Life changing

Aetna Critical Illness Plan

Life's ups and downs. One day you're in a wedding dress — and the next a hospital gown. You're worried about your health and missing weeks of work. How are you going to pay for everything? Be better prepared for moments like these with an Aetna Critical Illness Plan.



We pay *you* cash benefits



It's your money to spend

Our 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. Use the money to help pay medical bills or everyday living expenses like groceries or rent. The choice is yours. You can also sign up for direct deposit to get your benefits faster.

Our plan works 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 it pairs well with your major medical plan.

Insurance plans are offered and/or underwritten by Aetna Life Insurance Company (Aetna). Policy forms issued in Idaho include: GR-96844.

2376952-01-01

aetna®

An Aetna Simplified Claims Experience™

To file a claim, it takes about 90 seconds or less. If you've got Aetna® medical, you typically don't need to provide any documents. We'll access your medical records to help process your claim.* That's less paperwork for you. Don't have Aetna medical? No problem. Just upload a PDF or picture of your medical bill. If your claim is approved, we'll mail you a check or deposit cash directly into your bank account.

Manage your plan 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 continue to access your account and receive important reminders — even if you leave your company.

It happened to me — it could happen to you

"I'm on the mend. But when I had my heart attack, I forgot I had the Aetna Critical Illness Plan — until I got an email reminding me. I went online, signed up for direct deposit and filed a claim. I got my money fast. I used some of it to help cover out-of-pocket treatment costs. And the rest to take a long belated honeymoon."*

— Danielle*



*FOR CLAIM PROCESSING: Sometimes you may need to provide documentation if the benefit doesn't create a medical claim, or we need more details to process your claim.
*FOR COVERAGE LIMITATIONS: Benefits paid for covered critical illness diagnoses that occur on or after the coverage effective date.
*FOR MEMBER TESTIMONIAL: The above member story is for illustrative purposes and doesn't reflect events experienced by actual participants.

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-96843.
Policy forms issued in Missouri include: GR-96844-01.

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2376952-01-01

BENEFIT SUMMARY

SAP America, Inc.

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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 $20,000 $30,000
Spouse face amount	50% of EE face amount
Spouse benefit amount	50% of EE benefit amount
Child(ren) face amount	50% of EE face amount
Child(ren) benefit amount	50% 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%
Multiple sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	100%
Myasthenia Gravis Pays a benefit when you are diagnosed with Myasthenia gravis by a physician.	25%
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
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: • 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 1, 2 or 3 for both major domains.	$1,500
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%
Down syndrome 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.	100%
Sickle cell anemia Pays a benefit when you are diagnosed with Sickle cell anemia by a physician.	100%
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. *No Maximum diagnoses per Plan year*	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 Pays a benefit when you are diagnosed with Cholera by a physician.	25%
Coronavirus "Pays a benefit when you are diagnosed with Coronavirus. Coronaviruses (CoV) are a large family of viruses that cause illness in people such as: • 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."	100%
Creutzfeldt-Jakob disease 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.	25%
Diphtheria Pays a benefit when you are diagnosed with Diphtheria by a physician.	25%
Ebola 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.	25%
Encephalitis 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.	25%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Hepatitis - occupational Pays a benefit when you are diagnosed with Occupational hepatitis B, C, or D resulting from accidental exposure by contaminated body fluids.	100%
Human immunodeficiency virus (HIV) 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.	100%
Legionnaire's disease Pays a benefit when you are diagnosed with Legionnaire's disease by a physician.	25%
Lyme disease Pays a benefit when you are diagnosed with Lyme Disease by a physician.	25%
Malaria Pays a benefit when you are diagnosed with Malaria by a physician.	25%
Meningitis - Bacterial , Viral , Fungal , Parasitic , Amebic Pays a benefit when you are diagnosed with Bacterial meningitis by a physician.	25%
Methicillin-resistant staphylococcus aureus (MRSA) Pays a benefit when you are diagnosed with Methicillin-resistant staphylococcus aureus (MRSA) by a physician.	25%
Necrotizing fasciitis 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.	25%
Osteomyelitis Pays a benefit when you are diagnosed with Osteomyelitis by a physician.	25%
Pneumonia - Bacterial , Viral 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.	25%
Poliomyelitis 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.	25%
Rabies Pays a benefit when you are diagnosed with Rabies by a physician.	25%
Rocky mountain spotted fever (RMSF) Pays a benefit when you are diagnosed with Rocky mountain spotted fever (RMSF) by a physician.	25%
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%

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
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%
Maximum infectious disease diagnosis per plan year	*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, Tularemia, 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.	25%
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%
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%
Benign brain tumor including spinal cord tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%
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.	100%
Huntington's disease Pays a benefit when you are diagnosed with Huntington's Disease by a physician.	25%
Parkinson's disease Pays a benefit when you are diagnosed with Parkinson's disease by a psychiatrist or neurologist.	100%
Persistent vegetative state (PVS) Pays a benefit when diagnosed with Persistent vegetative state (PVS) by a physician.	100%
Ruptured aneurysm Pays a benefit when you are diagnosed with Ruptured aneurysm by a physician.	100%
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.	100%
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.	25%
Maximum per lifetime	*1*

Critical Illness Benefits – Other

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Acute respiratory distress syndrome (ARDS) Pays a benefit when you are diagnosed with Acute respiratory distress syndrome (ARDS) by a physician.	25%
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.	25%
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.	100%
Maximum per lifetime	*1*
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).	100%
Hemophilia Pays a benefit when you are diagnosed with Hemophilia by a physician.	100%

Infertility (Initial & Advanced)
Pays a benefit when you are diagnosed with infertility, or advanced infertility.
• **Infertility** must be due to:
  • Antiphospholipid antibody syndrome
  • Azoospermia or have severe deficits in semen quality, quantity, motility or morphology based on a semen analysis.
  • Oligospermia
  • Tubal factor infertility
  • A disease of the reproductive tract such that timed egg-sperm contact would be ineffective.
• **Advanced Infertility** diagnosis must be confirmed by any of the following:
  • For female factor infertility, your physician recommends you undergo gamete intra-fallopian transfer (GIFT), intra-cytoplasmic sperm injection (ICSI), zygote intra-fallopian transfer (ZIFT), or in-vitro fertilization (IVF)
  • For male factor infertility, your physician recommends specialized sperm retrieval techniques.
	$1,000

Maximum infertility per lifetime	*1*

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
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 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%
Mental health condition Pays a benefit when you are diagnosed with a mental health condition, and as a direct result of such diagnosis, you have a stay in a hospital or mental health treatment facility for at least **3 consecutive days.**	25%
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: The Sarcoidosis require a hospital stay of at least 5 days.
Note: The Mental health conditions require a hospital stay of at least 3 days.

Critical Illness Benefits – Vascular (Heart)

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Coronary artery condition requiring angioplasty Pays a benefit when you are diagnosed with a Coronary artery condition requiring angioplasty and your physician has recommended the insured person undergo balloon angioplasty, percutaneous transluminal angioplasty, or percutaneous transluminal coronary angioplasty. Other surgical or non-surgical techniques such as laser relief or any other intra-arterial procedures are excluded.	100%
Coronary artery condition requiring bypass surgery 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.	100%
Coronary artery condition requiring heart valve replacement or repair surgery Pays a benefit when you are diagnosed with Coronary artery condition requiring you undergo open heart surgery to replace or repair one or more valves.	100%
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%
Heart arrhythmia 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).	25%
Sudden cardiac arrest 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.	25%
Maximum per lifetime	*1*

Critical Illness Benefit Features

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
Subsequent critical illness diagnosis	100%
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.	
Recurrence critical illness diagnosis 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.	100%
Minimum days between diagnosis of same condition *No benefit payable if the recurrence occurs within a timeframe that is less than the number of days specified*	*90 days*

Cancer Benefits

Covered Benefit	Percent of Face Amount / Employee Benefit Amount
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.	100%
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.	25%
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.	10%
Maximum per lifetime	*1*
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.	100%
*Minimum days between diagnosis of cancer (invasive)***	
No benefit payable if the recurrence occurs within a time frame less than the number of days specified	*90 days*
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.	100%
*Minimum days between diagnosis of carcinoma in situ***	
No benefit payable if the recurrence occurs within a time frame less than the number of days specified	*90 days*

* 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.

** 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.

Health Screening Rider

Covered Benefit	Benefit Amount
Health screening	$50
Pays once per plan year, per member for one of the preventive tests listed below.	
Note: Your plan year may not be based on the calendar year.	
Maximum per plan year	*1*

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 30th 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 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.

Questions and Answers about the Critical Illness Plan

How do I know if I'm considered a tobacco user and should select the tobacco rates?

You are a Tobacco User if you currently use or have used any tobacco products in the past 12 months. Tobacco products include, but are not limited to, cigarettes, cigars, snuff, dip, chew, pipe and/or any nicotine delivery system.

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.

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.

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.



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**.

Proprietary

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 (TTY: 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, TTY: 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, 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/

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TTY: **711**

English	**To access language services at no cost to you, call** 1-888-772-9682 **.**
Amharic	እርስዎ ወጪ ሳያወጡ የቋንቋ አገልግሎቶችን ለመድረስ ወደ 1-888-772-9682 ይደውሉ።
Arabic	للحصول على خدمات اللغة مجانًا، اتصل على 1-888-772-9682
Armenian	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք հեռախոսահամարով: 1-888-772-9682
Carolinian (Kapasal Falawasch)	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-772-9682 .
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-888-772-9682 .
Chinese Traditional	如欲使用免費語言服務，請致電 1-888-772-9682 .
Cushitic-Oromo	Tajaajila afaanii bilisaan argachuuf, 1-888-772-9682 irratti bilbilaa.
French	Afin d'accéder aux services langagiers sans frais, composez le 1-888-772-9682 .
French Creole (Haitian)	Pou w jwenn aksè ak sèvis lang gratis pou ou, rele 1-888-772-9682 .
German	Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie 1-888-772-9682 an.
Greek	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-888-772-9682 .
Gujarati	તમારે કોઇ તના ખર્ચ વના ભાષાની સેવાઓની પહચ માટે, કોલ કરો 1-888-772-9682 .
Hindi	आपके लए बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, 1-888-772-9682 पर कॉल करे।
Hmong	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-888-772-9682 .
Italian	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-772-9682 .
Japanese	無料の言語サービスをご利用いただくには、1-888-772-9682 にお電話ください。
Karen	လၫကမၤနှဲ့ ကျိာ်တၢ်မၤစၢၤတၢ်မၤ လၫတလိဉ်လာ်ဘူဉ်လာ်စုၤ လၫနဂီၢ်အဂီၢ်, 1-888-772-9682 .
Korean	무료로 언어 서비스를 이용하려면 1-888-772-9682 번으로 전화하세요
Laotian	ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ, ໃຫ້ໂທຫາ 1-888-772-9682 .
Mon-Khmer, Cambodian	ដើម្បីទទួលនេសវាផ្នែនកភាសាដោយមិនគិតៃថ្លលពីអ្នែនកសូមទូរសព្ទទេលខ 1-888-772-9682 ។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó kojį' hólne' 1-888-772-9682 .
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff 1-888-772-9682 .
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-772-9682 تماس بگیرید.
Polish	Aby uzyskać bezpłatny dostęp do usług językowych, zadzwoń pod numer 1-888-772-9682 .
Portuguese	Ligue para 1-888-772-9682 para receber assistência linguística gratuita.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-772-9682 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Чтобы получить бесплатные языковые услуги, позвоните по номеру 1-888-772-9682 .
Samoan	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-772-9682 .
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite 1-888-772-9682 .
Spanish	Para acceder a los servicios de idiomas sin costo, llame al 1-888-772-9682 .
Syriac-Assyrian	ܒܗ، ܡܒܪܟ ܠܟ ܒܫܘܬܦܐ ܕܫܝܪܘܬ ܠܫܢܐ ܕܠܐ ܡܫܟܚ ܥܠ ܝܠܦ ܠܟ ܒܠܫܢ ܕܡܬܝܠ ܠܟ ܐܢ ܬܨܠ ܠ 1-888-772-9682 .
Tagalog	Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tumawag sa 1-888-772-9682 .
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-772-9682 .
Ukrainian	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-772-9682 .
Vietnamese	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-772-9682 .

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