Large Group and Public & Labor Insured Medical Disclosure as of 01/01/2024

Contents

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This supplemental underwriting disclosure document (the “Supplement Document”) provides additional information regarding your programs and services and is intended to be used in conjunction with your new business proposal or renewal letter. The Supplemental Document applies to our Large Group and Public & Labor Accounts Insured medical relationships administered by Aetna Life Insurance Company and its affiliates, including Innovation Health Insurance Company, Texas Health + Aetna Health Insurance Company, Banner Health and Aetna Health Insurance Company, Allina Health and Aetna Insurance Company and Sutter Health and Aetna Administrative Services, LLC. For purposes of this document, Aetna may be referred to using ‘we’, ‘our’ or ‘us’ and your company may be referred to using “you” or “your”.

Contract Period

Our policies provide for automatic renewal upon the completion of each contract period unless either party invokes the termination provision requiring 31 days advance written notice of termination to the other party. This provision may be invoked at any time during the continuance of the contract (that is, not just limited to termination occurring on the renewal date).

Medical Disclosure Information

At the time of annual enrollment, your plan participants should be provided with the Medical Disclosure information related to their plan of benefits. Go to www.aetna.com and enter the word "Disclosure" in the search field and then select the appropriate state and product under Group Plans. Please provide the applicable Medical Disclosure document and any required Addendum to your plan participants. If you have any questions, please contact your broker or account management team.

Eligibility

Employee Eligibility

Eligibility applies to:

- Permanent full-time employees working 25 hours or more per week, on a regularly scheduled basis or as mandated by legislative or regulatory requirements.
- Eligible dependents include an employee's spouse, domestic partner, and children up to the limiting age of the plan or as mandated by legislative or regulatory requirement. Individuals cannot be covered as an employee and dependent under the same plan.
- Children eligible for coverage through both parents cannot be covered by both under the same plan.

Dependent Eligibility

Eligible dependents include an employee's spouse and children up to the limiting age of the plan. Individuals cannot be covered as an employee and dependent under the same plan, nor may both under the same plan cover children eligible forcovered as an employee and dependent under the same plan, nor may both under the same plan cover children eligible for coverage through both parents. Dependents must enroll in same benefit option as the employee. Domestic partners may be covered as eligible dependents if the employer elects this designation at contract effective date or renewal date. Coverage is available to eligible dependents who are same sex or opposite sex partners. If the plan sponsor elects to cover domestic partners, the plan sponsor is responsible for determining whether the domestic partner is eligible.

Eligibility Transmission

We will receive eligibility information weekly or biweekly, from the Plan Sponsors location(s) and/or by the Plan Sponsor's designated vendor. Our preferred method of submission is via electronic connectivity. We do not charge for the first 4 electronic reporting (ELR) segments whether associated with one transmission or by multiple methods. Costs associated with more than 4 electronic reporting segments or with any custom programming necessary to accept the Plan Sponsor's eligibility information and/or information coming from a designated vendor are not included in this proposal and will be assessed separately. During the installation, we will review all available methods of submitting eligibility information and identify the approach that best meets the Plan Sponsor's needs or the needs of their designated vendor.

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Member ID Cards

Our standard is to provide new customers with physical ID cards for the family ("family style") except where individual ID cards are mandated by state law. The number of cards mailed is dependent on the type of coverage and state laws. For existing customers at renewal, digital ID cards are issued to members with an email address on file when changes are minor. Customers requesting a reissue of ID cards without a business reason may incur an additional charge. Examples of a business reason for reissuing physical ID cards where charges will be waived include, but are not limited to:

- Key Benefit Plan Changes
- New Hires/Rehires
- Member elects a different benefit plan option
- Member calls to request a replacement/additional ID card

Customer requests to issue individual ID cards (one card to each member versus family style) may also result in additional fees (except where mandated by state law.) ID cards and member plan details which include plan deductibles and out of pocket limits are always available electronically through our secure member website. Members can visit www.aetna.com to register and sign into their account.

Producer Compensation

Aetna will honor "Agent of Record" or "Broker of Record" letters when an agent, broker or consultant sells new business or takes over one of its customers from another agent, broker or consultant. Please have an appropriate representative from your company sign such a letter using your company's letterhead. The change will become effective on the first day of the month following the date the payment unit receives the "Agent of Record" or "Broker of Record" letter unless another future date is designated in the letter. Aetna has various programs for compensating agents, brokers and consultants. If your company would like information regarding commission and additional bonus programs for which your agent, broker, or consultant may be eligible for, payments (if any) which Aetna has made to your agent, broker, or consultant (including commission and applicable bonus payments), or other material relationships your agent, broker, or consultant may have with Aetna, you may contact your agent, broker, or consultant, or your Aetna Account Executive. Information about Aetna's programs for compensating agents, brokers and consultants is also available at www.aetna.com.

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Network Services

Primary Care Physician Referrals

Due to certain provider contractual arrangements with some Independent Provider Associations (IPAs) and medical groups, we will permit specific exemptions to the requirement that a member obtain a referral from their primary care physician (PCP) before receiving care from other providers.

California Primary Care Physician Referrals

Given the unique nature of the health care system in California, referral registration for members in California is generally not required *. The delegated model in place in the state already encourages providers to make appropriate referral decisions for our members. We believe this decision is in the best interests of plan sponsors, members and providers. * However, please note that referral registration is required in California in the event that the servicing provider is not in the same network area (e.g., Los Angeles, Northern California, San Diego and Central Valley) as the member or the member's PCP. In addition, PCP selection is required. Par provider claims for members that do not select a PCP will be processed at the par non-authorized level.

Relationship Advisor

At times, we secure the assistance of third parties in support of procuring business and responding to RFPs. Any payments to such third parties will be disclosed to you in case you choose to include such information in your Schedule 5500.

Claim and Member Services

Alternate Office Processing (AOP)

We regularly use both internal and external claim adjudication services to meet service requirements of our business. These services may be located inside or outside of the United States. Aetna quality standards and controls apply to all claims regardless of where they are processed. Standard pricing assumptions are in effect based on type of product, auto-adjudication, plan design, and customer specific requirements. We may adjust rates based on the above factors and/or where plan sponsors wish to limit use of Alternative Office Processing (AOP).

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Medical Explanation of Benefits (EOBs)

Aetna doesn't produce paper EOBs for members registered through our member website. Aetna doesn't' produce EOBs for claims when there is no member liability. EOBs are always available electronically through our secure member website. Members can visit www.aetna.com to register and sign into their account.

Federal Mandates

Federal Mental Health Parity

The Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) applies to fully-insured Traditional and HMO Middle Market (MM), Public and Labor (P&L) & National Accounts (NA) commercial plans for plan years beginning on or after October 3, 2009. Please speak to your Account Manager if you would like additional information.

European Union: General Data Protection Regulations (GDPR)

Aetna International has implemented a framework to follow the General Data Protection Regulation (GDPR), which became law in all European Union (EU) and European Economic Area (EEA) countries on May 25, 2018. This law gives people greater protection over their personal data, with the potential for significant fines for privacy breaches. GDPR includes requirements related to data collection, storage and usage among the companies and organizations that process personal data of individuals in the European Union. Our domestic plans are not in scope. To help support operational requirements of GDPR, members based in the EU and EEA must be enrolled in Aetna International plans.

Health Care Reform

Aetna believes this new business proposal or renewal letter is compliant with health care reform.

For Customers with Grandfathered and Non-Grandfathered Plans

For your company's plans that are currently certified as grandfathered, in order to retain grandfathered status, the plan must meet all grandfathering criteria and must have done nothing to cause the loss of grandfathered status in relation to the benefits in place on March 23, 2010. It is your responsibility to inform us whether changes to your plan have resulted in a loss of grandfathered status. We recommend that you seek the advice of legal counsel in making this determination and/or before making changes to your medical plan or your business that might defeat grandfathered status.

You are also required to notify us if your contribution rate changes for a grandfathered plan at any point during the plan year. By accepting your renewal, you represent that your contribution rate towards the cost of coverage for the upcoming plan year has not decreased by more than 5 percentage points below the contribution rate that was in effect on March 23, 2010.

Except for specific and limited scenarios described as transitional rules in the health care reform legislation, if a plan's grandfathered status has been lost, it cannot be regained. If, after reviewing the grandfathering rules with your benefit consultant or counsel, you determine that your coverage could be or is grandfathered, and you want to retain grandfathered status, you should contact your Account Executive for further instructions.

For Customers Claiming Religious Exemption

Certain employers and organizations with a religious or moral objection, may claim an exemption from ACA contraceptive services coverage requirements, or request an accommodation. If you qualify and want to claim an exemption or request an accommodation, please work with your Aetna Account Executive to submit the required Certification so Aetna can handle accordingly. Aetna will treat your plan as subject to the ACA contraceptive services coverage requirements without an executed Certification on file.

Retiree Only Plan Status Certification

Guidance issued by the Internal Revenue Service (IRS), and the U.S. Department of Labor (DOL), and Department of Health and Human Services (HHS) has indicated that "retiree-only" plans are exempt from the benefit mandates under the ACA (though retiree-only plans are subject to certain ACA fees and assessments). In order to demonstrate the establishment of a retiree-only plan, a plan should maintain, separately from the plan for current (i.e., active) employees, a separate plan document and Summary Plan Description (SPD) and file a separate Form 5500. If your company has a retiree-only plan, and wants to be considered exempt, you may be asked to submit a retiree-only certification form and required documentation by your Aetna Account Executive.

The benefits and fees within the new business proposal or renewal letter are subject to change pending any required approvals or future guidance from state or federal regulatory agencies. If you have questions, please contact your Aetna Account Executive.

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Waiting Period Requirement

When renewing your plan(s) with us, you represent that:

- You will give us effective dates for your employees and their dependents that take into account all state and federal eligibility conditions and waiting period requirements, including a reasonable and bona fide orientation period.
- If this information changes, you will inform us immediately.

Summaries of Benefits and Coverage (SBC)

The SBC must include statements about whether the plan or coverage provides minimum essential coverage (MEC) and if the coverage meets minimum value (MV) requirements. Under the Affordable Care Act (ACA), MV and MEC determinations are associated with the employer shared responsibility provisions. We will review the MV standard for each plan based on the MV calculator criteria provided by the Department of Health and Human Services (HHS) and will indicate within the SBC whether the plan meets or does not meet the MV standard based on this review. We do not provide legal or tax advice and recommend that plan sponsors consult with their own legal and tax counselors when reviewing MEC and MV determinations. We have no responsibility or liability regarding the MV or MEC evaluation, regardless of the role we may have played in reviewing/producing the SBC documents. To the extent you disagree with our evaluation, we will make changes to reflect your determination, as you are responsible for the final determination of these SBC elements.

Employer Reporting Requirements

Under Internal Revenue Code (IRC) Section 6055 health insurance issuers, certain employers, government agencies and other entities that provide Minimum Essential Coverage (MEC) to individuals must report to the IRS information about the type and period of coverage and furnish related statements to covered individuals. This information is used by the IRS to administer the individual shared responsibility provision and by individuals to show compliance with the individual shared responsibility provision.

For insured group health plans, the reporting obligation under Section 6055 is our responsibility. We will report the required information to the IRS about the type and period of coverage provided to each individual member enrolled in our insured plans and will furnish the required statements to subscribers.

IRC Section 6056 requires applicable large employers (those having employed an average of 50 or more full-time employees during the preceding calendar year) to report to the IRS information about the health care coverage they have offered and furnish applicable statements to employees. The purpose is to allow the IRS to enforce the employer responsibility provisions.

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To satisfy the 6056 employer reporting requirements, an applicable large employer must file the required returns with the IRS by no later than February 28 of the year following coverage (if filing on paper) or March 31 (if filing electronically,) and furnish a statement to all full-time employees by January 31st of the year following the calendar year to which the return relates.

State Mandates

Alaska Dental, Vision, and Hearing Mandated Offer

Alaska law requires that we offer you a buy-up for optional coverage for hearing, vision, and dental benefits at an additional premium.

Arkansas Musculoskeletal Disorders Mandated Offer

In accordance with the provision of Arkansas House Bill 2363, as enacted by the 2001 Session of Arkansas Legislature, Aetna Life Insurance Company must offer coverage, for the treatment of musculoskeletal disorders. Benefits for treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including TMJ and craniomandibular disorder. Treatment includes surgical and non-surgical procedures and diagnosis and treatment whether the conditions are a result of accident, trauma, congenital defects, developmental defect or pathology. Coverage will include in-mouth appliances.

California Infertility Mandated Offer

Per California Ins. Code § 10119.6 & Cal Health & Safety Code §1374.55, we are required to offer you a buy-up option for comprehensive infertility services, available for an additional premium. It provides additional infertility treatment services including gamete intra-fallopian transfer (GIFT). The Comprehensive infertility/GIFT Benefit Rider includes coverage for 6 cycles of ovulation induction, 6 cycles of artificial insemination and 1 cycle of gamete intra-fallopian transfer in the lifetime of the member.

California HMO Outpatient Behavioral Health

Based upon guidance provided by the California Department of Managed Health Care in conjunction with a regulatory filing pertaining to CA HMO plans, certain outpatient benefits, including outpatient medical, behavioral health, and substance use disorder benefits, were re-classified for purposes of federal mental health parity law. As a result, the cost share for certain outpatient medical and surgical benefits require a revision. Please refer to the Rate Exhibit bullet for the specifics. The cost shares for outpatient

medical and surgical benefits did not change as a result of this outpatient behavioral health reclassification. Outpatient behavioral health and substance use disorder benefits include the following: Mental Health/Substance Abuse Office Visits, psychological testing; medication therapy monitoring, partial hospitalization, intensive outpatient programs, substance abuse day treatment, medical treatment for withdrawal symptoms, autism behavioral therapy/Applied Behavior Analysis (ABA), Home health care for behavioral health or substance abuse disorders. As a result, the cost share for all outpatient behavioral health and substance use disorder benefits changed from $ Copay to Covered at 100%, no deductible, no copay. The cost share for outpatient behavioral health and substance use disorder benefits did not change as a result of this outpatient behavioral health reclassification.

California Traditional Products Outpatient Behavioral Health

Based upon guidance provided by the California Department of Insurance in conjunction with a regulatory filing pertaining to CA PPO based plans, certain outpatient behavioral health benefits were re-classified for purposes of federal mental health parity law. As a result of mental health parity testing, the cost share for certain outpatient medical and surgical benefits requires a revision. Please refer to the Rate Exhibit bullet for the specifics. The cost shares for outpatient medical and surgical benefits did not change as a result of this outpatient behavioral health reclassification. Outpatient behavioral health all other benefits include the following: Electroconvulsive therapy (ECT), Outpatient monitoring of injectable therapy, partial hospitalization, transcranial magnetic stimulation, neuropsychological testing, psychological testing, intensive outpatient programs, outpatient detoxification, ambulatory detoxification, medical treatment for withdrawal symptoms, behavioral health treatment for pervasive development disorder/autism, Home health care for behavioral health or substance abuse disorders. As a result, the cost share for Behavioral Health - All Other benefits requires a revision to be covered at plan coinsurance after deductible. As a result, the cost share for all outpatient behavioral health and substance use disorder benefits changed from $ Copay to Covered at 100%, no deductible, no copay. The cost share for outpatient behavioral health and substance use disorder benefits did not change as a result of this outpatient behavioral health reclassification.

Connecticut Premium Refund (HB 5669)

CT HB 5669 allows employers to elect to stop paying group premiums for employees and their dependents if: 1) the employee was voluntarily terminated from employment or is terminated for any other reason, but layoff, and; 2) the employer elects to stop payment within 72 hours of the termination by notifying both the carrier and the employee. In order to make this election, notify your Aetna billing area.

California HMO Rate Request

Upon receiving such notice of a rate change at least 120 days before the contract renewal effective date, please note the following important information for your large group health care service plan contract in California

a) The rate does not include any portion of the excise tax paid by the health plan.
b) Beginning July 1, 2021, upon receiving notice of a rate change, a large group contract holder that has coverage that is experience rated in whole or blended can request the DMHC to review a rate change, if the contract holder makes the request within 60 days of receipt of their notice. A large group contract holder may only request a review of a rate change from a health plan licensed by the DMHC. To apply for a review of a rate change for a particular group**,** at least one of the followings must apply:
    - The contract holder has a combined total of more than 2,000 enrollees (employees plus dependents) enrolled in all health plans.
    - The rate change is from a health plan that failed to provide you with information required under Article 6.2 of the Knox-Keene Act (Review of Rate Increases) or Section 1385.10 of the California Health and Safety Code (Health Plan Annual Claims Reporting Requirements).
c) Plan Sponsors may apply to have the Department of Managed Health Care (DMHC) review the rate change by sending an e-mail with the completed form, found on the DMHC website https://wpso.dmhc.ca.gov/LargeGroupRateReview/

Connecticut Copayment and Benefit Category Requirements

Please be advised that your renewal plan will meet the Connecticut Insurance Department's (CID) copayment and benefit category requirements. These requirements are explained in CID Bulletin HC-109 issued on February 5, 2016. The bulletin can be found in this URL: http://www.ct.gov/cid/lib/cid/HC-109-MaximumCostSharing.pdf

Delaware Plans

We will provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopeciaareata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your Benefit Plan will apply but coverage for scalp hair prosthesis as a result of alopecia areata will not exceed $500 per year.

Florida Plans

The rates assume that all lives residing in FL and within the HNOnly or HNOption service area will be provided HNOnly or HNOption plans only and any lives residing outside of the FL or outside the HNOnly/ HNOption service area will be provided another plan option. Plan designs will be provided at point of sale.

Illinois TMJ and Craniomandibular Disorder Mandated Offer

Illinois law requires that we offer you optional coverage for the treatment of temporomandibular joint disorder and craniomandibular disorder for an additional premium and subject to standards of insurability. The maximum lifetime benefit for treatment of these disorders must be no less than $2,500. If you'd like to know more about adding this optional coverage to your plan, please contact your sales representative. Please note that continuing of your plan without adding this optional coverage constitutes a declination of this offer.

Illinois Hearing Related Services Mandated Offer

Illinois law requires that we offer you optional coverage for hearing instruments and related services at an additional premium. Coverage can be limited to a maximum benefit of no more than $2,500 per hearing instrument every 24 months. If you'd like to know more about adding this optional coverage to your plan's renewal, please contact your sales representative. Please note that renewal of your plan without adding this optional coverage constitutes a declination of this offer.

Illinois Registration of Business Entities

If awarded your business, we will comply with Section 20-160 of the Illinois Procurement Code. If Aetna fails to comply with Section 20-160 of the Illinois Procurement Code, any contract between us shall be voidable under Section 50-60 of the Illinois Procurement Code. We have registered as a business entity with the State Board of Elections and our

registration certificate is enclosed. We acknowledge that we have a continuing duty to update the registration in compliance with applicable Illinois law.

Kentucky Dependent Age

If you have plans situsedin Kentucky that do not have to follow Federal dependent age law, please let us know as the Kentucky dependent age offer may apply.

Louisiana Balance Billing

Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those out-of-network services, in addition to applicable amounts due for co-payments, coinsurance, deductibles, and non-covered services. Specific information about in-network and out of – network facility-based physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan.

Massachusetts Health Care Reform Law

Massachusetts Health Care Reform Law requires that, a Massachusetts resident age 18 and older must have health coverage that satisfies certain minimum creditable coverage (MCC) requirements or be subject to personal income tax penalties. We must disclose to insured plan sponsors and subscribers with Massachusetts contracts whether their medical plan meets these MCC requirements.

Massachusetts Premium Contribution Non-Discrimination Requirement

Massachusetts laws and regulations as further specified in Massachusetts Bulletin 2007-04 require that a health insurance carrier may only enter into a contract with an employer if: a) the employer offers the same health benefits plan(s) to all of its full-time subscribers living in Massachusetts in the carrier's approved network service area; and b) for each benefits plan, the employer does not make a smaller premium contribution percentage to a full-time subscriber residing in Massachusetts than the employer makes to any other full-time subscriber who resides in Massachusetts and receives an equal or greater total hourly or annual salary. This does not apply to contribution percentages established in a collective bargaining agreement. For information on how you can satisfy these statutory requirements, please refer to Massachusetts Bulletin 2007-04.

Maine Religious Employer

Maine law allows religious employers to exclude coverage for abortions that are not necessary to preserve the health or life of the mother. Contact your account representative for details on the process for excluding this coverage.

Missouri Groups Offering an EPO Medical Plan

If your group has selected an EPO Plan, a plan offering out-of-network coverage must also be included as a dual option. Enrollees must be given the option to select or reject a plan with out-of-network coverage. Upon request, you must provide to Aetna evidence of the enrollee's election.

Missouri Open Access Managed Choice (OAMC) Notice

Members residing in Missouri may not be enrolled in an OAMC plan. They would need to be enrolled in another product, such as PPO.

New Jersey Notice of Religious Exclusion

A religious employer may request, an exclusion for medical and surgical abortion coverage if coverage conflicts with the religious employer's bona fide religious beliefs and practices.

New York Religious Opt Out Requirements for Medically Necessary Abortion, Contraceptive drugs and devices

New York Law requires that insurers provide you with the following option: verified religious employers may choose to exclude coverage for medically necessary abortion, contraceptive drugs and devices, as well as tubal ligation. To be a religious employer groups must meet the criteria for being a religious employer as defined in NY State Insurance Law. Contact your account representative for details to learn if you qualify for the exemption processes for medically necessary abortions (including the annual certification requirement) and contraceptive drugs and devices and tubal ligation surgery.

New York Dependent Age 30 Mandated Offer

New York law requires that we offer you the option to provide dependent coverage to age 30 or to allow dependents who reach the maximum age to continue his or her coverage to age 30 under certain conditions.

New York Out-of-Network Ambulatory Surgical Coverage Mandated Offer

New York law requires an insurer to make available, upon your request, a plan that covers Out of Network Ambulatory Services versus our standard plan setup of Not applicable or not covered benefit Out of Network. If you are interested, please contact your Account Representative regarding quotation.

New York Skilled Nursing Facility Mandated Offer

New York law requires an insurer to make available, upon your request, a plan that provides unlimited benefits (no day limits) for non-custodial care provided in a Skilled Nursing Facility. The services are subject to medical necessity review and pre-authorization. These benefits are also subject to the terms of your plan selected.

New York Hospice Coverage Mandated Offer

Upon request, you can select a plan that provides the following hospice coverage: (i) a total of two hundred ten days of coverage beginning with the first day on which care is provided, for inpatient hospice care in a hospice or in a hospital and home care and outpatient services provided by the hospice, including drugs and medical supplies, and (ii) five visits for bereavement counseling services, either before or after a covered person's death, provided to the covered family members of the terminally ill person.

New York Out-Of-Network Fair Health Mandated Offer

New York law requires an insurer to make available, upon your request, a plan that covers at least 80% of the usual and customary cost of each out-of-network health care service after you meet your deductible or any out-of-pocket benefit maximum. If you are interested, please contact your Account Representative regarding quotation.

New York National Medical Support Notice

A National Medical Support Notice ("Notice") issued by the New York State Division of Child Support Enforcement pursuant to a court order requires a non-custodial parent to provide health insurance for a dependent child. If we receive a Notice, we must enroll the dependent child and, if necessary, the parent. This applies even if a non-custodial parent fails to sign the required enrollment form. Importantly, if a party fails to comply with the court order, that party will be responsible for any health care costs incurred due to that failure. Once the child is enrolled, we will forward ID cards and any other coverage documents either to the custodial parent or, if that parent's name and address is not on the enrollment form, to the issuing agency listed on the Notice. We may include a letter in those materials requesting that the custodial parent contact us regarding a HIPAA authorization form.

NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FORTHE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSUR-ANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYERWELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIALLOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSEPREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSECOVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THEPERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TOHEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THEGENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THEFEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANYPERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSONTO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OFTHE TERMINATION OF THE INSURANCE.

Oregon Religious opt Out for Abortion and Contraceptive drugs and devices

Oregon law requires health benefit plans to include coverage for abortion procedures and contraceptive drugs, devices, and products. Religious employers may choose to exclude coverage for abortion and contraceptives from the health benefit plan. Contact your account representative for details on the exemption process.

Tennessee Physical Therapy, Occupational Therapy, and Chiropractic Care

Tennessee law requires that we offer a plan option in which Physical Therapy, Occupational Therapy and Chiropractic Care benefits have member cost share (copayments and coinsurance) that is the same as for Primary Care Physicians. If your current benefit plan offering does not include this feature and you would like to make a plan change, please contact your Account Manager.

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Texas In Vitro Fertilization Procedures Mandated Offer

Per Texas Ins. Code § 1366.001-1366.007, we are required to offer you ~~a~~ buy-up option for optional coverage which includes expenses incurred by the employee or dependent wife of a male employee for outpatient in vitro fertilization procedures to the same extent as other pregnancy-related procedures.

Texas Routine Speech and Hearing Exams Mandated Offer

Per Texas Ins. Code § 1365.001-1365.004, we are required to offer you ~~a~~ buy-up option for optional coverage which includes routine speech and hearing exams. Coverage required under this option: (1) may not be less favorable than coverage for physical illness generally under the plan; and (2) must be subject to the same durational limits, dollar limits, deductibles, and coinsurance factors as coverage for physical illness generally under the plan.

Notice to large group employers located outside the state of Vermont

This quote is based on the [representation/census] that your plan covers fewer than 25 certificate holders in Vermont. Aetna cannot quote or renew cases that cover 25 or more Vermont residents who work at an employer location in Vermont.

Notice to large group employers located inside and outside the state of Vermont

Health insurers who offer coverage in the state of Vermont must offer employers the option to cover all part-time employees who are Vermont residents and work 17.5 hours or more. Please note, however, that we are not filed and approved to sell medical coverage to employers located in the state of Vermont and must offer coverage to out of state coverage as noted above. Please contact your Account Manager for details.

If you are a person with a disability who needs assistance using our websites (or mobile apps), our Customer Service Representatives can assist you. Please call them at the number on your member ID Card or at 1-855-401-5713 from 9 a.m.-5 p.m. ET Mon-Fri. Persons with a hearing or speech disability can use 711 for Telecommunications Relay Service (TRS). Additional information can be found on the following URL: ***https://www.aetna.com/accessibility/accessibility-services.html****.*