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, 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, PROVIDENCE, RI 02908
TEL (401) 273-2921

The 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 Rhode Island. You should not rely on coverage by the Association in selecting an insurance company or 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 or self funded plans.

Insurance companies or their agents are required by law to give or send you this summary. However, they are prohibited by law from using the existence of the Association to induce you to purchase any kind of insurance policy. Should you seek information as to the financial condition of any insurer or should you have any complaint as to an insurer's violation of the Act, you may contact the Division of Insurance at the address listed below.

RHODE ISLAND DIVISION OF INSURANCE
222 Richmond Street, Providence, RI 02903
TEL (401) 222-2223

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 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.

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, including any net cash surrender and net cash withdrawal values;
- $ 300,000 for disability insurance;
- $ 500,000 for basic hospital, medical, and surgical or major medical insurance;
- $ 100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal value;
- $ 100,000 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;
- $ 100,000, 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 $ 100,000 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.

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

A

Policyholder No. 473072

Group Accident and Health Insurance Policy

a contract between

Aetna Life Insurance Company

(A Stock Company herein called Aetna)

and

University of Connecticut
(Policyholder)

Policy Number: GP-473072

Date of issue: August 31, 2007

To take effect: September 1, 2007

Policy delivered in: Connecticut

This policy will be construed in line with the law of the jurisdiction in which it is delivered.
Based on timely premium payments by the Policyholder, Aetna agrees with the Policyholder, to pay benefits in line with the policy terms.

The duties and the rights of all persons will be based solely on policy terms. This policy is non-participating.

Signed at Aetna's Home Office in Hartford, Connecticut on the date of issue.

Ronald A. Williams
Chairman, Chief Executive Officer, and President

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, Connecticut 06156
860-273-0123

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Policy Contents

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Policy Contents

This policy consists of:

The Face Page, Index, this Policy Contents page, and all the provisions of Parts I and II; and

The provisions found in the Certificate(s) listed in this section.

The words "you" or "your" in any Certificate included in this policy, will refer to a covered Employee.

The Certificate(s) included in this policy are as follows:

A "Certificate" consists of a Certificate Base document ("Cert. Base") and any Summary of Coverage ("SOC") or Certificate Rider ("Rider") which may be issued to support or amend the Cert. Base.

Identification	Issue Date	Effective Date	Eligible Group and/or Type of Coverage
Cert Base: 1	**August 31, 2007**	**September 1, 2007**	**TDI**
SOC: 1A	**August 31, 2007**	**September 1, 2007**	**Plan 1 ee's**
SOC: 1B	**August 31, 2007**	**September 1, 2007**	**Plan 2 ee's**
SOC: 1C	**August 31, 2007**	**September 1, 2007**	**Plan 3 ee's**
SOC: 1D	**August 31, 2007**	**September 1, 2007**	**Close Group**
Cert Base: 2	**August 31, 2007**	**September 1, 2007**	**LTD**
SOC: 2A	**August 31, 2007**	**September 1, 2007**	**Close group**
Cert Base: 3	**August 31, 2007**	**September 1, 2007**	**LTD**
SOC: 3A	**August 31, 2007**	**September 1, 2007**	**Plan 1, 2 & 3 ee's**
Rider: 1	**August 31, 2007**	**September 1, 2007**	**LTD-AAW Rule**
ET Rider 1	**August 31, 2007**	**September 1, 2007**	**ET States Riders**

Part I

Eligible Classes

All classes of employees of a Member Employer are eligible except those who are:

Part-time;

Temporary;

Substitute; or

In a class for which a Certificate is not in this policy.

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

If a Member Employer is a partnership or proprietorship, each of its natural-person partners, or the proprietor, will be deemed to be an employee. This applies only if the person is working on a mostly full-time basis for the Employer.

Change In Amounts

Employee Coverage (Contributory) (This section does not apply to Long Term Disability Coverage or Managed Disability Coverage)

Earnings or Status Change

If, at any time, the employee's rate of earnings or status changes so as to warrant an amount of contributory coverage other than that for which the employee is then covered, the amount of his or her coverage will be changed as follows:

A reduction will be effective:

On the date the employee requests it under Life Insurance and Accidental Death and Personal Loss Coverage.

On the date of the earnings or status change under all other coverages.

An increase will be effective on the date of the earnings or status change. For any coverage other than Health Expense Coverage, the Active Work Rule must be met. The employee may refuse an increase in Life Insurance or Accidental Death and Personal Loss Coverage. This must be done within 31 days of the date it would have taken effect. If refused, no other increase because of the earnings or status change will be made until the date Aetna gives written consent.

Schedule or Benefit Level Change

If, at any time, any schedule or the level of any benefit is changed so as to warrant an amount of contributory coverage other than that for which the employee is then covered, the amount of coverage will be changed to the new amount. For any coverage other than Health Coverage, an increase will be subject to the Active Work Rule.

The employee may refuse an increase in Life Insurance and Accidental Death and Personal Loss Coverage. This must be done within 31 days of the date it would have taken effect. If the employee later elects the increase, it will be made on the date Aetna gives written consent.

Change In Amounts (Continued)

Employee Coverage (Contributory) (Continued)

All Changes

A retroactive change in an employee's rate of earnings or status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in earnings or status is made.

This section will not apply to reductions due to reaching a stated age or due to retirement.

Employee Coverage (Non-Contributory) (This section does not apply to Long Term Disability Coverage or Managed Disability Coverage)

Earnings, Status, Schedule, or Benefit Level Change

If, for any reason and at any time, the employee's rate of earnings, or the employee's status, or any schedule, or the level of any benefit is changed so as to warrant an amount of non-contributory coverage other than that for which the employee is then covered, the amount of his or her coverage will be changed to the new amount. For any coverage other than Health Expense Coverage, an increase will be subject to the Active Work Rule.

A retroactive change in an employee's rate of earnings or status will not result in a retroactive change in coverage. Any change in coverage will be effective on the date the change in earnings or status is made.

This section will not apply to any reductions due to reaching a stated age or due to retirement.

Changes

Employee Coverage

Change in Eligibility Date

An increase in any required period of service will apply only to an employee who enters service on or after the effective date of the increase. A decrease in any required period of service will permit an employee to become eligible on the effective date of the decrease if he or she then has worked the new period of service. Otherwise he or she is eligible on the date he or she completes it.

Special Provisions

Active Work Rule

This Active Work Rule does not apply to any Health Expense Coverage.

If the employee is ill or injured and away from work on the date any of his or her Employee Coverage (or any increase in such coverage) would become effective, the effective date of coverage (or increase) will be held up until the date he or she goes back to work for one full day.

Special Provisions (Continued)

Other Long Term Disability Insurance

If there is other group long term disability insurance:

under which benefits are payable for the same period of disability; and

which contains the same or similar provisions for reduction in benefits payable because of other income benefits;

the long term disability part of this contract will be liable only for a pro rata share of the total benefits payable.

"Pro rata share" means the result of the following:

the amount payable under this contract in the absence of other group long term disability insurance benefits and before any reduction in benefits payable due to other income benefits; divided by:

the total amount payable under all group long term disability insurance plans before any reduction in benefits payable due to other income benefits; times

the benefit payable under this contract after reduction by all other income benefits except any amount payable under another group long term disability insurance plan.

Special Provisions (Continued)

Effect of Prior Long Term or Managed Disability Insurance

If the coverage of any employee replaces any "prior long term or managed disability coverage" in effect for the member, the rules below will apply.

"Prior long term or managed disability coverage" is any plan of group long term or managed disability coverage carried or sponsored by a Member Employer (or its predecessor). It was provided by any carrier other than Aetna. It has been replaced as a whole or in part, as to the class of employees of which the employee is a member, by coverage under this policy. Any such plan shall be considered "prior long term or managed disability coverage" only if provided by group insurance.

The employee Active Work Rule will be waived on the day right after the date the employee's coverage under the prior long term or managed disability coverage terminated.

Any long term or managed disability coverage which becomes effective due to the waiver of the Active Work Rule will not be in effect and benefits will not be available as to the particular period of disability for which benefits are available, or would be available in the absence of coverage under this policy, under any extension of benefits provision of the prior long term or managed disability coverage until the end of the period for which such benefits are available, or would be available, in the absence of any coverage under this policy under such extension of benefits.

Special Provisions (Continued)

Effect of Prior Long Term or Managed Disability Insurance (Continued)

The Policyholder will be liable for the premium required by Aetna for the terms of this provision to apply to the employee.

If the coverage of an employee insured in accordance with this provision terminates and the employee again becomes eligible for coverage under this policy, this policy shall then apply to the employee as though this provision were not included.

If an employee insured in accordance with this provision later meets the Active Work Rule and the employee remains insured under this policy, this policy shall, while the employee remains so insured, apply to the employee as though this provision were not included; except if the employee has a new period of disability:

which starts after such return to work; and

which is due to the same or related causes as a period of disability which started while the employee was insured under the prior long term or managed disability coverage and continues beyond the day the Active Work Rule was waived; and

for which benefits are not available for such period of disability under the prior long term or managed disability coverage because the rule under the prior long term or managed disability coverage regarding separate periods of disability does not apply after termination of such coverage;

coverage will be available under this policy for the new period of disability if coverage would have been available for such period of disability under the prior long term or managed disability coverage had the prior long term or managed disability coverage remained in force.

If an employee who met the Active Work Rule on the day prior long term or managed disability coverage was replaced by coverage under this policy starts a period of disability while insured under this policy, and if:

the period of disability is due to the same or related causes as a period of disability which started while the person was insured under the prior long term or managed disability coverage; and

benefits are not available for such period of disability under the prior long term or managed disability coverage because the rule under the prior long term or managed disability coverage regarding separate periods of disability does not apply after termination of such coverage;

coverage will be available under this policy for the new period of disability if coverage would have been available for such period of disability under the prior long term or managed disability coverage had the prior long term or managed disability coverage remained in force.

Part II

Policyholder and Insurance Company Matters

Declarations

The first "policy month" starts on September 1, 2007.
Each subsequent policy month starts on the first
of a calendar month.

The first "policy year" starts on September 1, 2007
and ends on August 31, 2008.
Each subsequent policy year starts on September 1.
It ends on August 31.

Member Employers

Member Employers are those employers which are included under this policy by written agreement between the Policyholder and Aetna.

An employer may be a Member Employer if not against the law of the jurisdiction in which this policy is delivered.

The Policyholder may act for all Member Employers in all policy matters. Each such act, or agreement made between Aetna and the Policyholder, or notice given by one to the other will be binding on all the Employers.

Clerical Error

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 Aetna will be used to decide if insurance is in force and its amount.

Misstatements

If any fact as to a person to whom the insurance relates is found to have been misstated, a fair change in premiums will be made. If the misstatement affects the existence or amount of insurance, the true facts will be used to decide if insurance is in force and its amount.

Policyholder and Insurance Company Matters (Continued)

Duties of the Policyholder

The Policyholder and each Member Employer must give Aetna such information as Aetna may reasonably require to administer this policy and must agree to:

- Maintain a reasonably complete record of such information in electronic or hard copy format, including but not limited to:
  - evidence of eligibility;
  - changes to such elections; and
  - terminations;

  for at least seven years or until the final rights and duties under this policy have been resolved; and to make such information available to Aetna upon request.

The information shall be provided when requested:

- on Aetna forms; or
- such other forms as Aetna may approve.

All data which may have a bearing on insurance or premiums will be open for Aetna to inspect while this policy is in force.

The Policyholder must notify employees of the termination of the policy in compliance with all applicable laws. However, Aetna reserves the right to notify employees of termination of the policy for any reason, including non-payment of premium. The Policyholder shall provide written notice to employees of their rights upon termination of coverage.

The Policyholder must:

- notify all eligible employees of their right to continue coverage under any applicable state law; and
- provide notification to each employee within 15 days after termination of coverage, of their conversion right, including:
  - a description of plans available;
  - premium rates;
  - and application forms.

Policyholder and Insurance Company Matters (Continued)

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 risk.

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

Aetna can rely on such action. It will not have to probe into the details.

Certificates

Aetna will provide the Policyholder with either a supply of paper copies or electronic certificates. The Policyholder shall distribute or otherwise make the certificates available to each insured employee. The insurance in force will be set forth. Statements as to whom benefits are payable will appear. Any applicable Conversion Privilege will also be described.

Policy Changes

This policy may be amended by Aetna:

with 30 days written notice to the Policyholder; or

by written agreement between Aetna and the Policyholder.

The consent of any employee or other person is not needed. All agreements made by Aetna are signed by one of its executive officers. No other person can change or waive any of the policy terms or make any agreement binding Aetna.

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

- The Policyholder has asked for the change and Aetna has 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 Aetna and is not resulting in either:

  a reduction or elimination in benefits or coverage; or

  an increase in premium.

Policyholder and Insurance Company Matters (Continued)

Policy Changes (Continued)

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.

This policy shall be deemed to be automatically amended to conform with the provisions of applicable laws and regulations.

Policyholder and Insurance Company Matters (Continued)

Contract

This policy and application of the Policyholder are the entire contract. A copy of the application is attached. 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 Aetna in a contest unless:

a copy of the statement is: or

has been furnished to:

the employee; or

his beneficiary; or

the person making the claim.

Aetna's 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 Aetna's 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.

Accident and Health Coverage Statements

Except as to issues concerning premiums due:

No statement made by the Policyholder or an employee 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 used in defense to a claim for loss incurred or starting after coverage as to which claim is made has been in force for 2 years.

No statement made by an eligible employee shall be used in defense to a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

Policyholder and Insurance Company Matters (Continued)

Premium Rates (Continued)

Other Accident and Health Benefits

The premium rates for accident and health coverage are as follows. They can be changed as shown below. The premium rates are for a period of one month.

The current premium rates for all of the Accident and Health Coverages provided under this policy are on record with both Aetna and the Policyholder.

Temporary Disability Benefits -
premium per $ 10.00 of Weekly Benefit: Plan 1

Under Age 35	$ 0.440
Age 34-44	$ 0.500
Age 45-54	$ 0.550
Age 55 +	$ 0.610

Temporary Disability Benefits -
premium per $ 10.00 of Weekly Benefit: Plan 2

Under Age 35	$ 0..250
Age 34-44	$ 0..280
Age 45-54	$ 0.310
Age 55 +	$ 0.350

Temporary Disability Benefits -
premium per $ 10.00 of Weekly Benefit: Plan 3

Under Age 35	$ 0..110
Age 34-44	$ 0.120
Age 45-54	$ 0.140
Age 55 +	$ 0.150

Temporary Disability Benefits -
premium per $ 10.00 of Weekly Benefit: Plan 4

Under Age 35	$ 0.270
Age 34-44	$ 0.300
Age 45-54	$ 0.330
Age 55 +	$ 0.370

Long Term Disability Benefits -
premium per $ 100 of Covered Monthly Payroll: Plan 1

Under Age 35	$ 0.560
Age 34-44	$ 0.820
Age 45-54	$ 1.240
Age 55 +	$ 1.650

Long Term Disability Benefits -
premium per $ 100 of Covered Monthly Payroll: Plan 2

Under Age 35	$ 0.210
Age 34-44	$ 0.310
Age 45-54	$ 0.470
Age 55 +	$ 0.630

Long Term Disability Benefits -
premium per $ 100 of Covered Monthly Payroll: Plan 3

Under Age 35	$ 0.150
Age 34-44	$ 0.230
Age 45-54	$ 0.340
Age 55 +	$ 0.450

Long Term Disability Benefits -

premium per $ 100 of Covered Monthly Payroll: Plan 4

	Plan 4
Under Age 35	$ 0.130
Age 34-44	$ 0.190
Age 45-54	$ 0.290
Age 55 +	$ 0.390

Policyholder and Insurance Company Matters (Continued)

Fees

In addition to the premium, Aetna may charge:

An installation fee upon:

initial installation of coverage; or

any significant change in installation, including but not limited to:

a substantial change in the number or composition of persons insured under this policy; or

a change in the method of reporting eligibility to Aetna.

A billing fee with 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.

A reinstatement fee if any or all coverage is terminated and later reinstated under this policy.

Policyholder and Insurance Company Matters (Continued)

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 then provided under this policy.

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 ceases 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.

The premium charges will be figured at the premium rates shown before. Aetna may change them 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 Aetna.

No experience reduction or increase in premium rates shall become effective less than 12 months after the effective date of the group policy unless there is:

- a significant change in factors bearing a material impact on the risk assumed by Aetna; or
- changes in applicable state or federal:
  - law;
  - policy;
  - regulation; or
  - a judicial decision;

Policyholder and Insurance Company Matters (Continued)

Premiums Due - Experience Rating (Continued)

having a material impact on the cost of providing the coverages then provided under this group policy. As used here, "group policy" shall be deemed to include any group policy previously issued by Aetna that has been replaced in whole or in part by this policy.

The premium charges for any coverage under this policy may be refigured, as of a premium due date, only:

By reason of a change in factors bearing on the risk assumed. This must be requested by Aetna.

Once during any continuous 12 month period. The Policyholder must request this. 60 days advance notice has to be given to Aetna.

They will be refigured using:

The ages of the employees;

The amounts of insurance in force;

The premium rates; and

Any other pertinent factors.

All facts will be taken into account as of the date of the refiguring.

Policyholder and Insurance Company Matters (Continued)

Premiums Due - Experience Rating (Continued)

At the end of a policy year, Aetna may declare an experience credit. The amount of each credit Aetna declares will be returned to the Policyholder. Upon request by the Policyholder, part or all of it will be applied against the payment of premiums or in any other manner as may be agreed to by the Policyholder and Aetna.

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. Aetna 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 Aetna that comes up with about the same amount of premiums.

Aetna will not have to refund any premium 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, if this produces a larger refund.

This applies even if the premium was paid in error.

Premium and Fees Due

Payment of Premiums and Fees

The Policyholder will pay premiums and fees in advance. They may be paid at Aetna's Home Office or to its authorized agent.

A premium is due to be paid on the Monthly day of each policy month.

The Policyholder may change the number of premium payments as of a premium due date. This needs Aetna's written consent.

Aetna may accept a partial payment of premium without waiving its right to collect the entire amount due.

If the premiums and any fees are not paid by the Premium Due Date and before the end of the Grace Period, this policy will automatically terminate when the Grace Period ends. Aetna will require the Policyholder to pay 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 1 1/2% per month for each:

month; or

partial month;

Premiums and Fees Due (Continued)

Payment of Premiums and Fees (Continued)

the balance remains unpaid. Aetna may recover from the Policyholder:

costs of collecting any unpaid premiums or fees; including reasonable attorney's fees; and

costs of suit.

As to any Long Term Disability Benefits Coverage and Managed Disability Benefits Coverage under this policy for an employee, premium payments shall not be required on any premium due date during a period for which the employee is entitled to receive a benefit under Long Term Disability Benefits Coverage or a Monthly Benefit under Managed Disability Benefits Coverage.

Retroactive Adjustments

Aetna may, at its discretion, make retroactive adjustments to the Policyholder's billings for the termination of employees not posted to previous billings. However, the Policyholder may only receive a maximum of 1 month's credit for employee terminations that occurred more than 30 days before the date the Policyholder notified Aetna of the termination. Aetna may reduce any such credits by the amount of any payments Aetna may have made on behalf of such employees before Aetna was informed their coverage had been terminated. Retroactive additions will be made at Aetna's discretion based upon eligibility guidelines stated in the certificate, and are subject to the payment of all applicable premiums.

Grace Period

A grace period of 31 days after the due date will be allowed the Policyholder for the payment of each premium and fee. If premiums and fees are not paid by the end of the Grace Period, the policy will automatically terminate at the end of the Grace Period.

Policyholder and Insurance Company Matters (Continued)

Discontinuance of Policy

The Policyholder may terminate this policy as to any or all coverage of all or any class of employees of any one or more Member Employers. A Member Employer may terminate this policy as to any or all coverage of 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 Aetna as to the coverage.

Aetna may terminate this policy as to any or all coverage, other than Health Expense Coverage, which includes:

Comprehensive Medical Expense Coverage;

Major Medical Expense Coverage;

Prescription Drug Expense Coverage; and

Hospital Expense Benefit;

but does not include:

Comprehensive Dental Expense Coverage; and

Comprehensive Vision Expense Coverage;

of all or any class of employees or dependents of any one or more Member Employers by giving written notice of when it will terminate. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna. This right to terminate shall be in accordance with the Grace Period and Payment of Premiums and Fees provisions and is subject to the terms of any laws or regulations.

Comprehensive Medical Expense Coverage; Major Medical; Prescription Drug Expense Coverage; Hospital Expense Benefit may be terminated by Aetna as follows:

When the premium for the employees' coverage has not been paid. This right to terminate shall be in accordance with the Grace Period and Payment of Premiums and Fees provisions and is subject to the terms of any laws or regulations.

When the Policyholder ceases to meet the requirements for a group as defined under applicable state law or regulation.

Policyholder and Insurance Company Matters (Continued)

Discontinuance of Policy (Continued)

When the Policyholder fails to meet Aetna's contribution or participation requirements. Aetna may request:

certification of the Policyholder's compliance with Aetna's participation and contribution requirements; and

certification of group status;

prior to renewal. Aetna may exercise its right to non-renew if such certification is not provided.

When the Policyholder fails, without good cause, to perform in good faith its obligations under this policy including an act or practice that constitutes fraud or intentional misrepresentation of a material fact relevant to the coverage provided under this policy.

In accordance with any applicable state or federal law, rule or regulation.

When Aetna decides to discontinue offering:

a particular type of group health expense coverage; or

all its group health expense coverage in the state the policy is issued; provided all group health expense coverages issued or delivered for issuance in such state are discontinued and not renewed.

Except if Aetna discontinues offering a type of group health expense coverage, Aetna will give the Policyholder advance written notice of when it will terminate the policy. The date shall not be earlier than 31 days after the date of the notice unless it is agreed to by the Policyholder and Aetna.

If Aetna discontinues offering a particular type of group health expense coverage, it shall:

provide written notice to each affected employer, (and all covered employees and dependents), of the discontinuance within 90 days before such plans discontinue;

offer each affected employer the option, on a guaranteed issue basis; to purchase any other group health benefit plan currently being offered in that market; and

act uniformly without regard to the claims experience of the affected employers; or any health status-related factor relating to any covered employee or dependent who may become eligible for coverage.

If Aetna discontinues offering all its group health expense coverages, it shall provide written notice to each affected employer, (and all covered employees and dependents), of the discontinuance at least 180 days before such discontinuance.

Discontinuance of Policy (Continued)

If:

This policy terminates as to any of the employees of a Member Employer; and

Premiums and fees have not been paid for the period this policy; or any coverage included was in force for those employees;

then the Policyholder and the Employer shall be jointly and severally liable to Aetna for the unpaid premiums and fees, including those due for the grace period. Employees shall also remain liable for employee cost sharing and other required contributions to coverage for any period of time the policy is in force during the Grace Period.

Aetna 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 Aetna's written confirmation to the Policyholder, Aetna 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.

Aetna may charge the Policyholder a reinstatement fee if any or all coverage is terminated; and later reinstated under this policy.

Policyholder and Insurance Company Matters (Continued)

Administrative Matters

Aetna has complete discretionary authority to review all denied claims for benefits under this policy. In performing its review, Aetna 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.

Aetna shall be deemed to have properly exercised such authority. It must not abuse its discretion by acting arbitrarily and capriciously. Aetna has 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 Aetna.