

Waiver of Premium**

Covered Benefit	Employer Paid Plan
If, as a result of an accidental injury you miss 30 continuous days of work we will waive the premium beginning on the first premium due date that occurs after the 30 th day of your absence, through the next 6 months of coverage. During such absence, you must remain employed with the policyholder.	Included

**The premium waiver does not apply to your covered dependents nor does it apply to any other plan benefits, including Medical/Dental.

Accident Plan: Exclusions and Limitations

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.

Benefits under the policy will not be payable for any care, service or supply for an accidental injury related to the following:

1. Certain competitive or recreational aeronautical activities, including but not limited to: ballooning, parachuting, skydiving;
2. Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment;
3. Act of war, riot, war;
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not;
5. Committing or attempting to commit a felony;
6. Bacterial infections that are not caused by a cut or wound from an accidental injury;
7. Care provided by immediate family members or any household member;
8. Elective or cosmetic surgery;
9. Nutritional supplements
10. Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, or any form of intentional asphyxiation, except when resulting from a diagnosed disorder;
11. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle;
12. Accidental injury sustained due to the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, unless prescribed by your physician
13. Accidental injury sustained due to being legally intoxicated or under the influence of any drug intoxicant, including those prescribed by a physician that are misused.

We will not pay any benefits for a service or supply rendered or received that are not specifically covered or not related to an accidental injury.

The stay visit or service must be on or after the effective date of coverage, while coverage is in force and take place in the United States or its territories.

Portability

Your plan includes a option which allows you to keep your existing coverage by making direct payments to the carrier. You may exercise this option, if your employment ceases for any reason. Refer to your Certificate for additional provisions.

Questions and Answers about the Accident Plan

Do I have to answer any questions about my health to enroll?

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

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.

Can I have more than one Accident Plan?

No, you are not allowed to have more than one Aetna Accident Plan.

To whom are benefits paid?

Benefits are paid to you, the member.

Is my Aetna Accident policy compatible with a Health Savings Account (HSA)?

Yes, Aetna Accident policies are compatible with Health Savings Accounts.

How do I submit a claim?

Go to myaetnasupplemental.com and either "Log In" or "Register", depending on if you've set up your account. Click the "Create a new claim" button and answer a few quick questions. You can even save your claim to finish later. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail you a printed form.

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

*Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives Monday through Friday, 8 a.m. to 6 p.m., by calling **1-800-607-3366**. We're here to answer questions before and after you enroll.*

What should I do in case of an emergency?

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What happens if I lose my employment, can I take the Accident Plan with me?

Yes, you are able to coverage under the Portability provision; however, you will need to pay premiums directly to Aetna.

Important information about your benefits

THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

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If you require language assistance, please call Member Services at 1-800-607-3366 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al Servicios al Miembro a 1-800-607-3366, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

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**.

Plans are underwritten by Aetna Life Insurance Company (Aetna). This material is for information only and is not an offer or invitation to contract. Each insurer has sole financial responsibility for its own products.

Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. 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 **www.aetna.com**.

Financial Sanctions Exclusions Clause

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/resourcecenter/sanctions/Pages/default.aspx>.

Policy forms issued in Idaho, Oklahoma and Missouri include: GR-96841, GR-96842.





By your side

Aetna Critical Illness Plan

Be prepared for what happens next

Critical illness coverage can help you keep your focus on your health when it matters most. This extra coverage can help ease some financial worries during a difficult time.

What is the Critical Illness Plan?

The Aetna Critical Illness Plan pays benefits when a doctor diagnoses you with a covered serious illness or condition, like heart attack, stroke, cancer and more*. You can use the benefits to help pay out-of-pocket medical costs or towards personal expenses.

How is this different from a major medical plan?

Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that can come with a serious illness.

The Aetna Critical Illness Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

*Refer to your plan documents to see all covered illnesses under the plan.

How can you use the cash benefits?

It's completely up to you. You can use the money any way you want, like:

- deductibles or copays
- mortgage or rent
- groceries or utility bills

...or for anything else you choose.

Rest assured

Enrollment is guaranteed. We don't ask you any questions about your health. And, you get benefits paid directly to you by check or direct deposit.



Did you know?

Someone in the U.S. has a heart attack **every 40 seconds**¹.

A hospital stay for a heart attack, on average, costs **\$20,246**².

Having less to worry about

Dan* knows that heart disease runs in his family. And when a heart attack struck, he was thankful he had the Aetna Critical Illness plan.

He submitted his claim easily online and benefits were deposited directly into his bank account. As an Aetna medical member, he didn't need to upload any paperwork either.

He was able to use the money to help pay his out-of-pocket medical costs and other bills while he recovered. And, he could even keep his kids in daycare.

Handy online tools for you

You can find everything you need in one place at our member website: **myaetnasupplemental.com**. Aetna medical members can also access the site from **aetna.com**. You view see your plan documents, submit and track the status of claims, and even sign up for direct deposit.

Filing a claim is easy. Just create or log into your account on the member website. Click "Report New Claim" and answer a few quick questions. If you have an Aetna medical plan, we'll automatically retrieve any medical information needed to process your claim. That's less paperwork for you.



You can also print and mail a paper claim form to Aetna Voluntary Plans. Once your claim is approved, we will send you a check, or deposit your benefits directly into your bank account. You choose.

¹Centers for Disease Control and Prevention. Heart attack. August 18, 2017. Available at: [cdc.gov/heartdisease/heart_attack.htm](https://www.cdc.gov/heartdisease/heart_attack.htm). Accessed May 8, 2018.

²Michaels M. The 35 most expensive reasons you might have to visit a hospital in the US — and how much it costs if you do. Business Insider. March 1, 2018. Available at: [businessinsider.com/most-expensive-health-conditions-hospital-costs-2018-2](https://www.businessinsider.com/most-expensive-health-conditions-hospital-costs-2018-2). Accessed April 26, 2018.

*This is a fictional example of how the plan could work.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

The Aetna Critical Illness Plan is underwritten by Aetna Life Insurance Company (Aetna). 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 provider's 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. For more information about Aetna plans, refer to **aetna.com**.

Policy forms issued in Oklahoma include: GR-96843, GR-96844.

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



CAUTION!

AETNA LIFE INSURANCE COMPANY

SPECIFIED DISEASE/CRITICAL ILLNESS COVERAGE

OUTLINE OF COVERAGE

Read Your Certificate Carefully - This outline of coverage provides a very brief description of the important features of your certificate. This is not the insurance contract and only the actual certificate provisions shall control. The certificate sets forth in detail the rights and obligations of both you and Aetna. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

Specified disease, also referred to as critical illness, coverage - The certificate is designed to provide, to certificate holders, restricted coverage paying benefits ONLY when certain losses occur as a result of treatment or diagnosis of the critical illness. The certificate does NOT provide general health insurance.

The certificate is NOT A MEDICARE SUPPLEMENT certificate. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Aetna.

Some notes on how we use words:

- Some words appear in **bold** type. **We** define them in the Glossary section of **your** certificate.
- When we say "**we**," we mean **Aetna**.
- When we say "**you**" and "**your**," **we** mean the **employee**.

BENEFITS

Employee Face Amount	\$5,000
Insured Spouse Face Amount	50% of the employee Face Amount
Insured Children Face Amount	50% of the employee Face Amount

The applicable **Critical Illness Benefit** is payable if an **insured person** is **diagnosed** with a **critical illness**, and:

1. The **date of diagnosis** must occur while coverage for the **insured person** is in force; and
2. The **critical illness** is not excluded by name or specific description in the Certificate.

Critical Illness Benefit	Percentage of Face Amount
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coronary Artery Condition Requiring Bypass Surgery	25%
Major Organ Failure	100%
End-Stage Renal Failure	100%
Coma	100%
Paralysis	100%
Occupational Human Immunodeficiency Virus (HIV)	100%
Benign Brain Tumor	100%
Loss of Sight (Blindness)	100%
Loss of Hearing	100%
Loss of Speech	100%
Third Degree Burns	100%
Alzheimer's Disease	25%
Parkinson's Disease	25%
Lupus	25%
Multiple Sclerosis	25%
Muscular Dystrophy	25%

EXCLUSIONS AND LIMITATION

Exclusions: Benefits under the Policy will not be payable for any **critical illness**, 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. Engaging in a felony for which the **insured person** has been convicted under state or federal law;
3. Any act of war, whether declared or not, or voluntary participation in a rebellion or civil insurrection.

Also, no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his **physician** for the insured.

Note – If any **critical illness diagnosed** outside the country and is subsequently confirmed through a **diagnosis** in the United States, including its territories, a benefit is payable for the **critical illness, cancer (invasive), carcinoma in situ** or **skin cancer** diagnosed.

PORTABILITY PROVISION

If **your** coverage under the Policy terminates while the Policy remains in force, **we** will provide portability coverage. Such coverage will be available to **you** and any of **your insured dependents**.

You must complete the Portability Coverage Election Form and return it to **us** along with the first premium payment for the portability coverage not later than 30 calendar days after **your** coverage under the Policy terminates. Portability coverage will be effective on the day after benefits under the Policy terminates.

The benefits, terms and conditions of portability coverage will be the same as those provided under the Policy on the date **your** coverage terminated. Any changes made to the Policy after **you** are covered under the Portability Provision will not apply to **you** unless required by law.

The initial premium rates will be based on the premium rates in effect at the time **you** apply for portability coverage. **You** must also pay any portion of the premium previously paid by **your employer** for the coverage.

CONVERSION PRIVILEGE

If **your** coverage under the Policy terminates while the Policy remains in force, or if the Policy terminates, and as a result your coverage under this Certificate ends, **you** and any of **your insured dependents** may convert to an individual policy. To convert to an individual policy, **you** must submit a Conversion Policy Application and the required premium must be received by **us** within thirty-one (31) days after **your** coverage under the Policy terminates. If a written application is not made within thirty-one (31) days following the termination of coverage under the Policy, a conversion policy will not be available.

An Evidence of Insurability Statement or satisfaction of a **waiting period** or **pre-existing conditions** limitation will not be required. The conversion policy will provide similar benefits as coverage under the Certificate.

BENEFIT SUMMARY



ORTHODOX HEALTHPLAN

802605

Critical Illness Plus

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at www.medicare.gov.

Insurance plans are underwritten by Aetna Life Insurance Company.

The benefits in the table below will be paid when you are diagnosed with a covered Critical Illness. Unless otherwise indicated, all benefits and limitations are per covered person.

Face Amounts

Covered Benefit	Benefit Face Amount
Employee Face Amount	\$5,000
Spouse Face Amount	50% of Employee Face Amount
Child(ren) Face Amount	50% of Employee Face Amount

Critical Illness Conditions

Covered Benefit	Percent of Face Amount:
Heart Attack (Myocardial Infarction) Pays a benefit when you are diagnosed with a Heart attack (Myocardial Infarction) resulting from a blockage of one or more coronary arteries.	100%
Stroke Pays a benefit when you are diagnosed with a Stroke resulting in paralysis or other measurable objective neurological defect persisting for at least 30 days.	100%
Coronary Artery Condition Requiring Bypass Surgery Pays a benefit when you are diagnosed with a Coronary artery condition requiring bypass surgery.	25%
Major Organ Failure Pays a benefit when you are diagnosed with a Major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the insured person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.	100%
End-Stage Renal Failure Pays a benefit when you are diagnosed with End stage renal failure, and the insured person has to undergo regular hemodialysis or peritoneal dialysis at least weekly.	100%
Paralysis Pays a benefit when you are diagnosed with Paralysis, resulting in paraplegia or quadriplegia (complete, total and permanent loss of use of two or more limbs) confirmed by the insured person's attending physician. The paralysis has to continue for a period of 60 consecutive days;	100%
Loss of Sight (Blindness) Pays a benefit when you are diagnosed with Loss of sight (blindness) that is total and irrecoverable loss of sight in both eyes. Loss of sight (blindness), has to continue for a period of 90 consecutive days.	100%
Loss of Speech Pays a benefit when you are diagnosed with Loss of speech that cannot be corrected to any functional degree by any procedure, aid or device. Loss of speech has to continue for a period of 90 consecutive days.	100%
Loss of Hearing Pays a benefit when you are diagnosed with Loss of hearing in both ears that cannot be corrected to any functional degree by any procedure, aid or device. Loss of hearing has to continue for a period of 90 consecutive days.	100%
Occupational HIV Pays a benefit when you are diagnosed with Occupational HIV. The date of a positive antibody test for HIV subsequent to a prior negative test for the same condition with a lapse of between 180 days between the two tests.	100%
Coma Pays a benefit when you are diagnosed with Coma, characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance (a medically induced coma is not covered). The Coma must last for a period of 14 or more consecutive days.	100%
Benign Brain Tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%

Covered Benefit	Percent of Face Amount:
Third-Degree Burns Pays a benefit when you are diagnosed with a Third degree burn that covers more than 10% of total body surface (also called full-thickness burn).	100%
Alzheimer's Disease Pays a benefit when you are diagnosed with Alzheimer's disease, diagnosis of the disease by a psychiatrist or neurologist.	25%
Parkinson's Disease Pays a benefit when you are diagnosed with Parkinson's disease by a psychiatrist or neurologist.	25%
Lupus Pays a benefit when you are diagnosed with Lupus by a physician.	25%
Multiple Sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	25%
Muscular Dystrophy Pays a benefit when you are diagnosed with Muscular dystrophy by a physician.	25%
Subsequent Critical Illness Diagnosis Benefit The Subsequent diagnosis benefit is payable if the insured person has been diagnosed with and received a benefit for a critical illness and is subsequently diagnosed with a different critical illness.	100%

Critical Illness: Exclusions and Limitations

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. Engaging in a felony for which the insured person has been convicted under state or federal law;
3. Any act of war, whether declared or not, or voluntary participation in a rebellion or civil insurrection.

Also, no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his physician for the insured.

Note – If any critical illness, cancer (invasive), carcinoma in situ or skin cancer is diagnosed outside the country and is subsequently confirmed through a diagnosis in the United States, including its territories, a benefit is payable for the critical illness, cancer (invasive), carcinoma in situ or skin cancer diagnosed.

Portability

Your plan includes a option which allows you to keep your existing coverage by making direct payments to the carrier. You may exercise this option, if your employment ceases for any reason. Refer to your Certificate for additional provisions.

Questions and Answers about the Critical Illness Plan

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.

Can I have more than one Critical Illness Plan?

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

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.

To whom are benefits paid?

Benefits are paid to you, the member.

Is my Aetna Critical Illness policy compatible with a Health Savings Account (HSA)?

Yes, Aetna Critical Illness policies are compatible with Health Savings Accounts.

How do I submit a claim?

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What happens if I lose my employment, can I take the Critical Illness Plan with me?

Should you lose your job, you are able to continue coverage under the Portability provision. You will need to pay premiums directly to Aetna.

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In order for benefits to be payable, the date of diagnosis must occur while coverage for the insured person is in force; you must be diagnosed while your coverage is in effect.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

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We protect your privacy

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When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

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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**.

Plans are underwritten by Aetna Life Insurance Company (Aetna). This material is for information only and is not an offer or invitation to contract. Each insurer has sole financial responsibility for its own products.

Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. 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 **www.aetna.com**.

Financial Sanctions Exclusions Clause

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>**.

Policy forms issued in Idaho, Oklahoma and Missouri include: GR-96843, GR-96844.



AETNA LIFE INSURANCE COMPANY

LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Policy form GR-96844 form GR-96843

Some notes on how we use words

- When we say “**you**” and “**your**”, we mean the **employee**.
- When we say “**us**”, “**we**”, and “**our**”, we mean **Aetna**.
- Some words appear in **bold** type. We define them in the *Glossary* section of **your** Certificate.

1. Read **Your** Policy Carefully – This outline of coverage provides a very brief description of the important features of **your** Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both **you** and **us**. It is, therefore, important that **you** READ **YOUR** POLICY CAREFULLY!
2. Limited benefit health coverage is designed to provide, to **insured persons**, limited or supplemental coverage.
3. **You** may contact the Idaho Department of Insurance at any time:
 Consumer Affairs
 700 W State Street, 3rd Floor
 PO Box 83720
 Boise ID 83720-0043
 1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

Benefits:

Employee Face Amount	\$5,000
Insured Spouse Face Amount	50% of the employee Face Amount
Insured Children Face Amount	50% of the employee Face Amount

We reserve the right to request that a **physician** of **our** choice review any **diagnosis** in the event of a dispute or disagreement regarding the appropriateness or correctness of a **diagnosis**. We reserve the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed **diagnosis**. We will pay for any such requested examination or review.

Critical Illness Benefit

We will pay the applicable benefit shown on the Schedule of Benefits if an **insured person** is **diagnosed** with a **critical illness**, and:

1. The **date of diagnosis** must occur while coverage for the **insured person** is in force; and
2. The **critical illness** is not excluded by name or specific description in the Certificate.

Critical Illness Benefit	Percentage of Face Amount
Heart Attack (Myocardial Infarction)	100%
Stroke	100%
Coronary Artery Condition Requiring Bypass Surgery	25%
Major Organ Failure	100%
End-Stage Renal Failure	100%
Coma	100%
Paralysis	100%
Occupational Human Immunodeficiency Virus (HIV)	100%
Benign Brain Tumor	100%
Loss of Sight (Blindness)	100%
Loss of Hearing	100%
Loss of Speech	100%
Third Degree Burns	100%
Alzheimer's Disease	25%
Parkinson's Disease	25%
Lupus	25%
Multiple Sclerosis	25%
Muscular Dystrophy	25%

4. **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:
- 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);
 - Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection.

5. **Additional Information:**

- **Renewability** – The policy is optionally renewable.
- **Premium Changes** – The premium rates may be changed by **us**. If the rates are changed, **we** will give at least 31 days advance written notice.
- **Portability** – If **your** employment ceases and as a result **your** coverage under the Policy terminates, **we** will provide portability coverage. Such coverage will be available to **you** and any of **your insured dependents**.

You must complete the Portability Coverage Election Form and return it to **us** along with payment the first premium for the portability coverage not later than 30 calendar days after **your** coverage under the Policy terminates. Portability coverage will be effective on the day after benefits under the Policy terminates.

The benefits, terms and conditions of portability coverage will be the same as those provided under the Policy on the date **your** coverage terminated. Any changes made to the Policy after **you** are covered under the Portability Provision will not apply to **you** unless required by law.

The initial premium rates will be based on the premium rates in effect at the time **you** apply for portability coverage. **You** must also pay any portion of the premium previously paid by **your employer** for the coverage.

A grace period of 31 days after the premium due date will be allowed for the payment of each premium. We will not pay benefits under the Certificate in the absence of payment of current premium, subject to this grace period.

Portability coverage will end on the earliest of the following dates:

- The date the Policy terminates;
- The date of the **insured person's** death;
- The date **you** attain age 120;
- The end of the portability grace period following the date the **insured person** fails to pay the required premium contribution;
- The end of the month on or following the date **you** are again covered under the Policy;
- The date coverage under this Portability Provision is cancelled or terminated by **us** for any reason upon 31 days advanced notice;
- The date **your** class of coverage is terminated;
- With respect to any **insured dependents**:
 1. The date **your** coverage terminates;
 2. The date **you** and **your insured spouse/domestic partner** divorce, end **your** or domestic partnership;
 3. The date **your insured dependent** ceases to be an eligible dependent under the Policy.

An **insured child** whose portability coverage terminates when he or she reaches the age limit may apply for portability coverage in his or her own name, or he or she is otherwise eligible.

Once portability coverage is cancelled or terminated, it cannot be reinstated.



Less stress

Aetna Hospital Indemnity Plan

Be prepared for what lies ahead

Maybe you're expecting to have a hospital stay — or maybe not. Either way, you can plan ahead to give yourself an extra financial cushion.

What is the Hospital Indemnity Plan?

The plan pays benefits when you have a planned, or unplanned hospital stay for an illness, injury, surgery or having a baby. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can use the benefits to help pay out-of-pocket medical costs or personal expenses.

How is this different from a major medical plan?

Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that might come with a stay in the hospital.

The Aetna Hospital Indemnity Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?

It's completely up to you. You can use the money any way you want, like:

- deductibles or copays
- mortgage or rent
- groceries or utility bills

...or for anything else you choose.

Rest assured

Enrollment is guaranteed. We don't ask you any questions about your health. And, you get benefits paid directly to you by check or direct deposit.



Because it happens

More than 35 million
Americans were hospitalized in 2016¹.

The average hospital stay in the U.S.
costs **\$10,700**².

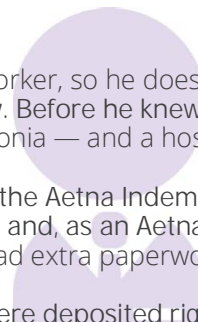


Ready...or not

Carter* is a hard worker, so he doesn't always slow down to listen to his body. Before he knew it, a little cough turned into pneumonia — and a hospital stay.

Good thing he had the Aetna Indemnity Hospital Plan. He submitted his claim and, as an Aetna medical member, didn't need to upload extra paperwork.

Carter's benefits were deposited right into his bank account. That money helped make up for the time he missed work to recover and to pay some of his deductible. Now, he can focus more on his health.



Handy online tools for you

You can find everything you need in one place at our member website: **myaetnasupplemental.com**. Aetna medical members can also access the site from **aetna.com**. You can see your plan documents, submit and track the status of claims, and even sign up for direct deposit.

Filing a claim is easy. Just create or log into your account on the member website. Click "Report New Claim" and answer a few quick questions. If you have an Aetna medical plan, we'll automatically retrieve any medical information needed to process your claim. That's less paperwork for you.



You can also print and mail a paper claim form to Aetna Voluntary Plans. If your claim is approved, we will send you a check, or deposit your benefits directly into your bank account. You choose.

¹American Hospital Association. Fast facts on U.S. hospitals, 2018. February 2018. Available at: aha.org/research/rc/stat-studies/fastfacts.shtml. Accessed April 25, 2018.

²Michaels M. The 35 most expensive reasons you might have to visit a hospital in the US — and how much it costs if you do. Business Insider. March 1, 2018. Available at: businessinsider.com/most-expensive-health-conditions-hospitalcosts-2018-2. Accessed April 25, 2018.

*This is a fictional example of how the plan could work.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

The Aetna Hospital Indemnity Plan is underwritten by Aetna Life Insurance Company (Aetna). The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan. 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 provider's 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. For more information about Aetna plans, refer to **aetna.com**.

Policy forms issued in Missouri and Oklahoma include: AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01, GR-96172 01.



BENEFIT SUMMARY

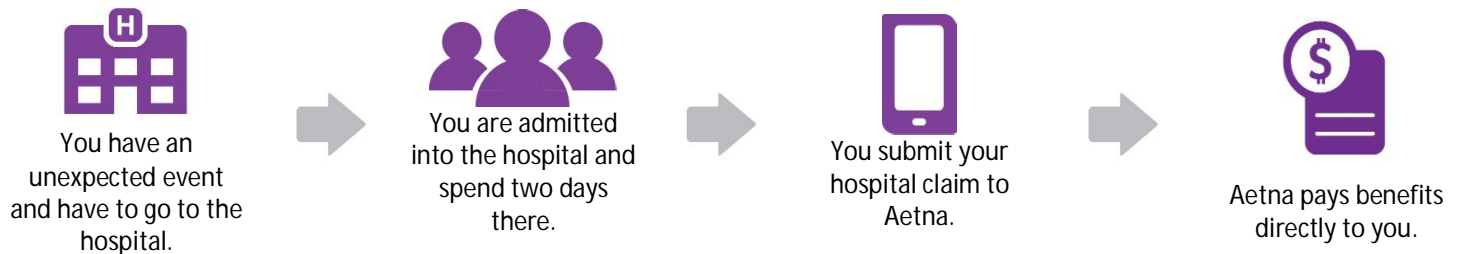
ORTHODOX HEALTHPLAN

802605

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.

Here's how the plan works:



Unless otherwise indicated, all benefits and limitations are per covered person.

The Aetna Hospital Indemnity Plan is a hospital confinement indemnity plan with other fixed indemnity benefits. THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at www.medicare.gov.

This policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

Inpatient Stays

Covered Benefit	Employer Paid Plan
Hospital stay - Admission Provides a lump sum benefit for the initial day of your stay in a hospital. <i>Maximum 1 stay per plan year</i>	\$1,000
Hospital stay - Daily Pays a daily benefit, beginning on day two of your stay in a non-ICU room of a hospital. <i>Maximum 31 days per plan year</i>	\$100
Hospital stay - (ICU) Daily Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital. <i>Maximum 31 days per plan year</i>	\$200
Newborn routine care Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.	\$100
Observation unit Provides a lump sum benefit for the initial day of your stay in an observation unit as the result of an illness or accidental injury. <i>Maximum 1 day per plan year</i>	\$100
Substance abuse stay - Daily Pays a daily benefit for each day you have a stay in a hospital or substance abuse treatment facility for the treatment of substance abuse. <i>Maximum 31 days per plan year</i>	\$100
Mental disorder stay - Daily Pays a daily benefit for each day you have a stay in a hospital or mental disorder treatment facility for the treatment of mental disorders. <i>Maximum 31 days per plan year</i>	\$100
Rehabilitation unit stay - Daily Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury. <i>Maximum 31 days per plan year</i>	\$50

Important Note: All daily inpatient stay benefits begin on day two and count toward the plan year maximum.

Portability

Your plan includes a option which allows you to keep your existing coverage by making direct payments to the carrier. You may exercise this option, if your employment ceases for any reason. Refer to your Certificate for additional provisions.

Waiver of premium

If you are in a hospital for more than 30 days in a row, we will waive the premium beginning on the first premium due date that occurs after the 30th day of your stay, through the next 6 months of coverage. During your stay, you must remain employed with the policyholder.

Exclusions and Limitations

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.

Benefits will not be paid for any stay or other service for an illness or accidental injury related to the following:

1. Certain competitive or recreational aeronautical activities, including but not limited to: ballooning, gliding, parachuting, skydiving;
2. Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment;
3. Act of war, riot, war;
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not;
5. Committing or attempting to commit a felony;
6. Care provided by a spouse, parent, child, sibling or any other household member;
7. Cosmetic services and plastic surgery, with certain exceptions;
8. Custodial Care;
9. Hospice services, except as specifically provided in the Benefits under your plan section of the certificate;
10. Self-harm, suicide, except when resulting from a diagnosed disorder;
11. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle;
12. Care or services received outside the United States or its territories;
13. Experimental or investigational drugs, devices, treatments, or procedures;
14. Education, training or retraining services or testing;
15. Accidental injury sustained while intoxicated or due to the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, unless prescribed by your physician;
16. Exams except as specifically provided in the Benefits under your plan section of the certificate;
17. Dental and orthodontic care and treatment;
18. Family planning services;
19. Any care, prescription drugs, and medicines related to infertility;
20. Nutritional supplements, including but not limited to: food items, infant formulas, vitamins;
21. Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason;
22. Vision-related care

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.

Can I enroll in the Aetna Hospital Indemnity plan even though I have a Health Savings Account (HSA)?

Yes, you can still enroll in the Aetna Hospital Indemnity plan if you have a Health Savings Account.

What is considered a hospital stay?

A stay is a period during which you are admitted as an inpatient; and are confined in a: hospital, non-hospital residential facility, rehabilitation facility; and are charged for room, board and general nursing services. A stay does not include time in the hospital because of custodial or personal needs that do not require medical skills or training. A stay specifically excludes time in the hospital for observation or in the emergency room unless this leads to a stay.

If I lose my employment, can I take the Hospital Indemnity Plan with me?

Yes, you are able to continue coverage under the provision. You will need to pay premiums directly to Aetna.

How do I file a claim?

Go to myaetnasupplemental.com and either "Log In" or "Register", depending on if you've set up your account. Click the "Create a new claim" button and answer a few quick questions. You can even save your claim to finish later. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail you a printed form.

What should I do in case of an emergency?

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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

Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives **Monday through Friday, 8 a.m. to 6 p.m.**, by calling **1-800-607-3366**. We're here to answer questions before and after you enroll.

Important information about your benefits

IN ORDER FOR THE HOSPITAL INDEMNITY BENEFITS TO BE PAYABLE, THE INITIAL DAY OF YOUR STAY AND OTHER SERVICES MUST BE ON OR AFTER YOUR EFFECTIVE DATE OF COVERAGE.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-800-607-3366** or visit us at **www.aetna.com**.

If you require language assistance, please call Member Services at 1-800-607-3366 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you're calling.

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<http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Plans are underwritten by Aetna Life Insurance Company (Aetna).

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Hospital Indemnity Policy forms issued in Idaho, Oklahoma and Missouri include: AL VOL HPOL-Hosp 01 and AL VOL HCOC-Hosp 01.



Aetna Life Insurance Company

151 Farmington Avenue, Hartford, Connecticut 06156

Outline of Coverage

Policy form AL VOL HPOL-Hosp 01, form AL VOL HCOC-Hosp 01

HOSPITAL CONFINEMENT INDEMNITY COVERAGE THIS POLICY CERTIFICATE PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

This Outline of Coverage is a summary of the policy which should be consulted to determine governing contractual provisions.

If you are eligible for Medicare: THIS IS NOT A MEDICARE SUPPLEMENT POLICY. Review the 'Guide to Health Insurance for People With Medicare' available from us.

You may contact the Idaho Department of Insurance at any time:

Consumer Affairs

700 W State Street, 3rd Floor

PO Box 83720

Boise ID 83720-0043

1-800-721-3272 or 208-334-4250 or www.DOI.Idaho.gov

1. Read Your Policy Carefully—This outline of coverage provides a very brief description of the important feature of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
2. Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

3. Benefits

Benefit	Benefit amount
Inpatient benefits	
Hospital stay – admission (initial day) Maximum per plan year	\$1,000 for the initial day of your stay 1 admission
Hospital stay – daily Non-ICU daily ICU daily Maximum days per plan year	\$100 per day, beginning on day two of your stay \$200 per day, beginning on day two of your stay 31
Newborn routine care	\$100 per stay per newborn
Observation unit Maximum observations per plan year	\$100 per initial day of observation 1
Rehabilitation unit stay – daily Maximum days per plan year	\$50 per day 31
Mental disorders stay – daily Maximum days per plan year	\$100 per day 31
Substance abuse stay – daily Maximum days per plan year	\$100 per day 31

4. Exclusions

Exclusions:

Benefits will not be paid for any stay or other service for an illness or accidental injury related to the following:

Act of war, riot, war

- Any act of war, whether declared or not
- Voluntary participation in a riot
- Rebellion or civil insurrection

Aircraft

Boarding or alighting in any vehicle or device for aviation except as a fare-paying passenger on a regularly scheduled commercial or charter flight.

Cosmetic surgery

Cosmetic **surgery**, except that cosmetic **surgery** will not include reconstructive **surgery** when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a **covered dependent** child.

Custodial care

Examples are:

- Institutional care. This includes room and board for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any services that a person without medical or paramedical training can perform or could be trained to perform.

Dental care

Routine/general dental care and dental surgery except:

- as the result of an accidental injury to a sound natural tooth
- as necessary for treatment of congenital disease or anomaly

Exams

Except as specifically provided in the *Benefits under your plan* section, benefits will not be paid for routine physical exams.

Family planning services

- A elective abortion. As used here, elective abortion means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.
- Any contraceptive methods, devices, material or sterilization procedures
- The reversal of voluntary sterilization procedures, including any related follow-up care

Felony

Participation in a felony

Mental disorders

Mental disorders in a hospital or mental disorder treatment facility.

Self-harm, suicide

Except when resulting from a diagnosed disorder, benefits will not be paid in connection with suicide or attempt at suicide, intentionally self-inflicted injury.

Vision

Eye glasses and exams for the prescription or fitting of them

- **Portability** - We will provide portability coverage if
 - Your employment ends and as a result your coverage under the policy ends
 - You or your covered dependent became totally disabled while covered under this certificate and the policy ends

Such coverage will be available to you and any of your covered dependents.

You must complete the Portability Coverage Election Form and return it to us along with payment the first premium for the portability coverage not later than 30 calendar days after your coverage under the policy ends. Portability coverage will be effective on the day after benefits under the policy end.

The benefits, terms and conditions of portability coverage will be the same as those provided under the policy on the date your coverage ended. Any changes made to the policy after you are covered under portability will not apply to you unless required by law.

The initial premium rates will be based on the premium rates in effect at the time you apply for portability coverage. You must also pay any portion of the premium previously paid by the policyholder for the coverage.

A grace period of 31 days after the premium due date will be allowed for the payment of each premium. We will not pay benefits under this certificate in the absence of payment of current premium, subject to this grace period.

Portability coverage will end on the earliest of the following dates:

- The date the underlying policy ends, unless you or a covered dependent became totally disabled while covered under this certificate.
- The date of your death
- The end of the portability grace period following the date you fail to pay any required premium
- The end of the month on or following the date you are again covered under the policy
- The date coverage under this portability provision is cancelled by us for any reason upon 31 days advanced notice
- The date your class of coverage ends
- With respect to any covered dependents:
 - The date your coverage ends
 - The date you and your spouse divorce, end your domestic partnership
 - The date your covered dependent ceases to be an eligible dependent under the policy

A covered dependent who is a minor child whose portability coverage ends because they reach the age limit may apply for portability coverage in their own name.

Once portability coverage ends, it cannot start again.



Please review the below notice for Aetna Supplemental Health plan members who reside in the state of New Mexico.

ATTENTION NEW MEXICO RESIDENTS

The coverage provided under your benefits plan or policy underwritten by Aetna Life Insurance Company is limited in nature and may not provide financial protection for significant costs that you could incur for the diagnosis or treatment of COVID-19 ("Corona virus") related illness.

If you do not have comprehensive major medical coverage, in addition to the plan or policy issued by our company, you may incur significant uninsured medical expenses associated with the diagnosis and treatment of illness caused by COVID-19.

Major medical plans offer robust consumer protections, and are required to waive all deductibles, co-pays and other cost sharing expenses for the diagnosis or treatment of COVID-19 related illness. Your policy or plan with us is not a major medical plan and does not provide such protections.

If you do not have major medical coverage, you may:

1. Contact a licensed insurance broker or agent to see about major medical coverage availability.
2. To see if you are eligible for a special enrollment period for major medical coverage through the New Mexico Health Insurance Exchange, contact beWellnm toll-free at **1-833-862-3935**.
3. To see if you are eligible for Medicaid coverage and to complete an application, please call the Human Services Department's Medicaid Expansion Hotline toll-free at **1-855-637-6574** or visit **<https://www.yes.state.nm.us/yesnm/home/index>**.
4. To see if you are eligible for high risk pool coverage, please contact the New Mexico Medical Insurance Pool (the "High Risk Pool") at **1-844-728-7896** or **<https://nmmip.org/>**. If you are uninsured and have a COVID-19 diagnosis, your condition qualifies you for Pool coverage.

The Centers for Disease Control and the New Mexico Department of Health each have websites with considerable information on COVID-19. Visit each website at **<https://www.cdc.gov/>** or **<http://cv.nmhealth.org/>**.

Individuals who have symptoms consistent with COVID-19 should immediately call the NM Department of Health at **1-855-600-3453**.

Non-Discrimination Notice

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-772-9682.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-888-772-9682 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-888-772-9682. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-888-772-9682，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-888-772-9682 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-888-772-9682 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-888-772-9682. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-888-772-9682. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-888-772-9682 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-888-772-9682. (Italian)

日本語で援助をご希望の方は 1-888-772-9682 (フリーダイヤル) までお電話ください。 (Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-888-772-9682번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان شما با شماره 1-888-772-9682 بدون هیچ هزینه ای تماس بگیرید. (Persian)

Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-888-772-9682. (Polish)

Para obter assistência no seu idioma, ligue gratuitamente para o 1-888-772-9682. (Portuguese)

Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-888-772-9682. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-888-772-9682. (Vietnamese)
