

**Aetna Hospital Indemnity plan, administered by Aetna Life
Insurance Company
Federal Disclosure**

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: **1-855-889-4325**) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna) at 151 Farmington Ave., Hartford, CT, 0615.



Life changing

Aetna Supplemental Health Plans

These plans pay you cash if a covered medical event happens — like an accident, a critical illness or a hospital stay.

Use the money to pay medical bills or everyday living expenses. The choice is yours.

And when you sign up for direct deposit, you'll get your money even faster.



We pay *you* cash benefits



Accident plan

Pays you lump-sum cash benefits for covered accidents and treatments.



Critical illness plan

Pays you lump-sum cash benefits for a wide range of covered conditions — including a heart attack, a stroke, cancer and more.



Hospital indemnity plan

Pays you lump-sum cash benefits for a planned or an unplanned hospital stay. This includes stays due to an injury, surgery, an illness — or even delivering a baby.

Insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna).



Our plans work with your health plan

We won't deny coverage based on your health. There are no doctor exams to take or medical questions to answer. And we pay you even if you have other insurance coverage. This means supplemental health plans pair well with your major medical plan.

Manage your plans online

After you become a member, register at MyAetnaSupplemental.com or on the **My Aetna Supplemental** app. Or simply scan the QR code. Use your personal email address to keep accessing your account and getting important reminders — even if you leave your company.



Enjoy an Aetna Simplified Claims Experience™

To file a claim, it takes about 90 seconds or less. Just upload a PDF or picture of your medical bill. You can also complete a paper form and return it by mail or fax to Aetna® Voluntary Plans.

If your claim is approved, we'll mail you a check or deposit cash directly into your bank account.*



*FOR COVERAGE LIMITATIONS: Benefits paid for covered accidents, critical illness diagnoses or hospitalizations that occur on or after the coverage effective date.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

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. Members are responsible for making sure the providers' bills get paid. These benefits are paid in addition to any other health coverage members may have.

THIS PLAN DOES NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT.

Policies are insured by Aetna Life Insurance Company (Aetna). Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. Refer to Aetna.com for more information about Aetna plans.

Policy forms issued in Oklahoma include: GR-96841, AL HPOL-VOL Acc 01, AL HCOC-VOL Acc 01, GR-96843, AL VOL HPOL-Hosp 01, AL VOL HCOC-Hosp 01.

Policy forms issued in Missouri and Wyoming include: GR-96842 01, AL HPOL-VOL Acc 01, AL HCOC-VOL Acc 01, GR-06844 01, AL VOL HPOL-Hosp 01, GR-96172 01.

BENEFIT SUMMARY

The Behavioral Wellness Center at Girard
803322

Aetna Off/On Job Accident Plan

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 receive covered treatment for a covered Accident. Unless otherwise indicated, all benefits and limitations are per covered person.

Note: Certain benefits are payable once per covered accident; while others are once per plan year. If a service or injury falls in more than one category, the plan will pay the greater of. Refer to the Certificate for more details.

Initial Care

Covered Benefit	Benefit Amounts
Ambulance	
Ground ambulance	\$400
Pays a benefit for when you are transported by a licensed professional ambulance company by a Ground ambulance to or from a hospital, or between medical facilities, where treatment for an accidental injury is received. Transportation to or from a hospital within 24 hours after an accidental injury.	
Air ambulance	\$1,600
Pays a benefit for when you are transported by a licensed professional ambulance company by an Air ambulance to or from a hospital, or between medical facilities, where treatment for an accidental injury is received. Transportation to or from a hospital within 48 hours after an accidental injury.	
<i>Maximum trips per accident, air and ground combined</i>	
	1

Covered Benefit	Benefit Amounts
Initial Treatment	
Emergency room/Hospital	\$175
Pays a benefit if an insured person requires initial examination and treatment in an emergency room as the result of an accidental injury. The initial examination and treatment must be received within 72 hours after the accidental injury.	
Physician's office/Urgent care facility	\$175
Pays a benefit if an insured person requires initial examination and treatment in a physician's office or urgent care center as the result of an accidental injury. The initial examination and treatment must be received within 72 hours after the accidental injury.	
Walk-in clinic/Telemedicine	\$175
<i>Maximum visits per accident, combined for all places of service</i>	1
<i>Maximum visits per plan year, combined for all places of service</i>	3
X-ray/Lab	\$75
Pays if an insured person receives an X-ray due to an accidental injury. The X-ray(s) must be prescribed by a physician and performed by a licensed facility within 30 days after the accidental injury.	
Medical imaging	\$400
Pays a benefit if an insured person receives a medical imaging test due to an accidental injury. Medical imaging tests include only the following:	
1. Positron Emission Tomography (PET)	
2. Computed Tomography Scan (CT)	
3. Computed Axial Tomography (CAT)	
4. Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI)	
5. Electroencephalogram (EEG)	
The test must be ordered by a physician and performed in a medical facility on an outpatient basis within 180 days after the accidental injury.	

Follow-up Care

Covered Benefit	Benefit Amounts
Accident follow-up	
Emergency room/Hospital Pays a benefit if an insured person receives follow-up treatment in emergency room or hospital for an accidental injury within one year of the accident.	\$75
Physician's office/Urgent care facility Pays a benefit if an insured person receives follow-up treatment in a physician's office or urgent care center for an accidental injury within one year of the accident.	\$75
Walk-in clinic/Telemedicine <i>Maximum visits per accident, combined for all places of service</i> <i>Maximum visits per plan year, combined for all places of service</i>	\$75 6 12
Appliances	
Major: Back brace, body jacket, knee scooter, wheelchair, motorized scooter or wheelchair	\$300
Minor: Brace, cane, crutches, walker, walking boot, other medical devices to aid in your physical movement <i>Maximum appliance per accident, major & minor combined</i>	\$150 1
Chiropractic treatment and alternative therapy	\$75
<i>Maximum visits per accident</i>	10
<i>Maximum visits per plan year</i>	30
Pain management (epidural anesthesia)	\$150
Pays a benefit if an insured person receives epidural anesthesia as the result of an accidental injury. The epidural anesthesia must be administered within 60 days after the accidental injury. <i>Maximum Benefit per accident</i>	1
Prescription drugs	\$15
Prosthetic device/Artificial limb	
One limb	\$1,000
Multiple limbs	\$2,000
<i>Maximum benefit per accident</i>	1
Repair or replace	25%
<i>Maximum benefit per plan year</i>	1
Therapy services - Speech, occupational, or physical therapy or cognitive rehabilitation	\$75
<i>Maximum visits per accident</i>	10
<i>Maximum visits per plan year</i>	30

Hospital Care

Covered Benefit	Benefit Amounts
Hospital stay – admission (initial day)	
Non-ICU admission Pays a benefit if an insured person is admitted into the hospital due to an accidental injury. We will not pay this benefit if you're admitted into an observation unit, treated in an emergency room or outpatient surgery. The stay must begin within 180 days after an accidental injury.	\$1,500
ICU admission Pays a benefit if an insured person is admitted directly to ICU due to an accidental injury. The stay must begin within 30 days after an accidental injury.	\$3,000
Hospital stay – daily*	
Non-ICU daily Pays a benefit if an insured person has a stay in a hospital due to an accidental injury.	\$300
ICU daily Pays a benefit if an insured person has a stay in an ICU due to an accidental injury. The stay must begin within 30 days after an accidental injury.	\$600
Step down intensive care unit daily <i>Maximum days per accident (combined for all stays due to the same accident)</i>	\$450 365
Rehabilitation unit stay – daily Pays a benefit if an insured person is transferred to a rehabilitation unit immediately after a stay in a hospital due to an accidental injury.	\$150
<i>Maximum days per accident</i>	30
Observation unit Pays a benefit if an insured person requires services in an observation unit as the result of an accidental injury. The Hospital Stay Admission Benefit will not be payable if the Observation Unit Benefit is payable. Observation services must begin within 72 hours after the accidental injury.	\$100

*** Important Note:** All Hospital stay – daily benefits begin on day one.

Surgical Care

Covered Benefit	Benefit Amounts
Blood/Plasma/Platelets	\$500
Pays a benefit if an insured person receives the transfusion of blood, plasma and/or platelets due to an accidental injury. The transfusion must take place within 90 days after the accidental injury	
Eye Injury	
Surgical repair	\$400
Removal of foreign object	\$200
Surgery (without repair)	
Arthroscopic or exploratory	\$300
Pays a benefit if an insured person undergoes exploratory or arthroscopic surgery, and no repair is done, within 60 days of the accidental injury.	
Surgery (with repair)	
Cranial, open abdominal or thoracic	\$2,000
Pays a benefit if an insured person undergoes cranial, open abdominal or thoracic surgery, and repair is done, within 72 hours of the accidental injury.	
Hernia	\$300
Pays a benefit if an insured person undergoes hernia surgery as the result of an accidental injury. A physician must diagnose the hernia within 30 days after the accidental injury; and perform surgery within 60 days after the accidental injury.	
Ruptured disc	\$1,000
Pays a benefit if an insured person sustains a ruptured disc in the spine as the result of an accidental injury. A physician must treat the ruptured disc within 60 days after the accidental injury; and repair it through surgery within one year after the accidental injury.	
Tendon/Ligament/Rotator cuff	
Single repair	\$1,000
Multiple repairs	\$2,000
Torn knee cartilage	\$1,000
Pays a benefit if an insured person sustains a torn knee cartilage (meniscus) as the result of an accidental injury. A physician must treat the torn knee cartilage within 60 days after the accidental injury; and repair it through surgery within 180 days after the accidental injury.	
Non-Specified	
Inpatient	\$300
Outpatient	\$300
<i>Maximum benefits per accident, combined for all Surgery (without repair) and Surgery (with repair) benefits</i>	2

Transportation/Lodging Assistance

Covered Benefit	Benefit Amounts
Lodging Pays for one motel/hotel room for a companion to accompany you for each day of a stay due to an accidental injury. Your stay must be more than 50 miles from your home. <i>Maximum days per accident</i>	\$200 30
Transportation We will pay the Transportation Benefit shown in the Schedule of Benefits for an insured person who must travel from his or her residence more than 50 miles one way on physician's advice for treatment of a payable Accidental injury. <i>Maximum trips per accident</i>	\$300 1

Dislocations and Fractures

Dislocations - Closed Reduction

Pays a benefit if an insured person sustains a dislocation as the result of an accidental injury.

*A physician must diagnose the dislocation within 90 days after the accidental injury and correct it by **closed reduction (non-surgical repair)**.*

Open reduction

Pays a benefit if an insured person sustains a dislocation as the result of an accidental injury.

*A physician must diagnose the dislocation within 90 days after the accidental injury and correct it by **open reduction (surgical repair)**.*

Covered Benefit	Benefit Amounts
Dislocations – Closed Reduction*	
Hip	\$3,000
Knee	\$2,000
Ankle – bone or bones of the foot (other than toes)	\$1,000
Collarbone (sternoclavicular)	\$1,000
Lower jaw	\$1,000
Shoulder (glenohumeral)	\$1,000
Elbow	\$1,000
Wrist	\$1,000
Bone or bones of the hand (other than fingers)	\$1,000
Collarbone (acromioclavicular and separation)	\$300
Rib	\$300
One toe or one finger	\$300
Partial dislocation	25%
<i>Maximum dislocations per accident</i>	3

*Open reduction pays 2.0 times the closed reduction benefit value

Fractures - Closed Reduction*

Pays a benefit if an insured person sustains a fracture as the result of an accidental injury.

A physician must diagnose the fracture within **90 days** after the accidental injury and correct it by **closed reduction**.

Skull (except bones of the face or nose), depressed	\$4,125
Skull (except bones of the face or nose), non-depressed	\$4,125
Hip, thigh (femur)	\$2,500
Vertebrae, body of (excluding vertebral processes)	\$1,500
Pelvis (inc. ilium, ischium, pubis, acetabulum except coccyx)	\$1,500
Leg (tibia and/or fibula malleolus)	\$1,500
Bones of the face or nose (except mandible or maxilla)	\$1,000
Upper jaw, maxilla (except alveolar process)	\$1,000
Upper arm between elbow and shoulder (humerus)	\$1,000
Lower jaw, mandible (except alveolar process)	\$1,000
Collarbone (clavicle, sternum)	\$1,000
Shoulder blade (scapula)	\$1,000
Vertebral process	\$1,000
Forearm (radius and/or ulna)	\$1,000
Kneecap (patella)	\$1,000
Hand/foot (except fingers/toes)	\$1,000
Ankle/wrist	\$1,000
Rib	\$400
Coccyx	\$400
Finger, toe	\$400
Chip fracture	25%
<i>Maximum fractures per accident</i>	3

*Open reduction pays 2.0 times the closed reduction benefit value

Accidental Death & Dismemberment and Paralysis Benefits

Covered Benefit	Benefit Amounts
Accidental death	
Pays a benefit if an insured person sustains an accidental injury which causes the insured person's death within 90 days after an accident.	
Employee	\$25,000
Covered dependent spouse	\$12,500
Covered dependent children	\$12,500
Accidental death common carrier	
Pays a benefit if an insured person sustains an accidental injury while the insured person is a fare paying passenger on a common carrier and the accidental injury causes the insured person's death within 90 days after an accident.	
Employee	\$50,000
Covered dependent spouse	\$25,000
Covered dependent children	\$25,000
Accidental dismemberment	
Pays a benefit if an insured person sustains one or more limbs due to an accidental injury as classified below and in the schedule of benefits. The loss must occur within 90 days after an accidental injury.	
Loss of arm	\$15,000
Loss of hand	\$15,000
Loss of leg	\$15,000
Loss of foot	\$15,000
Loss of sight	\$15,000
Loss of ability to speak	\$15,000
Loss of hearing	\$15,000
<i>Maximum dismemberments per accident (non-finger, toe)</i>	2
Loss of finger	\$2,000
Loss of toe	\$2,000
<i>Maximum dismemberments per accident (finger, toe)</i>	4
Home and vehicle alteration	\$1,500
Paralysis (complete, total and permanent loss)	
Pays a benefit if an insured person sustains paralysis as a result of an accidental injury. A physician must diagnose paralysis within 60 days after the accidental injury; and confirm the paralysis continued for a period of 90 consecutive days.	
Quadriplegia	\$20,000
Triplegia	\$15,000
Paraplegia	\$10,000
Hemiplegia	\$10,000
Diplegia	\$10,000
Monoplegia	\$5,000

Other Accidental Injuries

Covered Benefit	Benefit Amounts
Animal bite treatment	
Tetanus shot	\$100
Anti-venom shot	\$200
Rabies shot	\$300
Brain injury	
Concussion/Mild traumatic brain injury	\$300
Moderate/Severe traumatic brain injury	\$600
Burn	
Pays a benefit if an insured person receives a second degree burn or third degree burn as a result of an accidental injury. Treatment must be received by a physician within 72 hours after the accidental injury.	
Second degree burn, greater than 5% of total body surface	\$1,000
Third degree burn, less than 5% of total body surface	\$1,500
Third degree burn, 5-10% of total body surface	\$6,000
Third degree burn, greater than 10% of total body surface	\$18,000
Burn skin graft	50% of Burn
Pays a benefit if an insured person receives a skin graft for a burn as a result of an accidental injury. Treatment must be received by a physician within 365 days after the accidental injury.	
Coma/Persistent vegetative state (PVS)	
Coma (non-induced)	\$10,000
PVS	\$10,000
Coma (induced)	\$250
<i>Maximum days per accident</i>	10
Dental treatment	
Pays a benefit if an insured person sustains a broken tooth as the result of an accidental injury and the tooth is repaired by a dental crown and/or dental extraction. The dental services must begin within 60 days after the accidental injury.	
<i>Maximum 1 per accident</i>	
Extractions	\$100
Crown	\$300
Gunshot wound	\$2,000
Laceration	
Pays a benefit if an insured person receives a laceration as the result of an accidental injury. The laceration must be repaired by a physician within 72 hours after the accidental injury.	
Without stitches	\$25
With stitches, less than 7.5 centimeters	\$75
With stitches, 7.6 - 20.0 centimeters	\$300
With stitches, greater than 20.0 centimeters	\$600
Posttraumatic stress disorder (PTSD)	\$500
<i>Maximum diagnoses per lifetime</i>	1
Service dog	\$1,500
<i>Maximum service dogs per your lifetime</i>	1

Waiver of Premium

Covered Benefit	Benefit Amount
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. The premium waiver does not apply to your covered dependents.	Included

Organized Sports Rider

Covered Benefit	Benefit Amount
If while you are playing as a registered member of an organized sporting activity, you sustain an accidental injury, benefits payable under the certificate will be increased by the percentage shown, except for the excluded benefits below:	25%

Excluded benefits for Organized Sports Rider

- Accidental death
- Accidental death common carrier
- Animal bite
- Burn
- Burn skin graft
- Gunshot wound
- Service Dog

Health Screening Rider

Covered Benefit	Benefit Amount
Health screening	\$50
Pays once per member per plan year for covered preventive tests. <i>Maximum 1 test per plan year</i>	

Covered Health Screenings

- Bone marrow screening
- Bone mass density measurement (DEXA, DXA)
- Biopsies for cancer
- Blood chemistry panel
- Breast sonogram
- Cancer antigen 125 blood test for ovarian cancer (CA 125)
- Carotid doppler ultrasound
- Chest x-ray (CXR)
- Cytologic screening
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- Carcinoembryonic antigen blood test for colon cancer (CEA)
- Clinical testicular exam
- Colonoscopy
- Complete blood count (CBC)
- Dental exam
- Digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)
- Electroencephalogram (EEG)
- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Endoscopy
- Eye exam
- Fasting blood glucose test
- Fasting plasma glucose test
- Flexible sigmoidoscopy
- Hearing test
- Hemocult stool analysis
- Hemoglobin A1C
- Human papillomavirus vaccination (HPV)
- Immunizations
- Lipoprotein profile (serum plus HDL, LDL, total cholesterol, and triglycerides)
- Mammography
- Oral cancer screening
- Pap smear
- Prostate specific antigen (PSA) test
- Routine health check-up exam
- Skin cancer biopsy
- Skin cancer screening
- Skin exam
- Serum protein electrophoresis (blood test for myeloma)
- Successful completion of smoking cessation program
- Stress test on bicycle or treadmill
- Test for sexually transmitted infections (STIs)
- Thermography
- ThinPrep pap test
- Two-hour post-load plasma glucose test
- Ultrasound for cancer detection
- Ultrasound screening for abdominal aortic aneurysms
- Virtual colonoscopy

Note: COVID-19 testing is covered as an eligible health screening benefit

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 activities, including but not limited to: ballooning, bungee jumping, 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. Assault, felony, illegal occupation, or other criminal act;
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 while 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 portability 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 portability 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.

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. 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.

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.

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

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

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



BENEFIT SUMMARY

**The Behavioral Wellness Center at Girard
803322**

Aetna Critical Illness Basic

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	Amount
Employee face amount	\$10,000
Spouse face amount	100% of EE face amount
Spouse benefit amount	100% of EE benefit amount
Child(ren) face amount	100% of EE face amount
Child(ren) benefit amount	100% of EE benefit amount

Critical Illness Benefits – Autoimmune

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Addison's disease (adrenal hypofunction) Pays a benefit when you are diagnosed with Addison's disease (adrenal hypofunction) by a physician. This does not include adrenal insufficiency resulting from prolonged corticosteroid treatment.	25%
Lupus Pays a benefit when you are diagnosed with Lupus by a physician.	25%
Myasthenia Gravis Pays a benefit when you are diagnosed with Myasthenia gravis by a physician.	25%
Multiple sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	100%
Muscular Dystrophy Pays a benefit when you are diagnosed with Muscular dystrophy by a physician.	100%

Critical Illness Benefits – Childhood Condition

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Anal atresia Pays a benefit when your covered dependent child is diagnosed with anal atresia after live birth.	100%
Andersen disease Pays a benefit when your covered dependent child is diagnosed with Andersen disease after live birth, and such diagnosis is confirmed through enzyme or genetic testing.	100%
Anencephaly Pays a benefit when your covered dependent child is diagnosed with anencephaly after live birth.	100%
Autism spectrum disorder Level I, II or III Pays a benefit when your covered dependent child is diagnosed with autism spectrum disorder, and such diagnosis: <ul style="list-style-type: none">• Is based on the diagnostic criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association, and• Includes the DSM Severity Levels 2 or 3 for both major domains.	\$1,000
Biliary atresia Pays a benefit when your covered dependent child is diagnosed with biliary atresia after live birth.	100%
Canavan disease Pays a benefit when your covered dependent child is diagnosed with Canavan disease after live birth.	100%
Cerebral palsy Pays a benefit when you are diagnosed with Cerebral palsy by a physician. Other similar conditions that can be outgrown, are not included in this definition.	100%
Cleft lip or cleft palate Pays a benefit when you are diagnosed with a Cleft Lip or Cleft Palate after live birth by a physician.	100%
Congenital heart defect Pays a benefit when you are diagnosed with Congenital heart defect by a physician.	100%
Cystic fibrosis Pays a benefit when you are diagnosed with Cystic fibrosis by a physician. The diagnosis must be confirmed with sweat chloride concentrations greater than 60 mmol/L.	100%
Diaphragmatic hernia Pays a benefit when your covered dependent child is diagnosed with diaphragmatic hernia after live birth.	100%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Down syndrome</p> <p>Pays a benefit when you are diagnosed with Down Syndrome, the first date after live birth and based on the physician's study of the 21st chromosome revealing trisomy 21, translocation, or mosaicism.</p>	100%
<p>Ehlers-Danlos syndrome</p> <p>Pays a benefit when your covered dependent child is diagnosed with Ehlers-Danlos syndrome (EDS) after live birth.</p>	100%
<p>Fragile X syndrome</p> <p>Pays a benefit when your covered dependent child is diagnosed with fragile X syndrome (FXS) after live birth.</p>	100%
<p>Gastroschisis</p> <p>Pays a benefit when your covered dependent child is diagnosed with gastroschisis after live birth.</p>	100%
<p>Gaucher disease Level II & III</p> <p>Pays a benefit when your covered dependent child is diagnosed with Gaucher disease at severity levels 1, 2 or 3 after live birth and such diagnosis is confirmed through a blood test reviewing beta-glucosidase leukocyte (BGL).</p>	100%
<p>Glutaric acidemia</p> <p>Pays a benefit when your covered dependent child is diagnosed with glutaric acidemia types 1, 2 or 3 after live birth.</p>	100%
<p>Hexosaminidase activator deficiency</p> <p>Pays a benefit when your covered dependent child is diagnosed with hexosaminidase activator deficiency after live birth.</p>	100%
<p>Hirschsprung's disease</p> <p>Pays a benefit when your covered dependent child is diagnosed with Hirschsprung's disease after live birth.</p>	100%
<p>Infantile Tay Sachs</p> <p>Pays a benefit when your covered dependent child is diagnosed with infantile Tay-Sachs after live birth and before the age of 12 months, and such diagnosis is confirmed through a blood test reviewing Hexosaminidase A levels.</p>	100%
<p>Infantile-onset ascending spastic paralysis</p> <p>Pays a benefit when your covered dependent child is diagnosed with infantile-onset ascending spastic paralysis (IASP) after live birth.</p>	100%
<p>Juvenile primary lateral sclerosis</p> <p>Pays a benefit when your covered dependent child is diagnosed with juvenile primary lateral sclerosis (JPLS) after live birth.</p>	100%
<p>Lesch-Nyham syndrome</p> <p>Pays a benefit when your covered dependent child is diagnosed with Lesch-Nyham syndrome after live birth.</p>	100%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Mucopolysaccharidoses (MPS) Pays a benefit when your covered dependent child is diagnosed with these types of MPS after live birth:</p> <ul style="list-style-type: none"> - Hurler - Hunter - Sanfilippo A, B, C and D - Morquio A, B and C - Maroteaux-Lamy 	100%
<p>Niemann-Pick disease (NPD) Pays a benefit when your covered dependent child is diagnosed with NPD after live birth, and such diagnosis is confirmed through blood or genetic test.</p>	100%
<p>Omphalocele Pays a benefit when your covered dependent child is diagnosed with omphalocele after live birth.</p>	100%
<p>Osteogenesis imperfecta Pays a benefit when your covered dependent child is diagnosed with osteogenesis imperfecta types [1- 8] after live birth, and such diagnosis is confirmed through X-ray, dual energy X-ray absorptiometry scan (DXA or DEXA scan), lab test, or bone biopsy.</p>	100%
<p>Phenylketonuria (PKU) Pays a benefit when your covered dependent child is diagnosed with PKU after live birth, and such diagnosis is confirmed through screening.</p>	100%
<p>Pompe disease Pays a benefit when your covered dependent child is diagnosed with Pompe disease after live birth, and such diagnosis is confirmed through enzyme or genetic testing.</p>	100%
<p>Pyloric stenosis Pays a benefit when your covered dependent child is diagnosed with pyloric stenosis after live birth.</p>	100%
<p>Sandhoff disease Pays a benefit when your covered dependent child is diagnosed with Sandhoff disease after live birth.</p>	100%
<p>Sickle cell anemia Pays a benefit when you are diagnosed with Sickle cell anemia by a physician.</p>	100%
<p>Spina bifida Pays a benefit when you are diagnosed with Spina bifida by a specialist physician and must be associated with neurologic symptoms including motor impairment. Spina bifida does not include spina bifida occulta.</p>	100%
<p>Spinal muscular atrophy Pays a benefit when your covered dependent child is diagnosed with spinal muscular atrophy types 0-3 after live birth, and such diagnosis is confirmed through lab tests and imaging.</p>	100%
<p>Zellweger Syndrome Pays a benefit when your covered dependent child is diagnosed with Zellweger syndrome after live birth, and such diagnosis is confirmed through genetic testing.</p>	100%

Critical Illness Benefits - Chronic Condition

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Diabetes	
Type I	
Pays a benefit when you are diagnosed with Type I diabetes, in which your pancreas produces little or no insulin.	100%
Primary sclerosing cholangitis (PSC)	
Pays a benefit when you are diagnosed with Primary sclerosing cholangitis (PSC), also known as "Walter Payton's disease" by a physician.	25%
Systemic sclerosis (scleroderma)	
Pays a benefit when you are diagnosed with Systemic sclerosis (scleroderma) by a physician.	25%

Critical Illness Benefits - Infectious Disease

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Cholera	25%
Pays a benefit when you are diagnosed with Cholera by a physician.	
Coronavirus	25%
"Pays a benefit when you are diagnosed with Coronavirus. Coronaviruses (CoV) are a large family of viruses that cause illness in people such as:	
<ul style="list-style-type: none">• CoV or SARS-CoV-1 is the coronavirus that causes severe acute respiratory syndrome (SARS).• SARS-CoV-2 is the coronavirus that causes COVID-19.• MERS-CoV is the coronavirus that causes Middle East Respiratory Syndrome (MERS).	
MIS-C and MIS-A are associated with the COVID-19 coronavirus strain. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days."	
Creutzfeldt-Jakob disease	25%
Pays a benefit when you are diagnosed with Creutzfeldt-Jakob disease (CJD). You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days.	
Diphtheria	25%
Pays a benefit when you are diagnosed with Diphtheria by a physician.	
Ebola	25%
Pays a benefit when you are diagnosed with Ebola. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days.	
Encephalitis	25%
Pays a benefit when you are diagnosed with Encephalitis by a physician. Encephalitis does not include encephalitis resulting from any human immuno-deficiency virus (HIV) infection or other ancillary infections resulting from the HIV infection.	

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Hepatitis - occupational</p> <p>Pays a benefit when you are diagnosed with Occupational hepatitis B, C, or D resulting from accidental exposure by contaminated body fluids.</p>	100%
<p>Human immunodeficiency virus (HIV)</p> <p>Pays a benefit when you are diagnosed with Human immunodeficiency virus (HIV). HIV means the presence of HIV or antibodies to the HIV virus which is caused by an accidental needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid.</p>	25%
<p>Legionnaire's disease</p> <p>Pays a benefit when you are diagnosed with Legionnaire's disease by a physician.</p>	25%
<p>Lyme disease</p> <p>Pays a benefit when you are diagnosed with Lyme Disease by a physician.</p>	25%
<p>Malaria</p> <p>Pays a benefit when you are diagnosed with Malaria by a physician.</p>	25%
<p>Meningitis - Bacterial , Viral , Fungal , Parasitic , Amebic</p> <p>Pays a benefit when you are diagnosed with Bacterial meningitis by a physician.</p>	25%
<p>Methicillin-resistant staphylococcus aureus (MRSA)</p> <p>Pays a benefit when you are diagnosed with Methicillin-resistant staphylococcus aureus (MRSA) by a physician.</p>	25%
<p>Necrotizing fasciitis</p> <p>Pays a benefit when you are diagnosed with Necrotizing fasciitis, commonly known as flesh-eating disease or flesh-eating bacteria syndrome, and requiring a surgical procedure to be performed by a physician.</p>	25%
<p>Osteomyelitis</p> <p>Pays a benefit when you are diagnosed with Osteomyelitis by a physician.</p>	25%
<p>Pneumonia - Bacterial , Viral</p> <p>Pays a benefit if you are diagnosed with bacterial or viral pneumonia. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days.</p>	25%
<p>Poliomyelitis</p> <p>Pays a benefit when you are diagnosed with Poliomyelitis resulting from poliovirus type 1, 2, or 3 that is characterized by fever, paralysis and atrophy of skeletal muscles by a physician.</p>	25%
<p>Rabies</p> <p>Pays a benefit when you are diagnosed with Rabies by a physician.</p>	25%
<p>Rocky mountain spotted fever (RMSF)</p> <p>Pays a benefit when you are diagnosed with Rocky mountain spotted fever (RMSF) by a physician.</p>	25%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Septic shock including severe sepsis Pays a benefit if you are diagnosed with septic shock and sepsis. You must have a stay in a hospital, rehabilitation unit, or skilled nursing facility for at least 5 consecutive days	25%
Tetanus Pays a benefit when you are diagnosed with Tetanus by a physician.	25%
Tuberculosis (TB) Pays a benefit when you are diagnosed with Tuberculosis (TB) by a physician.	25%
Tularemia Pays a benefit when diagnosed with Tularemia (sometimes called rabbit fever) by a physician.	25%
Typhoid Fever Pays a benefit when you are diagnosed with Typhoid fever by a physician.	25%
Variant influenza virus (swine flu in humans) Pays a benefit when you are diagnosed with Variant influenza virus by a physician.	25%
<i>Maximum infectious disease diagnosis per plan year</i>	1
Note: the following infectious disease benefits require a hospital stay of at least 5 days: Coronavirus, Creutzfeldt-Jakob disease, Ebola, Pneumonia, Septic shock and severe sepsis, Variant influenza virus (swine flu in humans)	

Critical Illness Benefits – Neurological (Brain)

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Advanced dementia Pays a benefit when you are diagnosed with Advanced dementia that is manifested by memory impairment and other cognitive disturbances. This does not include Alzheimer's disease, schizophrenia or psychoses, any form of Parkinson's disease or any reversible dementias such as those cause by thyroid or other hormonal abnormalities, or vitamin deficiencies.	100%
Alzheimer's disease Pays a benefit when you are diagnosed with Alzheimer's disease, diagnosis of the disease by a psychiatrist or neurologist. You must have the inability to independently perform 3 or more of the activities of daily living.	100%
Amyotrophic lateral sclerosis (ALS) Pays a benefit when you are diagnosed with Advanced amyotrophic lateral sclerosis (ALS), also known as "Lou Gehrig's disease" by a physician. ALS does not include other motor neuron diseases. This disease is characterized by the progressive degeneration of motor neurons, shown by permanent neurological defect with persisting clinical signs and symptoms such as the inability to perform 3 or more activities of daily living, and or the need for either a feeding tube or non-invasive ventilation.	100%
Benign brain tumor including spinal cord tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Coma (non-induced) 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.</p>	100%
<p>Huntington's disease Pays a benefit when you are diagnosed with Huntington's Disease by a physician.</p>	100%
<p>Parkinson's disease Pays a benefit when you are diagnosed with Parkinson's disease by a psychiatrist or neurologist.</p>	100%
<p>Persistent vegetative state (PVS) Pays a benefit when diagnosed with Persistent vegetative state (PVS) by a physician.</p>	100%
<p>Ruptured aneurysm Pays a benefit when you are diagnosed with Ruptured aneurysm by a physician.</p>	50%
<p>Stroke Pays a benefit when you are diagnosed with a Stroke resulting in paralysis or other measurable objective neurological defect persisting for more than 24 hours.</p>	100%
<p>Transient ischemic attack (TIA) Pays a benefit when you are diagnosed with Transient ischemic attack (TIA) by a physician. TIA does not include a stroke.</p>	25%
<p><i>Maximum per lifetime</i></p>	1

Critical Illness Benefits – Other

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Aplastic anemia Pays a benefit when you are diagnosed with acquired or inherited aplastic anemia, and such diagnosis is confirmed by a bone marrow biopsy and/or blood chemistries, evaluation of liver and kidney functions, and genetic studies.</p>	25%
<p>Bone marrow transplant (Include Autologous) We will pay the Bone Marrow Transplant Benefit shown on the Schedule of Benefits when a physician determines that the transplant is necessary or would be recommended if the insured person were well enough to undergo the surgery. All Bone Marrow Transplant will use the same base rate. Please create new benefit if base rates will differ.</p>	100%
<p><i>Maximum per lifetime</i></p>	1
<p>End-stage renal or kidney failure Pays a benefit when you are diagnosed with End stage renal or kidney failure, and the insured person has to undergo regular hemodialysis or peritoneal dialysis at least weekly or your physician determines that complete replacement of the entire organ is necessary, and you are placed on a national transplant list, such as UNOS (United Network for Organ Sharing).</p>	100%
<p>Hemophilia Pays a benefit when you are diagnosed with Hemophilia by a physician.</p>	100%

Idiopathic pulmonary fibrosis

Pays a benefit when you are diagnosed with Idiopathic pulmonary fibrosis and such diagnosis is confirmed by lung biopsy. This does not include Interstitial pneumonia, Sarcoidosis or Silicosis. 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%

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%

Major organ failure (heart, liver, lung(s), or pancreas)

Pays a benefit when you are diagnosed with a Major organ failure of the heart, liver, lung(s), or pancreas resulting in the insured person being placed on the UNOS (United Network for Organ Sharing) list for a transplant. 100%

Paralysis

Pays a benefit when you are diagnosed with any of the types of paralysis below, and your physician confirms the paralysis continued for a period of 60 consecutive days.

Quadriplegia 100%

Triplegia 100%

Paraplegia 100%

Hemiplegia 100%

Diplegia 100%

Monoplegia 100%

Sarcoidosis

Pays a benefit when you are diagnosed with sarcoidosis, and as a direct result of such diagnosis, you have a stay in a hospital for at least **5 consecutive days**. 25%

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%

Note: Sarcoidosis requires a hospital stay of at least 5 days

Critical Illness Benefits – Vascular (Heart)

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Coronary artery condition requiring bypass surgery</p> <p>Pays a benefit when you are diagnosed with a Coronary artery condition in which the patient is placed on a cardiac pulmonary bypass machine and a bypass graft is performed.</p>	50%
<p>Heart attack (myocardial infarction)</p> <p>Pays a benefit when you are diagnosed with a Heart attack (Myocardial Infarction) resulting from a blockage of one or more coronary arteries.</p>	100%
<p>Heart arrhythmia</p> <p>Pays a benefit when you are diagnosed with Heart arrhythmia based on an EKG, and your physician recommends that you undergo Surgical placement of an internal pacemaker, Implantable or internal cardioverter defibrillator (ICD), or Cardiac resynchronization therapy (CRT).</p>	25%
<p>Sudden cardiac arrest</p> <p>Pays a benefit when you are diagnosed with Sudden cardiac arrest by a physician. Sudden cardiac arrest does not include heart attack. The sudden cardiac arrest benefit is not payable if the sudden cardiac arrest is caused by, or contributed to by, a heart attack.</p>	100%

Critical Illness Benefit Features

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Subsequent critical illness diagnosis</p> <p>Subsequent diagnosis of a different covered Critical Illness is payable at the original amount if it occurs after the previous date of diagnosis for which a benefit was paid.</p>	100%
<p>Recurrence critical illness diagnosis</p> <p>If an insured person has been initially diagnosed with and received a benefit under this plan for a critical illness and then is diagnosed with the same critical illness again at the number of days specified in the minimum below or later, we will pay the stated percentage of the benefit as shown in the Schedule of Benefits for the recurring critical illness diagnosed.</p> <p><i>Minimum days between diagnosis of same condition</i></p> <p><i>No benefit payable if the recurrence occurs within a timeframe that is less than the number of days specified</i></p>	100%
	90 days

Cancer Benefits

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
<p>Cancer (invasive) Pays a benefit when you are diagnosed with Cancer (invasive) that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.</p>	100%
<p>Carcinoma in situ (non-invasive) Pays a benefit when you are diagnosed with Carcinoma in situ that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of this Certificate.</p>	25%
<p>Skin cancer Pays a benefit when you are diagnosed with Skin Cancer (melanoma of Clark's Level I or II Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin. Skin cancer benefit provides coverage for invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic. <i>Maximum per lifetime</i></p>	\$500 1
<p>Recurrence cancer (invasive) diagnosis If an insured person has been initially diagnosed with and received a benefit for cancer (invasive) under this plan and is then diagnosed with any kind of cancer (invasive) again at the number of days specified in the minimum below or later, we will pay the stated percentage of the Cancer Benefit for Cancer (invasive) as shown on the Schedule of Benefits for the cancer (invasive) diagnosed. <i>Minimum days between diagnosis of cancer (invasive)**</i> <i>No benefit payable if the recurrence occurs within a time frame less than the number of days specified</i></p>	100% 90 days
<p>Recurrence carcinoma in situ diagnosis If an insured person has been initially diagnosed with and received a benefit for carcinoma in situ (non-invasive) under this plan and is then diagnosed with any kind of carcinoma in situ (non-invasive) again at the number of days specified in the minimum below or later, we will pay the stated percentage of the carcinoma in situ (non-invasive) as shown on the Schedule of Benefits for the carcinoma in situ (non-invasive) diagnosed. <i>Minimum days between diagnosis of carcinoma in situ**</i> <i>No benefit payable if the recurrence occurs within a time frame less than the number of days specified</i></p>	100% 90 days

** In addition to the separation period, the insured person must be treatment free during the separation period. Treatment does not include maintenance drug therapy or routine follow-up visits to a physician to confirm the initial cancer or carcinoma in situ has not returned.

*For those members who were diagnosed with cancer prior to their effective date of coverage under the Aetna plan and then receive another cancer diagnosis (the first time) while covered under the Aetna plan, we will treat their diagnosis as an 'initial' diagnosis under the Aetna plan.

Health Screening Rider

Covered Benefit	Benefit Amount
Health screening Pays once per member per plan year for covered preventive tests. <i>Maximum 1 test per plan year</i>	\$50

Covered Health Screenings

- Bone marrow screening
- Bone mass density measurement (DEXA, DXA)
- Biopsies for cancer
- Blood chemistry panel
- Breast sonogram
- Breast MRI
- Breast ultrasound
- Cancer antigen 125 blood test for ovarian cancer (CA 125)
- Carotid doppler ultrasound
- Chest x-ray (CXR)
- Cytologic screening
- Cancer antigen 15-3 blood test for breast cancer (CA 15-3)
- Carcinoembryonic antigen blood test for colon cancer (CEA)
- Clinical testicular exam
- Colonoscopy
- Complete blood count (CBC)
- Dental exam
- Digital rectal exam (DRE)
- Doppler screening for cancer
- Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)
- Electroencephalogram (EEG)
- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Endoscopy
- Eye exam
- Fasting blood glucose test
- Fasting plasma glucose test
- Flexible sigmoidoscopy
- Hearing test
- Hemoccult stool analysis
- Hemoglobin A1C
- Human papillomavirus vaccination (HPV)
- Infectious disease testing
- Immunizations
- Lipoprotein profile (serum plus HDL, LDL, total cholesterol, and triglycerides)
- Mammography
- Oral cancer screening
- Pap smear
- Prostate specific antigen (PSA) test
- Routine health check-up exam
- Skin cancer biopsy
- Skin cancer screening
- Skin exam
- Serum protein electrophoresis (blood test for myeloma)
- Successful completion of smoking cessation program
- Stress test on bicycle or treadmill
- Test for sexually transmitted infections (STIs)
- Thermography
- ThinPrep pap test
- Two-hour post-load plasma glucose test
- Ultrasound for cancer detection
- Ultrasound screening for abdominal aortic aneurysms
- Virtual colonoscopy

Note: COVID-19 testing is covered as an eligible health screening benefit

Waiver of Premium

Covered Benefit	Benefit Amount
If, as a result of your covered critical illness 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. The premium waiver does not apply to your covered dependents.	Included

Critical Illness Plan Exclusions Limitations 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.

Benefits under the policy will not be payable for a diagnosis related to the following:

1. Act of war, riot, war;
2. Care provided by immediate family members or any household member;
3. 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;
4. Being under the influence of a stimulant (such as amphetamines), depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by the covered person, except when resulting from a diagnosed disorder;

The critical illness date of diagnosis must be on or after the effective date of the certificate and while coverage is in force. The diagnosis must be given or received in the United States or its territories.

Portability

Your plan includes a portability 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 portability provisions.

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?

The face amount is the maximum benefit a plan pays for a covered diagnosis for a member. Your benefits are based on a percentage of the face amount, or a specific dollar amount, as shown. Your dependents' benefits are based on a percentage of your benefits.

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?

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 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.

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. 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.

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.

Please review your Cancer buyer's guides:

http://demo.avpenroll.com/media/1591/maine-nh-prod_serv_consumer_guide_cancer.pdf

http://demo.avpenroll.com/media/1590/aetna-utah_ci_buyersguide.pdf

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.

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 the website below:

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

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



BENEFIT SUMMARY

The Behavioral Wellness Center at Girard
803322

Aetna Hospital Indemnity

Insurance plans are underwritten by Aetna Life Insurance Company.


Here's how the plan works:


You have an unexpected event and have to go to the hospital.




You are admitted into the hospital and spend two days there.




You submit your hospital claim to Aetna.




Aetna pays benefits directly to you.

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. 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	Benefit Amounts
<p>Hospital stay - Admission</p> <p>Provides a lump sum benefit for the initial day of your stay in a non-ICU room of a hospital.</p> <p><i>Maximum 3 stays per plan year; separated by 30 days in a row</i></p>	\$1,500
<p>Hospital stay - Daily</p> <p>Pays a daily benefit, beginning on day two of your stay in a non-ICU room of a hospital.</p> <p><i>Maximum 90 days per plan year</i></p>	\$300
<p>Hospital stay - ICU Admission</p> <p>Provides a lump sum benefit for the initial day of your stay in an ICU room of a hospital.</p> <p><i>Maximum 3 days per plan year; separated by 30 days in a row</i></p>	\$3,000
<p>Hospital stay - (ICU) Daily</p> <p>Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital.</p> <p><i>Maximum 90 days per plan year</i></p>	\$600
<p>Newborn routine care</p> <p>Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth.</p> <p><i>Maximum 1 day per plan year</i></p>	\$300
<p>Observation unit</p> <p>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.</p> <p><i>Maximum 1 day per plan year</i></p>	\$100
<p>Substance abuse stay - Daily</p> <p>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.</p> <p><i>Maximum 90 days per plan year</i></p>	\$150
<p>Mental disorder stay - Daily</p> <p>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.</p> <p><i>Maximum 90 days per plan year</i></p>	\$150
<p>Rehabilitation unit stay - Daily</p> <p>Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury.</p> <p>Maximum 90 days per plan year</p>	\$150

Important Note: All daily inpatient stay benefits begin on day two and count toward the plan year 90 days maximum. The admission ICU pays instead of, not in addition to, the benefits for non-ICU hospital admission benefits.

Important Note: Hospital Stay – Admission, Hospital Stay – Daily, & Hospital Stay – Daily (ICU) are payable for NICU, accident and sickness for newborns.

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.

Portability

If your employment ends, and as a result your coverage under the policy ends, you can choose to continue your coverage by enabling the portability provision in your coverage. Such coverage will be available to you and any of your covered dependents.

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 activities, including but not limited to: ballooning, bungee jumping, 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. Assault, felony, illegal occupation, or other criminal act;
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 under the influence of any drug intoxicant;
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

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 does not include routine nursery and newborn expenses. 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 portability 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.

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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.

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

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www.aetna.com.

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





RATE SHEET

Rates shown are based on monthly deductions. Your payroll deductions will be taken after taxes are taken.



Hospital Indemnity Plan

Coverage	Cost
Yourself only	\$52.74
Yourself & spouse	\$102.69
Yourself plus child(ren)	\$72.57
Yourself and family	\$123.05

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



Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call [1-800-872-3862](tel:1-800-872-3862) (TTY: [711](tel:711)) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

Attn: 1557 Coordinator

CVS Pharmacy, Inc.

1 CVS Drive, MC 2332,

Woonsocket, RI 02895

Phone: [1-800-648-7817](tel:1-800-648-7817), TTY: [711](tel:711)

Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

[1-800-368-1019](tel:1-800-368-1019), [1-800-537-7697](tel:1-800-537-7697) (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Aetna Inc.'s website: <https://www.aetna.com/>

