

Health Supplement Plan – Frequently Asked Questions

How does the Health Supplement Plan work?

The Health Supplement Plan pays cash benefits directly to you for services related to an accident, covered inpatient hospital stay and/or critical illness diagnosis while you are covered under the plan.

Who can be covered under the plan?

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

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

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

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

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

How soon after I enroll do my benefits start?

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

Can I have more than one Health Supplement Plan?

No, you are not allowed to have more than one Health Supplement Plan.

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

Yes, the Health Supplement Plan is compatible with Health Savings Accounts.

Is there a member website?

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

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

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

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

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

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

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

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

How is an accident defined?

An accident is defined as an unforeseen event that is the direct cause of an accidental injury to an insured person, which occurs while coverage is effective.

Are organized sports-related injuries covered?

Yes, as long as the insured isn’t participating in a semi-professional or professional competitive athletic contest, including officiating or coaching, for which the insured receives any compensation or remuneration.

Do benefits pay for a pregnancy stay?

Yes. The hospital indemnity section of the plan would pay admission and daily stay benefits.

How does the Therapy Services benefit work if I receive multiple therapies in one day?

Only one Therapy Services benefit will be paid per day, no matter how many different Therapy Services you receive.

What does Face Amount mean?

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

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

The critical illness portion of the plan pays based on diagnosis of a covered condition, not its treatment.

Exceptions include the major organ failure benefit, which requires the insured person being placed on the United Network for Organ Sharing list for a transplant, and a coronary artery condition requiring bypass surgery.

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

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

What happens if a covered person dies while covered under the Health Supplement Plan?

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

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

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

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

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 plan may contain exceptions to this list based on state mandates or the plan design purchased.

Accident Plan: Benefits under the Policy will not be payable for any loss or accidental injury caused in whole or in part by or resulting in whole or part from the following: 1. Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM) 2. Being under the influence of a stimulant, depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by the insured person, except when resulting from a diagnosed disorder in the most current version of the DSM 3. Engaging in an assault, felony, illegal occupation or other criminal act 4. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection 5. Operating, learning to operate or serving as a crewmember of an aircraft, whether motorized or not 6. Engaging in hang gliding, bungee jumping, parachuting, sail gliding, parasailing, mountaineering using ropes and/or other equipment, or motor-driven vehicle racing 7. Participating in any semi-professional or professional competitive athletic contest, including officiating or coaching, for which the insured person receives any compensation or remuneration 8. Services ordered or performed by a physician, or supplies purchased from a provider, who is an insured person, the insured person's immediate family member, or someone who resides with or is employed by or who employs an insured person 9. Any form of intentional asphyxiation 10. Elective or cosmetic surgery 11. No benefit is paid for or in connection with the following stays or visits or services: Those received outside the United States; and its territories. Those for education, special education or job training, whether or not given in a facility that also provides medical or psychiatric treatment. *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.*

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

Hospital Indemnity Plan: Benefits will not be payable for any Stay resulting in whole or part from the following: 1. Suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury, except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM) 2. Being under the influence of a stimulant, depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by the insured person, except when resulting from a diagnosed

disorder in the most current version of the DSM 3. Engaging in an assault, felony, illegal occupation or other criminal act 3. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection 4. Services ordered or performed by a physician, or supplies purchased from a provider, who is an insured person, the insured person's immediate family member, or someone who resides with or is employed by or who employs an insured person 5. Any form of intentional asphyxiation 6. Outpatient care, services, prescription medications or supplies 7. Custodial care.

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

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

Policy forms issued in Idaho include: GR-96841, GR-96842, GR-96843, GR-96844.

Policy forms issued in Missouri include: GR-96842 01; GR-96841 01; GR-96844 01; GR-96843 01; AL VOL HPOL-Hosp 01; AL VOL HCOC-Hosp 01.

Policy forms issued in Oklahoma include: GR-96841, GR-96842, GR-96843, GR-96844.

