Facing a serious diagnosis

An Aetna Critical Illness Plan can help

Nobody is ready to receive a diagnosis of a serious illness. But an Aetna Critical Illness Plan pays benefits when you are diagnosed with a covered illness or condition, after your coverage effective date. This can help you feel a little more financially prepared to focus on the road to recovery.

Support in times of need

Loretta's story*

"After a routine mammogram, being diagnosed with breast cancer was not something I'd expected. Who can ever plan for something like that?"

"After surgery, chemo and many visits to the oncologist, my out-of-pocket medical costs really added up. My critical illness plan helped my finances."

"Filing a claim online was fast and easy. And the benefits were deposited directly into my account. I used the cash for medical bills – plus extras, like childcare and groceries."

Your plan – your benefits

Here's what your plan would pay if you enrolled in the **low $10K critical illness plan** and experienced a situation like Loretta's.

Covered diagnosis	Benefit
Health screening benefit	$50
Cancer diagnosis	$10,000
Total paid:	**$10,050**

Covered Aetna Critical Illness Plan benefits

For as little as **$11.84 per month for a 36-year-old with family coverage,** an Aetna Critical Illness Plan can help ease some financial worries. Take a look at some of the benefits:

- Heart attack & stroke
- Major organ failure
- Invasive & non-invasive cancers
- Acute Respiratory Distress Syndrome (ARDS)
- Loss of sight, speech, or hearing
- Skin cancer
- Alzheimer's & lupus
- Childhood illnesses
- Recurrence & subsequent illnesses**
- Health screening benefit

Want to learn more? You have a choice of plan options. Check out your benefit summary for a complete list of benefits, details, exclusions, and limitations that apply.

*The above member story is for illustrative purposes and does not reflect events experienced by actual participants.
**Recurrence illness diagnoses must occur at least 180 days after initial diagnosis. Subsequent illness diagnosis of a different critical illness must occur at least 30 days after initial diagnosis.

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Exclusions and Limitations

These plans have 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 plans may contain exceptions to this list based on state mandates or the plan design purchased. Benefits under the policy will not be payable for anything related to the following:

Exclusions: Benefits under the Policy will not be payable for any critical illness, cancer (invasive), carcinoma in situ or skin cancer that is diagnosed or for which care was received outside the United States and its territories, or for any loss caused in whole or in part by or resulting in whole or part from the following:

Critical Illness Plan Exclusions and Limitations

1. Suicide or attempt at suicide, intentional self-inflicted injury or sickness, any attempt at intentional self-inflicted injury, injury caused by a self-inflicted act or sickness, while sane or insane; except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM);
2. Engaging in felony crimes;
3. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection.

Also, as to intoxicants and controlled substances: We shall not be liable for any loss sustained or contracted in consequence of the insured person's being intoxicated or under the influence of any controlled substance unless administered on the advice of a physician.

Critical Illness Policy form issued in Oklahoma include: GR-96843, AL HCOC-VOL CI 01, and AL HPOL-VOL CI 01
Critical Illness Policy form issued in Missouri include: GR-96844 01, AL HCOC-VOL CI 01 and AL HPOL-VOL CI 01

THESE PLANS DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE ARE A SUPPLEMENT TO HEALTH INSURANCE AND NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **Aetna.com**.

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