Live it

Knowing you're covered always feels so good

We're focused on you — all of **you**: body, mind and spirit. And that includes your financial well-being. With the Critical Illness Plan, we pay you cash to use on medical expenses, like your deductible. Or everyday expenses, like groceries. You can access your benefits through a personalized website — and a whole lot more.

You can focus more on your health, no matter what happens. Enroll in the Critical Illness Plan today.

The Aetna Critical Illness Plan is offered and/or underwritten by Aetna Life Insurance Company (Aetna).

aetna.com

57.02.424.1 (5/19)

We've got your back

Critical Illness Plan overview

When the unexpected happens, we want you to focus on what matters most — your health. The Aetna Critical Illness Plan pays you cash benefits for a critical illness diagnosis, such as a heart attack or stroke. You can use the benefits to pay for medical expenses, such as your medical deductible, or for everyday expenses, such as food and childcare. Below are examples of the services covered and the cash benefit amount you'd receive. For more in-depth plan details, just view the Critical Illness Plan benefits summary.

Services

- 21 covered critical illnesses (CIs), including cancer
- Subsequent diagnosis — CI (after 6 months)
- Recurrence — CI conditions, including cancer (after 6 months)

Benefits

- $10,000, $20,000 or $30,000 face amount
- 100% of face amount — employee
- 50% of face amount — spouse
- 50% of face amount — children
- 100% subsequent diagnosis — CI
- 100% recurrence — CI
- 100% recurrence — cancer

Find what you need, when you need it

Your member website is your one-stop shop for all things related to your plan. You can do things like:

- File a new claim or view the status of submitted claims
- See coverage or claims information for yourself or your dependent(s)
- Review plan documents, including your benefits summary and certificate of coverage
- Sign up to receive your benefits via direct deposit

Savor the savings

Aetna offers access to exclusive discounts on health products and programs, including gym memberships, fitness products, weight-loss programs and much more.

We've got your back

Email customer service through the member website anytime. Or connect with us via phone at **1-800-607-3366 (TTY: 711)**, Monday through Friday, 8 a.m. – 6 p.m. your local time.

THIS PLAN IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. This plan provides limited benefits. It pays fixed-dollar benefits for covered services without regard to the health care provider's actual charges. This benefit payment is not intended to cover the full cost of medical care. You are responsible for making sure the providers' bills get paid. These benefits are paid in addition to any other health coverage you may have.

This plan has exclusions and limitations. Refer to the actual policy and certificate to determine which benefits are not payable. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

Critical Illness Plan: Benefits under the Policy will not be payable for any critical illness that is diagnosed or for which care was received outside the United States and its territories, or for any loss caused in whole or in part by or resulting in whole or in part from the following: 1. Suicide or attempt at suicide, intentional self-inflicted injury or sickness, any attempt at intentional self-inflicted injury, injury caused by a self-inflicted act or sickness, while sane or insane, except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM). 2. Being under the influence of a stimulant (such as amphetamines or nitrates), depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician, that are misused by the insured person, except when resulting from a diagnosed disorder in the most current version of the DSM. 3. Engaging in an assault, felony, illegal occupation or other criminal act. 4. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection.

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

ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age or older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information, call the Connector at **1-877-MA-ENROLL (1-877-623-6765)** or visit the Connector website (**mahealthconnector.org**). THIS POLICY ALONE DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling **617-521-7794** or visiting its website at **mass.gov/doi**.

This material is for information only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Information is believed to be accurate as of the production date; however, it is subject to change.

Policy forms issued in Idaho include: GR-96843.

Policy forms issued in Missouri include: GR-96844 01.

Policy forms issued in Oklahoma include: GR-96843.

Aetna Inc.
57.02.424.1 (5/19)

Critical Illness Plan – Frequently Asked Questions

How does the Critical Illness Plan work?

The Critical Illness Plan pays cash benefits directly to you for services related to a critical illness while you are covered under the plan.

Who can be covered under the plan?

Coverage is available for employees, their spouse and dependent children under the age of 26 (state mandates may apply).

Do I have to be actively at work to enroll in coverage?

Yes, you must be actively at work in order to enroll and for coverage to take effect. You are actively at work if you are working, or are available to work, and meet the criteria set by your employer to be eligible to enroll.

Do I need to answer medical questions to enroll in this coverage?

No, you do not have to answer any questions about your health to enroll.

How soon after I enroll do my benefits start?

Your benefits will start based on the beginning date set by your employer.

Can I have more than one Critical Illness Plan?

No, you are not allowed to have more than one Critical Illness Plan.

Is the Critical Illness Plan compatible with a Health Savings Account (HSA)?

Yes, the Critical Illness Plan is compatible with Health Savings Accounts.

Is there a member website?

Yes, you can see your plan information anytime once you register at myaetnasupplemental.com. From there you can find important plan documents, file a claim online, view the status of current and past claims, and contact customer service.

How do I submit a claim? When can I submit a claim for benefit payment under my coverage?

You can submit a claim online through the member website at myaetnasupplemental.com. Or you can download a paper claim form or request one be sent to you by our customer service and mail it to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079.

You can submit a claim as soon as a covered event occurs. If we need supporting documentation from you, such as a hospital bill, we can’t process your claim until we have all the documentation in hand.

When a claim is filed and benefits are paid, who receives the benefits: me or my doctor?

You, the member, receive the benefits directly. You can sign up for direct deposit in the member website or a check will be mailed to you.

If I leave the company, can I keep my coverage? What is the cost, and how do I go about keeping the plan?

Yes. The Critical Illness Plan allows you to keep your existing coverage for the same rate and make direct payments to the carrier. We call this "a portability option." You may exercise this option if your employment ends for any reason other than for gross misconduct. The portability form is in the plan documents section of the member website. Refer to your certificate of coverage for more portability provisions. The portability option is not available in New York and Vermont.

What does Face Amount mean?

Face Amount means the maximum fixed dollar amount you could receive for each critical illness benefit. The Face Amount for your spouse and each of your dependents is a percentage of the employee's Face Amount. Some benefits pay a fixed amount that equates to a percentage of the Face Amount. Benefit amounts vary, based on your plan design.

What happens if a covered person is diagnosed with a covered critical illness condition, and does not seek more treatment?

The Critical Illness Plan pays based on diagnosis of a covered condition, not its treatment. Exceptions include the major organ failure benefit, which requires the insured person being placed on the United Network for Organ Sharing list for a transplant, and a coronary artery condition requiring bypass surgery.

What happens if I have a heart attack a month into coverage under the Critical Illness Plan and get diagnosed with cancer two months later?

The Critical Illness Plan does cover a heart attack. If you are diagnosed with a heart attack while your coverage is active, you'll be paid the Face Amount of the plan. The plan also provides coverage for a subsequent covered condition, when a later diagnosis occurs at least 180 days after the previous diagnosis. The 180-day separation period is waived if the later diagnosis is in a different benefit category, which is defined as either cancer or non-cancer benefits. So in the example above, both benefits would be payable, as long as you were not previously diagnosed with and receiving treatment within 180 days of the date your plan started.

What happens if a covered person dies while covered under the Critical Illness Plan?

Benefits will be paid to the member's beneficiary on file. If one isn't on file, payment will go to the member's estate.

What if I don't understand something I've read here, or have more questions?

We want you to understand these benefits before you decide to enroll. Reach out to us. Call us toll-free at 1-800-607-3366, (TTY: 711), Monday through Friday, 8 a.m. to 6 p.m your local time. We're here to answer questions before and after you enroll.

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This plan provides limited benefits. It pays fixed-dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. You are responsible for making sure the providers' bills get paid. These benefits are paid in addition to any other health coverage you may have.

This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. Aetna does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna® plans, refer to **aetna.com**.

This plan has exclusions and limitations. Refer to the actual Booklet-Certificate and schedule of benefits to determine which services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

Exclusions: Benefits under the Policy will not be payable for any critical illness, that is diagnosed or for which care was received outside the United States and its territories, or for any loss caused in whole or in part by or resulting in whole or part from the following: 1. Suicide or attempt at suicide, intentional self-inflicted injury or sickness, any attempt at intentional self-inflicted injury, injury caused by a self-inflicted act or sickness, while sane or insane; except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM) 2. Being under the influence of a stimulant (such as amphetamines or pitrates), depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by the insured person; except when resulting from a diagnosed disorder in the most current version of the DSM 3. Engaging in an assault, felony, illegal occupation or other criminal act 4. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection. Financial Sanctions Exclusion If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx. ATTENTION MASSACHUSETTS RESIDENTS: As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL (1-877-623-6765) or visit the Connector website (www.mahealthconnector.org). THIS POLICY, ALONE, DOES NOT MEET MINIMUM CREDITABLE COVERAGE STANDARDS. If you have questions about this notice, you may contact the Division of Insurance by calling 1-617-521-7794 or visiting its website at www.mass.gov/doi.

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57.03.459.1 (4/19)

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