit - offset amount
- Other offsets
- Monthly disability benefit (gross, before taxes)
- Claim status (active, pending, denied, closed)
- Work state code
- Medical provider
- Date of first medical examination
- Diagnosis, primary and secondary
- Return to work status - Yes/No
- Date released return to work (RTW) with restrictions
- Date of release without restrictions
- Date of return to work
- Vocational rehabilitation - Yes/No
- Litigation - Yes/No

For fully insured business we would never release a report containing diagnosis and employees name or ID. We would only provide summary level diagnostic data or claimant level but without any information that would reveal the claimants ID. In addition, we do our best when providing the latter of the two to make sure there are no other reports available to the customer that contain a common field which would allow them to connect the dots and identify the person.

For ASC business, either their ASC contract must be signed or in the absence of this, we need a signed Indemnification letter in order for the customer to pull a report from WKAB that has both employee name/id and diagnosis information.

All data requested must be the minimum amount of information necessary to allow the customer to administer their plan and must be used for plan related purposes.

Please refer to the Samples and Brochures section of this proposal for a copy of our Life and Disability Reporting Packages.

D. Describe the process for the County to request non-standard reports and any charges associated with non-standard reports.

If the County wants to request that we generate a report that is not available as a standard report they would alert their Account Team. They will then submit an individual request through our IT area and obtain a pricing for the development and generation of the report. Additional charges may apply based on the level of customization.

E. Copies of any reports, statements or other materials which be provided to the plan administrator.

Please refer to the Samples and Brochures section of this proposal for samples of our standard Reporting Packages.

Section 10: Technology

A. Provide technology description and requirements (i.e., network, firewall, file layouts, etc.) for electronic transfer of data

---

We use a tiered firewall system to prevent intrusion of unauthorized traffic into Aetna's internal network. The Cisco 1st tier firewalls check to see if incoming requests are requesting access to data or services on a particular server located in the De-Militarized Zone (DMZ). If the appropriate host is located, the request is sent to the appropriate server otherwise the request is denied. The 1st tier firewalls have been setup as default to block everything, except what has been defined to them as acceptable.

All 2nd tier Sidewinder firewalls, by default, are set-up to deny initiation of requests from outside hosts. This means that only requests initiated by servers within the DMZ will be accepted by the 2nd tier firewalls or depending on the type of service requested, the firewall has been configured to allow certain traffic through.

There are no software or hardware components that the County is required to load and or have in order to support data exchange.

B. Please explain your ability to administer the plan electronically. (i.e.: electronic enrollment and beneficiary designation, employee self-service, medical underwriting, claims administration, billing, etc.).

Beneficiary Designations

Under our Beneficiary Management Program, we accept electronic beneficiary information from our customers. Prior to setting up this program, our IT specialists need to review the procedures for collecting and transmitting beneficiary information. We also require a signed hold harmless agreement to indemnify us against adverse claim situations that may result due to the electronic data feed.

Online EOI

Members can complete their life and/or disability evidence of insurability (EOI) application online. The County sends us a standard Aetna eligibility file* and based on the information on the file, we produce and mail a personalized EOI package to the member. The cover letter provides the member with the website address for the online EOI submission system. The member has the choice of completing the EOI form online or mailing a paper EOI form.

If the member chooses to use the online tool, the system will request the:

Last name
Date of birth
Zip code
Social security number or Employee ID Number

The system verifies this information against our database. If the information matches, then the member can log into

the system. The system displays the life and/or disability coverage that the member currently has and the amount of coverage they are requesting. The medical questions from the online system are the same questions as those on the paper application. However, with the online application, the questions are dynamic. For example, the pregnancy question only displays if the member is a female. Also, depending on whether the member answers yes or no to a question, further questions may display.

Benefits of the online EOI submission include:

Online applications are submitted complete and legible
Eliminating processing delays and reducing turnaround time
Separate application for each applicant
Application status links to the Employer Secure Website
Online application eliminates mail time

Customer can submit the eligibility file as frequently as they wish. Our recommendation is for a weekly file during any annual enrollment period and then switching to a monthly frequency.

Online Claims Administration

We offer the ability for customers to create, save and submit life claims online through our online claim submission tool. The tool is available on our group insurance Employer Secure Website. The tool allows the attachment of any ancillary documents (e.g. attending physician statement, enrollment form) to the online claim. The claim will be in our imaging system within three hours of receipt.

The County or the employee may submit a claim via our Workability web portal. The intake script will be completed by responding to a series of prompts which will generate depending upon the conditions of the claim. If the script is not completed, it will be send to a queue for follow-up after assignment to an intake analyst.

After claim submission, an e-mail notification is sent to the designated the County contact as notification of the employee's absence from work. This notification specifies the dates of the employee's absence.

Employee Self Service

Our WorkAbility portal provides employees access for a variety of reasons. The functions available to employees include:

- Initiate a disability claim
- Provide a return-to-work notification
- Event triggered e-mail notification to supervisors or Human Resources
- Obtain claim status including payment information, if applicable
- Obtain leave balances
- Customer service inquiry
- Access downloadable forms
- Access a list of frequently asked questions
- View a listing of claim payments (within the last 3 years)
- Print and save a copy of the pay stub

Online Billing

We can set the County up to pay electronically if this is something they are interested in.

Online Administration and Enrollment

Aetna Group Insurance has several approaches by which we can either integrate with, or provide tools and services to the County, to support their requirement for Online Administration and Enrollment for the Aetna Group Insurance products under consideration.

We believe our approach allows the County to consider whether they would prefer to leverage their existing technologies already in place at the County, or to allow Aetna to provide solutions for the County that may allow for significant cost savings from what otherwise would be invested in the Oracle systems to satisfy the online enrollment needs.

Option 1: Leverage Existing Oracle Tools and Systems

Aetna would work with the County's Oracle administrators to ensure that our plans, products, rates, eligibility criteria, waiting periods, communications materials, content, and evidence of insurability rules are all configured in the Oracle system to meet the needs of properly determining an individual's ability to enroll in the various Aetna coverages selected. This would include being able to properly display the products and coverage amounts for which each person would be eligible, what amount would be considered as "Guaranteed Issue", and what amounts may be subject to Evidence of Insurability (EOI) processing.

Aetna would work with the County's Oracle administrators to determine what is needed to support both the employees themselves and the County's administrators to log into the Oracle system and make their own enrollment choices themselves, online.

Aetna would work with the County's Oracle administrators to determine what data files, and at what frequency they would need to be sent to Aetna for such "functional file" processing as determining the medical underwriting needs, any beneficiary data requested or needed by Aetna, or any other data files to enable such capabilities as our telephonic claim intake function for the Aetna Disability products.

Aetna would work with the County's Oracle administrators to determine the EOI Status Updates and Approvals file needs, so that correct reporting and payroll deductions for newly-approved coverages could be produced, and reporting from within the Oracle system correctly handled.

With the Aetna tools and systems functional, we would provide access and training to the Aetna Employer Secure Website for such items as the ability to file claims online, access reports for EOI status, Paid / Pending Claim status reports, and more.

Option 2: Leverage Aetna Tools And Solutions Instead of Oracle

Aetna would provide an online, web-based benefits administration and enrollment tool directly to the County's employees and administrators, so employees could each access their own personal data, see what they are each eligible for, and make enrollment transactions themselves. Administrators would have access to employee data, as they may perform tasks on the employee's behalf, but Aetna can restrict the administrator access to "only" their particular department's employees or bargaining or non-bargaining entities, depending on the County's preference. The Aetna tool could save the County significant direct expenses associated with Oracle consulting, programming and usage fees needed to customize the Oracle system to support the Aetna plans and products.

The Aetna solution would provide the direct ability for employees to make their own enrollment elections, online, and immediately complete any EOI paperwork, if so determined by the Aetna system. Upon the employee completing the EOI, decisions in most cases can be rendered on-the-spot and proper payroll authorization delivered back to the County on a weekly, bi-weekly, or monthly basis. Additional systems and tools at Aetna would be automatically updated, such as the Aetna Employer Secure Website for such items as the ability to file claims online, access reports for EOI status, Paid / Pending Claim status reports, and more.

The time and cost savings to the County could be greater, with enhanced workflow, automated processing, data file connectivity, already having been established and factored into the delivery of the Aetna tools and solutions. The dollar savings would be directly commensurate with the anticipated costs by the County to pursue the activities in Option 1 identified above, and would require further discussion between Aetna technical consultants, the County, and your Oracle administrators on how best to proceed.

We look forward to further discussions with the County regarding the option they may be interested in. Additional fees may apply based on the level of service established.

C. Please provide specifications of the format required for any interfaces and how data is transferred (i.e. secure website, ftp, secure email).

We are capable of accepting a variety of electronic eligibility feeds and work closely with our clients to establish mutually agreed upon methods. Our preference for electronic eligibility file transmission is through the secure file transfer protocol/standard. We support the following variations of this standard protocol - AS2, https, s/ftp, ftps, SSH/SSH2.

In regards to our Beneficiary Management Services, we accept 600 byte file feed or excel format for electronic eligibility information and 900 byte file feed for electronic beneficiary information. There are also several additional file layouts available depending on the services we will provide which could include Conversion/Portability support and On Line Evidence of Insurability. These layouts are available in Excel and TXT.

D. Describe any online access and tools the County, as Plan Administrator, will access and employers/beneficiaries may access.

Our internet service capabilities begin with our Employer Secure Website (ESW). The ESW is a web-based application that provides life and disability information to our customers and their designated representatives. This tool allows users to access information that previously required direct contact with Aetna employees. The site features:

One-stop benefits administration for your Aetna health, life and disability benefits and insurance plans and policies

Single sign-on to our various self-service applications and websites

Easy-to-navigate home page with the tasks you use most only a click away

We back ESW by a secure electronic interface, with encryption technology and a unique ID and password. The

County determines who has access to the ESW and we set security criteria for the site for each user.

We also offer support specific to disability and leave management. For our disability customers, we can link from the ESW to our claim administration system, WorkAbility®. Employers can initiate short-term disability, long-term disability, Family and Medical Leave Act and other leave claims through a standard Web browser. Employers are able to:

Initiate a disability claim
Provide a return-to-work notification
Event triggered e-mail notification to supervisors or human resources
Obtain claim status
Obtain leave balances
Customer service inquiry
Access downloadable forms
Access a list of frequently asked questions
View and download reports
Add and confirm an employee's eligibility
Update LOA intermittent time
Enter a return to work date
Enroll in direct deposit online via WorkAbility®
View expanded claim status information, including information on providers, vocational rehabilitation, workers' compensation, offsets and deductions, and social security information
Manage contact information

Customers have a robust web-based reporting tool available to them that provides users with online on-demand disability and leave reports.

Our technological tools are subject to strict security protocols and processes. This includes secure firewalls, significant use of various forms of encryption, virus and spy ware protection, stringent password protocols and intrusion safeguards.

E. Please include a link to or a CD with screen shots of your administrator and participant website(s).

A demo of our Employer Secure Website can be found through the following link:
https://qa3www.aetna.com/pssel/loginPssel.fcc

We have a presentation (demo) that provides an overview of the system's capabilities, located at http://www.aetna.com/plansandproducts/workability/WorkAbility©.html. We can also offer the County a webinar to demonstrate the look and feel of the system. If the County prefers, we can provide an ID and password to a specific contact for a limited access Vista demo site.

F. Describe any online access and tools employees may access.

Our WorkAbility portal provides employees access for a variety of reasons. The functions available to employees include:

- Initiate a disability claim
- Provide a return-to-work notification
- Event triggered e-mail notification to supervisors or Human Resources
- Obtain claim status including payment information, if applicable
- Obtain leave balances
- Customer service inquiry
- Access downloadable forms
- Access a list of frequently asked questions
- View a listing of claim payments (within the last 3 years)
- Print and save a copy of the pay stub

G. Describe how you ensure the security of information passed over the internet or through other electronic transmissions between the insurer, the County, and/or participants.

Encryption is one of the many security technologies Aetna uses to protect the confidentiality of data and information.

Consideration is given to:

- Regulations and national restrictions that might apply to the use of cryptographic techniques in different parts of the world,
- Issues of trans-border flow of cryptographic information, and

- Controls that apply to the export and import of cryptographic technology.

Where the use of encryption technology is appropriate, Security Services assessment takes into consideration not only the type of encryption algorithm to use, but the length of the required cryptographic keys as well.

E-Mail

Protecting the privacy and security of sensitive information has always been a priority at Aetna. We require that our employees encrypt all e-mails to third parties that contain member-specific health and financial information--this includes but is not limited to:

- Personal and demographic information (name, SSN, address)
- Employment information
- Payment of benefit information
- Identity of doctors, dentists and other health care professionals and facilities
- Diagnoses or treatments
- Claim status
- Services associated with behavioral health or sexually transmitted diseases

All e-mail sent from customer and provider service personnel through our Customer Relationship Management application are automatically encrypted. Employees must review the content of other e-mail and select the "Send Secure" option to encrypt other e-mail sent to external recipients.

All e-mail leaving the Aetna is scanned. If an e-mail message includes sensitive data the e-mail is automatically encrypted before it is sent to any external recipients.

We offer a variety of secure e-mail solutions. The most widely used methods include:

Transport Layer Service

We use Transport Layer Security, an encryption technology, to establish affiliate connections between Aetna and third parties. This method provides a seamless solution for Aetna and affiliates to send and receive encrypted e-mail transmissions.

Post-X

Post-X is a company-wide outbound e-mail encryption solution. Use of encrypted e-mail enables Aetna to send quick, reliable communications while maintaining our commitment to protecting the confidentiality of member-specific health and financial information. We scan outbound e-mail. If we detect sensitive data in an unencrypted e-mail, we automatically encrypt the e-mail and notify the sender. E-mails containing internal use only information are rejected and sent back to the sender.

Pretty Good Privacy (PGP)
PGP is available on an individual basis in order to meet e-mail encryption requirements not supported by TLS or Post-X. Use of PGP to create an encrypted communications channel between Aetna and any other party is not supported.

Transport

Other options for encrypting restricted or confidential information over a public communications network include:

Secure File Transport (SFTP)
We use SFTP for high-volume and/or large file transports. Data is at rest only within our internal network, which is behind two sets of firewalls. The encryption level is 128 bit SSL, and, to ensure changes to files have not occurred, data integrity checking is inherent.

Virtual Private Network (VPN)
We use VPN for external connections including off-site employee connections. 256 bit AES encryption is used, dual factor authentication for client to network VPN is required, and inactivity time-outs are built into the configuration.

H. What quality check and timelines are currently in place to ensure accuracy of the file transfer and loading of the data? Is there a timeframe to fix any errors?

Every implementation is unique and once a customer comes to Aetna, we start the discussions regarding producing a live file feed and the testing of the feed. We work with the customer regarding timelines on test files and our preference is to have 90 days to produce a live file and to test the file. This timeframe can be longer or shorter

depending on each implementation and if a third party vendor is involved.

Test files can be sent through password protected files or through the FTP secured
method. We can provide a Beneficiary Management Services (BMS) eligibility file error report to the County after we process each BMS file. Normally, we would post the error report to an FTP folder on our site for the County to retrieve, review, and make any needed corrections for their next BMS file. The error reports list each employee record that has encountered an edit along with the related error message. We will review the first few reports with the County so the County understands the reports and what corrections they need to resolve.

I. Describe your enrollment and claims processing systems, to include names, date of implementation, scheduled changes/upgrades, system limitations, etc.

We process life claims on Aetna's Life Claim System (LCS). The software we are currently using has been in place since 1993. We upgrade as product and services change or innovations warrant. We have a team of developers who maintain and update the software. We use the software package Endeavor to manage code.

Our claim system includes the following features:

- Automated claim payment
- Audit controls
- Security devices to reduce the potential for fraudulent claims
- Electronic interfaces with other pertinent in-house systems such as our Claim Reporting System and Coverage Card Inquiry system

Our claim system is an online, real-time mainframe system that we developed internally with assistance from full-time, on-site IBM personnel. The software is a modified package purchased from XYBERNET.

The system maintains an electronic file for each claim. A coverage record for each of the employee's life-based coverage's identifies the:

- Type of coverage
- Effective date of the coverage
- Benefit amount

We can add a series of action records to the file to identify incoming and outgoing mail, document events that affect the status of the claim, and document payments. We archive claim and financial records for at least seven years.

Our disability claim administration system, WorkAbility©, is a propriety system which Aetna owns exclusive rights to. We acquired it as part of the Aetna acquisition of Broadspire in April of 2006. WorkAbility FMLA/LOA administration became operational in 2003 and was enhanced to provide for any changes to federal, state, and company leave programs. WorkAbility has administered disability (STD, LTD and PFL) administration since 2005.

Our WorkAbility© (WKAB) intake and claim management system provides a totally integrated solution for short-and long-term disability management services and all other employee leave programs, including Family and Medical Leave Act administration. This web-based system enables sharing of all claim data across products and functions, resulting in increased productivity for the entire claim process.

In addition to improved functionality and flexibility, WKAB offers clinical analysis and benchmarking of trends that will help you manage your absence programs more effectively. The breadth and depth of this feature is unmatched in the disability industry today.

Finally, we provide a robust reporting capability called WKAB Reports. This is a web-based reporting tool that provides users with online on-demand disability and leave reports. The primary data source for the WKAB Reporting tool is the WKAB claim management system database. The reports have "real-time" reports that extract data directly from the WorkAbility claim management system database as well as reports that we run against the data warehouse.

The data warehouse refreshes each night. The data is also available for quarterly and annual historical reporting. You will be able to download data from your hosted reports

into Access, Excel or other format for data manipulating at your workstations, reducing the need for ad hoc reports. We have the ability to provide a wide range of standard reporting.

J. Describe the procedures in place for responding to a system failure and business continuity planning. Is redundant equipment maintained on or off premises? What arrangements are made for transferring paper files, telephone services and data processing services to another facility in the event of a severe interruption or disaster? How often are the business recovery procedures tested and updated? Please provide documentation

---

Our disaster back-up and recovery strategy is to provide and maintain an internal disaster recovery capability. The strategy leverages our internal computer processing capacity of our two large, state-of-the-art hardened computer centers located in Middletown and Windsor, Connecticut. Both facilities have extensive fire suppression systems, dual incoming power feeds, UPS and backup diesel generators which provide 24x7x365 operations. Physical access is strictly controlled and monitored and access to vital areas is segregated by floor and business function where appropriate. The two data centers house Aetna's computer processing capabilities on 3 major platforms, mainframe (Z/OS), mid-range (UNIX), and LAN (Windows). The data centers are load-balanced and supplemented by quick ship and capacity on demand contracts so each center can back the other up in the event of a disaster. Contracts with national vendors are maintained to obtain replacement equipment and supplemental capacity as needed to ensure recovery time objectives (RTO) can be met.

In the event of a data center disaster, the RTO to resume most production processing is four days from disaster declaration for all mainframe and mid-range systems, five days for LAN systems. A smaller portfolio of highly available applications such as web and pharmacy applications have RTOs of six hours or less and use mirroring and/or load balancing technologies between the data centers to provide for the RTO defined by the business unit. Our voice and data network backbones are fully redundant using Sonet ring technology and are recovered within one hour of a data center outage. In summary, Aetna's data center recovery strategy and its application

RTO's are consistent with, or better than, industry standards.

The Aetna Information Services (AIS) Executive IT Disaster Recovery Plan is the high level plan for recovery of a data center and its critical components. The plan is derived from 52 detailed IT infrastructure plans which are maintained by each critical support area. The plans contain processes and procedures to recover all functions, services, and equipment which are needed to recover either data center. These plans are centrally maintained by our disaster recovery group, are stored both locally and offsite and are updated quarterly or as needed by the respective infrastructure area.

Application recovery plans document technical and management contacts, application recovery specifics, application dependencies, integrated system synchronization, and checkout procedures. The plans are maintained routinely and utilize automated recovery processes to insure appropriate data identification and timely recovery. Plans are verified through yearly reviews with the application owners and business users as well as periodic integrated walk-troughs.

Escalation and notification procedures are contained within disaster recovery plans to ensure recovery team members, affected partners and business unit owners are activated in a timely manner.

Aetna Information Service's role in a disaster is to lead, manage and for the most part staff the recovery teams which will be augmented by vendor specialist under contract to do so.

Infrastructure and application data is secured and stored offsite on a daily basis. Backed-up data are cross vaulted between the two computer centers, with mainframe backups stored primarily on disk media and mid-range/LAN backups stored primarily on tape.

In addition to the backup mechanism, production data stored on Direct Access Storage Devices (DASD) are remotely and synchronously replicated from the Middletown systems to DASD target devices in the Windsor Data Center and from the Windsor production systems to DASD target devices in the Middletown Data Center.

Any customer data lost as a result of a data center catastrophe will be recovered through re-submittals by service providers and/or recovery reconciliation teams. Our current Disaster Recovery program has been in place since 2000, and the plans are updated semi-annually.

Please refer to the Samples and Brochures section of this proposal for a copy of our Disaster Recovery Plan.

Section 11: Financial Information

A. Describe in detail your premium billing process. Explain all options, including electronic options, available to the County for submitting premium payments to you. Provide sample invoices or other pertinent materials. Include information about timing for billing (i.e. due dates for enrollments/changes to be reflected), grace periods, payment reconciliation.

The County will self-account for billing purposes.

Our Administrative System Summary arrangement is a billing system based on estimates from the County. With summary billing, the County maintains and updates an insurance record for each employee. They will:

Enroll new employees
Discontinue coverage for terminated employees
Keep employee records updated

For those customers with automated payroll systems, we accept computer printouts to report paid premium or fees and covered lives/volume information. The printouts must contain the same basic information as the standard summary billing premium or fee statement and follow simple format standards so our system will recognize the information. The County must submit a sample of their printout for review and approval by the billing consultant.

The premium or administration charges are due no later than 31 days following the first calendar day of the month in which we provided the services.

While we expect the monthly premium payment by the due date, we allow a 31-day grace period following the due date.

We base reconciliation on the County's reported lives volume and premium.

We can set the County up to pay electronically if this is something they are interested in.

Please refer to the Samples and Brochures section of this proposal for a sample Summary Billing Statement.

B. Currently, the County enters aggregate coverage data online and then remits the premium via ACH and prefers to continue this arrangement. Can you accommodate this arrangement? If so, please describe information needed to substantiate premium payment.

Yes, we can set the County up to pay electronically if this is something they are interested in.

C. Describe the banking arrangements that you propose for this plan. How do you reconcile funds transmitted/received from the County? Do you confirm payment amounts received from the County?

In regards to the Self-Funded Disability coverage, we use a Single Account Multiple Participant account with either Bank of America or Citibank. All benefit payments are made on one of these accounts and as the claims record in our Claim Reporting System, we stockpile the recorded claims and ask for reimbursement from the County once we have $20,000 in stockpiled, recorded claims. The County funds our bank account through wire transfer or wire draw-down by Aetna, as well as automated clearing house (ACH) credit or ACH debit by Aetna. We can accommodate alternate methods, such requesting funds on a specific day of the week or date of the month, at an additional cost.

When we initiate a funding request, we can communicate a summary through fax or email. If preferred, the banks withdrawal information can serve as an advisory of monies drawn.

Three separate requests (wire lines) are available to clients that wire funds to our bank account. We tie separate funding requests to customer structure. Should the client require more than three wire lines, additional fees would apply.

D. Describe all reinsurance arrangements pertaining to the cost of coverage. Name the carrier and effective dates of the policy.

No reinsurance is included in this proposal.

E. Is a profit margin included in your rate, if so, at what percent?

This information is not available for prospectively rated plans.

F. Provide all performance guarantees you will provide to the County. Include frequency of reporting and payment of any missed performance measures.

Performance Guarantees are addressed in the Performance Guarantee document which accompanies this proposal.

G. Please provide your renewal formula for the group life insurance program. How many years of exposure do you require for 100% life plan credibility? What credibility factor was used for this proposal?

Our experience evaluation takes into consideration the County's claim experience during the current policy year, the County's accumulated experience, and our book of business experience for the coverage.

- Credibility - We apply a credibility formula in rating life insurance. Full credibility requires enough life-years of experience that 60 deaths could be expected within that experience. We define a life-year as one covered life for one year.

- Expected Claims - The total annual claims we would expect based on the current covered group and our experience evaluation, including the consideration of credibility.

- Retention - Expenses and profit charges are calculated based on commission, premium tax, funding arrangement and other services provided.

We require the County to provide current census data annually on the anniversary of the plan regardless if under rate guarantee, approximately 6 months prior to this date. We also require this when the composition of the group changes materially by 10 percent or more in lives and/or volume. The customer should electronically submit the following information for each covered employee:

- Benefit amounts by coverage type (as applicable)
- Class or salary information
- Date of birth
- Gender
- Work street address (street number, street name, city, state, and zip code)
- Residence state or zip code

Note that in situations where work street address is not available at the employee level, we would be happy to work with the County to develop alternative data sets that meet our underwriting process requirements.

H. If the County were to choose to offer a one-time open enrollment at the beginning of the contract for supplemental life insurance without medical underwriting, please describe the guaranteed issue amounts you would recommend and the maximum you would allow. Please also describe how this would impact the rates quoted.

We are willing to accommodate the one-time special open enrollment requested in Addendum 3 as follows:

No Evidence of Insurability (EOI) for:

- Current employees grandfathered at their current coverage.
- Current employee who waived coverage or have less than 2x for employee supplemental may purchase up to 2x ($450k max) without EOI
- Current employee who waived spousal coverage or have less than $50k for spouse life may purchase $50k without EOI

II. Written Proposal Follow Up Questions and Responses

The following responses either clarify and confirm responses from the initial proposal and in some cases confirm a change to the initial proposal response whereby the following response overrides earlier responses.

Aetna - Proposal Follow-up Questions:

1. Please identify disqualifying conditions/events for supplemental life insurance enrollment and for voluntary disability enrollment.

We use the body mass index method of determining overweight and obesity in adults and may automatically decline when an applicant's body mass index exceeds the allowed threshold.

The proprietary nature of the information contained within Aetna's Medical Underwriting Guidelines precludes us from releasing the highest mortality/morbidity rating to be accepted for medical evidence of insurability to anyone outside of Aetna. This includes the "debit" threshold at which declination is reached. We can, however, provide information related to approval and declination percentages as it relates to total volume of applications.

Aetna's Medical Underwriting Department evaluates each Evidence of Insurability Statement (EOI) per pre-determined guidelines. This ensures standards are met to objectively evaluate the level of insurance risk presented by build, tobacco use and certain health impairments. The goal is to underwrite as efficiently as possible making most determinations as possible directly from EOI. However, more information may be necessary and further information may be sought from medical providers. The returned information is evaluated in Medical Underwriting Manuals. These manuals are risk selection tools designed to assist underwriters in identifying and assessing the level of insurance risk imposed by health impairments.

The level of risk is measured in numerical "debits" that represent excess morbidity or mortality above "standard". "Standard" is the equivalent of "0" risk for incurring claims in excess of the pricing loss ratio for the benefit (health, short term disability, long term disability or life) being underwritten. Each benefit has a certain "debit" threshold at which a denial of coverage is determined for that coverage.

Examples of disqualifying conditions/events may be due to height, weight, smoker status, and other medical conditions that are noted on the EOI statement.

2. Please describe in more detail on your supplemental life enrollment appeals process. Provide data on the number of appeals in the past 3 years and the aggregate outcomes of the appeals.

Appeal Requirements

- The request for an appeal must be submitted in writing.
- The request for appeal will only be accepted from either the employee, denied applicant, applicant's representative or from the applicant's physician.
- Appeals must be received within 90 days of the date of the declination letter. Appeals after this time frame will not be accepted and a letter stating this will be sent to the applicant suggesting reapplication at next annual enrollment.

Appeal Review Process

Once an appeal request has been received:

- Acknowledgement letter will be mailed to applicant within 10 business days of receipt of appeal request.
- Appeals will be completed within 20 business days from receipt of additional information.
- Appeal will be reviewed by either an Appeal Analyst or an Appeal Consultant. Appeal requests will be reviewed in accordance with the applicable state specific rules and regulations.
- To ensure appeals are considered on a standardized and consistent basis, the Appeal Analyst/Consultant will utilize the current Medical Underwriting guidelines as well as all current Medical Underwriting policies and/or current medical data related to mortality/morbidity.
- Appeals will be reviewed FIFO and Appeals Workflow.
- Final decision letter and/or request for additional information will be sent to applicant.
- Arlington County will be notified if there is a change in decision and according to Plan Setup rules.

Number of appeals and outcome information is considered proprietary information and can not be release externally. We may receive approximately 3% of appeals annually.

3. Please describe in more detail your disability claim appeals process. Provide data on the number of appeals in the past 3 years and the aggregate outcomes of the appeals.

When we deny or terminate a claim, we issue a letter detailing the basis for the determination, including:

- Citing the contractual provision in support of the determination
- Detailing the explanation including key information sources and documents
- Explaining the member's right to review

We also send a letter to Arlington County. If the member chooses to appeal the decision, either with or without additional information, our disability appeals unit reviews the file and makes a decision to either uphold or overturn the prior adverse decision.

Upon receipt of the appeal it is routed back to the original disability benefits manager for a preliminary review to determine if they can overturn the adverse determination based on the appeal and information provided with the appeal. If the disability benefits manager cannot overturn the decision, the appeal is routed back to the disability appeals unit for assignment to an appeal specialist. The appeal specialist performs a telephonic interview with the member or the legal representative. As a part of the interview it is determined if additional information is forthcoming. If necessary, the member is afforded additional time to supplement the appeal. Once the appeal specialist has all the information necessary to complete the appeal review they can complete their review and render a determination. If the adverse determination is medically related, either in whole or part, prior to rendering a final determination, the appeal specialist will consult with a clinician with the proper training and experience in the field of medicine in question, and obtain a medical opinion regarding the claimant's functionality.

The appeal decision is based on all the information in the claim file, the appropriate plan or policy and any medical opinions obtained. When the appeal specialist makes their decision, they send a letter to the member or their legal representative informing them of the decision with complete details of the decision rationale.

If we overturn the original adverse decision, our appeals specialist will let the disability benefits manager know

and provide the rationale. The disability benefits manager will send a reinstatement letter to the member or the member's representative or, will send a letter explaining that we overturned the original decision and that we need additional information.

When Arlington County is the decision maker on the appeal, depending on the appeal option selected, the same process is followed; however, if the decision cannot be overturned by the appeal specialist a brief summary is compiled and that summary along with the entire claim file is forwarded to Arlington County so they can render the final decision.

Our centralized disability appeal unit receives on average between 6,000 and 7,000 appeals per year. This includes short and long term disability appeals. Our overturn rate on appeals is typically around 45%. This overturn rate includes appeals that are overturned by the disability benefits manager during the preliminary review. Typically overturns are due to the Disability Benefit Managers receiving additional medical information in support of the appeal.

---

4. Do you perform customer satisfaction surveys? If yes, please provide the questions asked and the results of the surveys from the past 3 years. How are negative responses addressed?

We conduct client satisfaction surveys. We offer an in-house satisfaction survey at the end of a call asking the caller if they would like to participate in a brief telephone survey.

The automated survey has five questions. There is an option to leave a detailed voice mail before moving on to the next question.

Supervisors review and respond to voice mail messages daily. We gather general data monthly.

Year end 2011, we had an overall customer satisfaction rate of 91.0 percent, and 95 perfect for 2009-2010.

Our Disability Satisfaction Survey results have been 4.49 out of 5 for 2011 4.69 out of 5 for 2010, and 4.53 out of 5 for 2009.

---

5. Describe the quality control process to ensure the County's enrollment records and your enrollment records are consistent. Describe how discrepancies resolved.

We audit evidence of insurability decisions on a daily basis. A full time auditor selects random samples daily. Our annual evidence of insurability volume is approximately 100,000 applications. We also provide reporting on a weekly, quarterly, and annual basis which reflects all activity including EOI during the specified reporting timeframe. These reports allow our customers to compare applicant status/information to their eligibility data for their audit purposes.

---

6. Describe the quality control process to ensure payments to life insurance beneficiaries and to disability claimants are accurate. Describe how errors are resolved.

Life

Quality consultants perform a daily audit on a random sample of processed life, premium waiver and AD&D claims. Our quality consultants also review the analyst's claim handling procedures, including:

- Correct coding
- Payment determinations
- Following settlement authority guidelines
- Obtaining proper claim documentation (e.g., proof of death, beneficiary designation, guardianship papers, etc.)
- Determination of beneficiary, including prompt handling of adverse claim situations
- Identification and handling of claims with possible AD&D benefits

Disability

We audit a random sample of short-term disability and long-term disability claims at any time during the life of the claim. We base the statistically valid sample size on three percent of claims. This sample size allows for a 90 percent confidence level with a 5 percent margin of error.

We evaluate the appropriateness of claim management decisions by auditing the reviews and/or investigations that apply to the time period being audited. The review may include (but is not limited to) the following:

- Review of eligibility for leave of absence or disability benefits and coverage exclusions or limitations
- Compliance with state and federal claim decision timeframes
- Evaluation of sufficient medical information including physical limitations to support the members inability to perform their job functions
- Calculation of leave of absence
- Calculation of disability payments
- Development of an appropriate plan for ongoing claim management

Our auditors continuously monitor quality. They measure the accuracy of our claim management staff and perform workflow and procedural analyses of all aspects of claim administration. The auditors issue monthly, quarterly and annual reports which document the results at the individual, unit and department level. We share these internal reports with the disability and absence management training department who provide training to employees whose results reflect that need.

---

7. The County currently uses Oracle for employees to self-enroll in all benefits and will be maintaining this process. Please describe how your organization would most efficiently handle the EOI process while still having our employees enroll on our Oracle enrollment system as opposed to being redirected to your website to enroll. Include in your response if the County send a file of those needing EOI.

With Aetna's Single Sign Off capability, Arlington County employees can submit an EOI form for supplemental life and disability insurance coverage in a secure, fast and simplified way. With this feature, Employees can log into Oracle's enrollment system and fill out and submit EOI forms in just minutes. It allows employees to bypass Aetna's own website login requirement and associated file needs. They just need to be securely logged on to Arlington County's company website or a third-party (e.g. Oracle) website that we have approved as trusted. Aetna does not

currently have any customers on its books that use Oracle as third party administrator to administer its Life and Disability enrollment. We can use an EOI file to mail out prepopulated EOI forms, as well as the member specific URL in case claimants want to complete the EOI online.

---

8. Please indicate the number of clients assigned to the person that will be responsible for our day-to-day account administration.

Dawn Fairhurst has 6 clients assigned to her.

---

9. What are your plans for being able to offer direct deposit for disbursements to beneficiaries for life insurance and to employees for long term disability payments?

Direct Deposit for disbursement of long term disability payments is already in place today. At this time we are investigating direct deposit and debit card use for beneficiary disbursements, however there is not currently a set date for these options to be available.

---

10. Our initial request indicated we wanted to have a one-time open enrollment for supplemental life insurance without EOI, up to the guaranteed issue amounts for those either currently not enrolled or enrolled with less than guaranteed issue amounts. In addition, annually, we allow employees with supplemental life insurance to increase their coverage by one level (i.e. from ½ times salary to 1 times salary or from 1 times salary to 2 times salary) without providing EOI, can you accommodate this current practice, up to the guaranteed issue amounts? How will this impact the quoted rates?

Confirmed. We are able to accommodate the current practice with no rate impact.

---

11. Please confirm your supplemental life insurance quote for active employees allows spouses up to $50,000 of guaranteed issue supplemental life insurance.

Confirmed.

---

12. Since Aetna separates their business between the public sector and private sector, how do you ensure what you are offering to public sector clients is competitive with what private sector employers are offering?

Aetna has had a long history of partnering with public clients over the course of its 158 year existence. We have underwritten insurance plans for multiple product lines on federal, state and municipal levels. As a result of our decades long involvement with government clients, we have a keen understanding of the unique needs of public entities. We have significant experience working with multi-layered clients possessing complex organizational structures. We understand the needs of an employer with a mix of salaried and collective bargained employee classes. We understand how to design programs that will support an employee population with a diverse range of professions. We also have strong expertise in regulatory compliance. All of these capabilities enable us to effectively support our public sector clients.

To further enhance our support, we operate a separate Public and Labor Sector Organization as part of our corporate structure. Our Public and Labor Sector focuses solely on serving the special needs of government entities, their employees, who have made the commitment to public service, and their families. We understand the economic challenges the market is facing today and the importance of the benefits we provide to America's working families. The people in our account teams, claims, underwriting and customer service units have been carefully selected for their experience and commitment to the public sector and receive ongoing training and support so they can best meet the needs of our customers. This is evidence by the strong, local account team we assigned (Kim Thielemann, Dawn Fairhurst, and Nancy LaRoche) who are responsible for our Public Sector business.

Our dedicated Public and Labor Sector is, in fact, aligned with our National Accounts division. This allows Arlington County to benefit from the additional customer service, flexibility, and high-end data analytics provided to both our Public Sector customers and National Account Private Sector customers.

---

13. What are the extra charges for printing hardcopies of the life insurance certificates?

There are no charges associated with printing a supply of these documents. Arlington County may request a limited supply to retain within its Benefits Department, a full supply to distribute a copy to each plan participant or just request an electronic draft to populate within its own company web site.

---

14. Your proposal indicates late entrant applicants pay the cost for additional information (paramedical exams, attending physician reports) needed to determine insurability. Is this negotiable? If so, what options are available? If not, why not?

We are willing to waive the cost of additional medical information for late entrants.

---

15. Please clarify if your online EOI capabilities provide a real-time response to the employee such that they would immediately know if their request is approved, pended or denied.

Yes, if medical underwriting is able to auto-adjudicate the EOI, then the employee can view the decision immediately.

---

16. It appears your "back-up" for disaster recovery is also in Connecticut - what happens if the disaster is wide-spread in Connecticut?

Aetna has made significant investments in its Data Center infrastructure to mitigate operational and unforeseen risks, fortifying Aetna's business continuity posture.

- Extensive hardening (i.e., redundant power, heating and cooling) installed within each data center's physical plant so that power outages, both planned (for required maintenance) and unplanned power outages are not experienced.
- Multiple power feeds entering both data centers from local substations to mitigate single power feed failure (i.e. power line cuts, etc).

- Diesel generator power to support data center power load capacity if street power or substation is affected. Each data center can run independently of street power for 4-5 days with current on-hand supply of diesel fuel.
- Each Data Center can run indefinitely on generator power as diesel supply is replenished by vendors. Multiple vendor contracts in place for continuous diesel delivery.
- Regular testing of diesel generators with power load
- Un-interruptible power supplies (UPS) attached to all critical components to ensure switchover from street to diesel power does not affect equipment.
- 24x7 staff support (4 teams) of each data center with 1 team onsite and other 3 teams available to provide emergency support.
- Work at Home capabilities for data center staff to support many data center functions remotely in the event of restricted access to the data center
- Business Continuity plans (including an extensive Pandemic Planning section) in place for all critical functions which provide manual workarounds in the event of a loss of systems, or access in any Aetna facility including the data center.

To further ensure its confidence in the dual data center, internal disaster recovery approach, in 2002, Aetna's Board of Directors initiated a risk assessment to be conducted by Price Waterhouse Coopers (PwC) to address possible vulnerabilities in the data centers. This assessment included: physical plant, power, network and systems and the assessment of whether or not there was a need for a 3rd data center (or move one) out of the Northeast region due to having two data centers within the same geographic location. PwC conducted an extensive study by reviewing engineering documentation, conducting detailed data center tours focusing on physical security, fire protection, utility services, and a review of local environmental hazards, both technical and natural.

PwC concluded that *Aetna's concern about the loss of both data centers is not materially supported. According to FEMA and the USGS, the state of Connecticut is not an area prone to major natural disasters. The most significant natural disasters are severe winter storms. While these storms can have a strong impact on the availability of power and telecommunications, given the robustness of the data centers and the size and redundancy of the power generators, it is not anticipated that Aetna would experience an outage of both locations. Given the robustness of the data centers and lack of material environmental risks, the cost of relocating a data center to another state is not supported. The current data*

backup regimes are on par with others in the industry and suitable for the business needs.

In conclusion, Aetna's Data Center Disaster Back-Up and Recovery strategy is one component of Aetna's comprehensive business continuity program. Aetna's extensive business continuity program is designed to prepare and react to a broad range of crises affecting employees, facilities and technology. Aetna maintains and implements a detailed business continuity program, with over 300 plans to address its critical business work group operations. One component of the Business Continuity plan is the mitigation of an extended system outage. Every Business Continuity plan owner identifies key processes and corresponding manual workarounds in the event that systems aren't available. The plans are updated quarterly or as business processes change.

As a result of extensive technological and comprehensive process related risk mitigation and validation from third parties, Aetna feels strongly that a dual data center outage is highly improbable and is considered out of scope. Aetna holds its commitment to serving constituents in the highest regard and has made prudent investments through the previously described means, to ensure that Aetna continues to exceed those commitments.

---

17. Please confirm you are able to offer a one-time open enrollment for all employees (regardless of current supplemental life insurance election) that would provide guaranteed issue coverage without EOI and no impact on the quoted rates.

Confirmed. Assuming that the employee's guaranteed issue is 2 times salary and the spouse guaranteed issue is $50,000 as indicated in Attachment F - Plan Design of the Request for Proposal, we confirm that we can offer a one-time open enrollment for all employees up to the guaranteed issue amount.

---

18. Performance guarantees seemed very customer service focused - are there financial measures (i.e. claim payment accuracy, etc.) that you also offer for performance guarantees? If so, please describe.

We can offer a variety of financial guarantees in addition to our customer service guarantees. Please refer to the

accompanying Performance Guarantee document which describes our available guarantees, including Claim Payment Accuracy, Turnaround Times, etc.

---

19. Please describe in detail how your firm ensures employee data will be kept confidential and secure.

Encryption is one of the many security technologies Aetna uses to protect the confidentiality of data and information.

Consideration is given to:

- Regulations and national restrictions that might apply to the use of cryptographic techniques in different parts of the world,
- Issues of trans-border flow of cryptographic information
- Controls that apply to the export and import of cryptographic technology.

Where the use of encryption technology is appropriate, Security Services assessment takes into consideration not only the type of encryption algorithm to use, but the length of the required cryptographic keys as well.

E-Mail

Protecting the privacy and security of sensitive information has always been a priority at Aetna. We require that our employees encrypt all e-mails to third parties that contain member-specific health and financial information--this includes but is not limited to:

- Personal and demographic information (name, SSN, address)
- Employment information
- Payment of benefit information
- Identity of doctors, dentists and other health care professionals and facilities
- Diagnoses or treatments
- Claim status
- Services associated with behavioral health or sexually transmitted diseases

All e-mail sent from customer and provider service personnel through our Customer Relationship Management application are automatically encrypted. Employees must review the content of other e-mail and select the "Send

Secure" option to encrypt other e-mail sent to external recipients.

All e-mail leaving the Aetna is scanned. If an e-mail message includes sensitive data the e-mail is automatically encrypted before it is sent to any external recipients.

We offer a variety of secure e-mail solutions. The most widely used methods include:

Transport Layer Service
We use Transport Layer Security, an encryption technology, to establish affiliate connections between Aetna and third parties. This method provides a seamless solution for Aetna and affiliates to send and receive encrypted e-mail transmissions.

Post-X
Post-X is a company-wide outbound e-mail encryption solution. Use of encrypted e-mail enables Aetna to send quick, reliable communications while maintaining our commitment to protecting the confidentiality of member-specific health and financial information. We scan outbound e-mail. If we detect sensitive data in an unencrypted e-mail, we automatically encrypt the e-mail and notify the sender. E-mails containing internal use only information are rejected and sent back to the sender.

Pretty Good Privacy (PGP)
PGP is available on an individual basis in order to meet e-mail encryption requirements not supported by TLS or Post-X. Use of PGP to create an encrypted communications channel between Aetna and any other party is not support.

Transport
Other options for encrypting restricted or confidential information over a public communications network include:

Secure File Transport (SFTP)
We use SFTP for high-volume and/or large file transports. Data is at rest only within our internal network, which is behind two sets of firewalls. The encryption level is 128 bit SSL, and, to ensure changes to files have not occurred, data integrity checking is inherent.

Virtual Private Network (VPN)
We use VPN for external connections including off-site employee connections. 256 bit AES encryption is used, dual factor authentication for client to network VPN is required, and inactivity time-outs are built into the configuration.

20. Explain why you took exceptions to the County contract terms and conditions and propose alternate language to any exceptions. Please note that provisions required by Virginia Law or the Arlington County Purchasing Resolution as indicated by an asterisk in the agreement are non-negotiable and cannot be changed. In your proposal your firm took exceptions to the following mandatory provisions such as Arbitration.

We have reviewed our original exceptions and we are pleased to support the majority of the requirements with a few additional commentary. In addition, we have deleted our exceptions to those mandatory provisions required by Virginia Law and the Arlington County Purchasing Resolution. Please refer to the attached revised exceptions grid.