Group Critical Illness and Cancer Plan

What Your Plan Covers and How Benefits are Paid

Prepared Exclusively For
Boyd ISD

Critical Illness 2.0 Plus with Cancer - Low Plan

Aetna Life Insurance Company
Certificate

This Certificate is part of the Group Critical Illness and Cancer Policy between Aetna Life Insurance Company and the Policyholder

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

Aetna Life Insurance Company (Aetna)

To get information or file a complaint with Aetna:

Call toll-free at 1-888-772-9682
Email: log onto myaetnasupplemental.com and click on Contact Us
Mail: Aetna Voluntary, P.O. Box 14463, Lexington, KY 40512-4463

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

Aetna Life Insurance Company (Aetna)

Para obtener información o para presentar una queja ante su compañía de seguros:

Teléfono gratuito: 1-888-772-9682
Correo electrónico: Ingrese en myaetnasupplemental.com y haga clic en “Contact Us” (Contáctenos).
Dirección postal: Aetna Voluntary, P.O. Box 14463, Lexington, KY 40512-4463

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

Critical Illness and Cancer Plan

Certificate

Prepared exclusively for:

Policyholder:	Boyd ISD
Policy number:	803072
Plan effective date:	September 1, 2023
Certificate issue date:	May 18, 2023

Underwritten by Aetna Life Insurance Company in the state of Texas
151 Farmington Avenue, Hartford, Connecticut 06156

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

This is a critical illness and cancer plan. This plan provides limited benefits. It pays fixed dollar amounts for covered benefits without regard to the provider's actual charges. The 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.

PLEASE READ THIS CERTIFICATE CAREFULLY

THE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM

Welcome

Thank you for choosing **Aetna**.

This is your certificate of coverage. It is one of two documents that together describe the benefits covered by your **Aetna Life Insurance Company** ("**Aetna**") plan.

This certificate will tell you about your benefits – what they are and how you get them. If you become insured, this certificate becomes your certificate of coverage under the **policy**, and it takes the place of all certificates describing similar coverage that were previously sent to you. In the certificate is the *Schedule of benefits* section. It tells you about your benefits and maximums.

The second document is the **policy** between **Aetna** and the **policyholder**. Ask the **policyholder** if you have any questions about the **policy**.

Also, each of these documents may have amendments or riders attached to them. They change or add to the documents they're a part of.

Where to next? Try the *Let's get started!* section as it gives you some details of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

Dan Finke
President
Aetna Life Insurance Company
(A Stock Company)

Table of contents

Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire certificate. And if you need help or more information, we tell you how to contact us.

Some notes on how we use words

- When we say "us", "we", and "our", we mean **Aetna**.
- When we say "you" and "your", we mean both the **employee** and any of their **covered dependents** unless we say otherwise.
- Some words appear in **bold** type. We define them in the *Glossary and Glossary - Cancer* sections.

What your plan does – providing benefits

This plan will pay the fixed dollar benefits listed in the *Schedule of benefits* when you are given a payable **diagnosis**.

How your plan works

So what are covered benefits? **Diagnosis** of a payable critical illness or cancer that meet the requirements in the *Benefits under your plan* section.

This plan does not pay for a **diagnosis** that occurs prior to your **effective date of coverage**. The **diagnosis** must occur on or after your **effective date of coverage** and while your coverage under the certificate is in force.

This plan does not cover a flare-up of certain critical illnesses that you were first **diagnosed** with before your **effective date of coverage**. These include:

- Lupus

This plan does not cover a flare-up, spread or metastasis of a cancer (invasive) or carcinoma in situ that you were first **diagnosed** with before your **effective date of coverage**.

Your coverage under the plan has a start and an end. To learn more see the *Who the plan covers and when coverage starts* and *When coverage ends* sections.

Ending coverage under the **policyholder's** plan doesn't necessarily mean you lose coverage with us. See the *Portability* section for details.

Disagreements

We know that people sometimes see things differently. In this certificate we tell you how we will work through our differences. For more information, see the *Claim decisions and appeal procedures for when you disagree* section.

How to contact us for help

We are here to answer your questions. You can contact us by:

- Calling **Aetna** Member Services toll-free at 800-607-3366
- Writing us at P.O. Box 14079, Lexington, KY 40512
- Logging onto the Aetna member website at www.aetna.com
- Logging onto Aetna member portal at www.myaetnasupplemental.com

Who the plan covers and when coverage starts

A note on how we use "you" and "your" in this section:

- When we say "you" and "your", we mean the **employee** only.

In this section we tell you about who the plan covers, how to join the plan, and when coverage starts.

Who the plan covers (who is eligible)

The **policyholder** decides and tells us who is eligible for coverage provided these requirements are met:

- You are **actively at work**
- You are in an eligible class, as defined by the **policyholder**
- You have reached your eligibility date.

When you and your eligible dependents can join the plan

You can enroll yourself and your eligible dependents:

- During the new hire enrollment period
- During the annual enrollment period
- When you want to add new dependents (see the *Who can be on your plan (who can be your dependents)* and *Adding new dependents and when their coverage starts* provisions below)

Once you become eligible for the plan you will have 31 days to enroll. If you do not enroll yourself and your eligible dependents when you first qualify for benefits under this plan, you have to wait until the next annual enrollment period to join.

When your coverage starts

If you enroll, your coverage will start on:

- The date you are eligible for coverage.
- The first day of the pay period after the pay period end date in which a deduction occurs.

If you enroll yourself and your dependents at the same time, your enrolled dependents' coverage starts on the same date that your coverage starts.

How you and your eligible dependents can join the plan

You can join the plan by completing the enrollment process. You must:

- Send all requested information, and
- Agree to pay any required **premium**.

Important note:

Actively at work rule:
If you are an eligible **employee** who is not **actively at work**, due to illness, **accidental injury**, or leave of absence, the coverage will not take effect until after you have returned to work and have completed one regularly scheduled work week.

This means that you must be **available to work** on the **effective date of coverage** in order to be eligible for coverage under this plan. You are **available to work** if you meet the eligibility requirements, if any, specified by the **policyholder** to govern eligibility for coverage under this plan, or if you have accrued hourly fringe benefit contributions.

This rule also applies to a change in your coverage.

Who can be on your plan (who can be your dependents)
When you enroll, you can also enroll these dependents on your plan:

- Your **spouse**
- An eligible dependent child who is:
  - Unmarried, and
  - Under age 26, or
  - Over the age limit above who is:
    - Not able to earn his or her own living due to a mental or physical handicap which started prior to the date he or she reaches the limiting age, and
    - Chiefly dependent on you for support.

    We require proof of such handicap no later than 31 days after your child's coverage would otherwise have ended due to the age limit. We, at our expense, may require proof that the handicap continues. Such proof may be required no more than once each two years from the date the child reached the age limit.

  You or your **spouse's** eligible dependent child includes:
  - Biological children
  - Legally adopted children, including any children placed with you for adoption
  - Stepchildren (meaning children of your **spouse**)
  - Foster children
  - A grandchild who is your dependent for federal tax purposes
  - Any children you are responsible for under a qualified medical support order, legal guardianship court order, or other court-order (without regard to whether or not the child resides with you)

  In the paragraph above, we use the phrase "placed with you for adoption." That phrase means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child.

Adding new dependents and when their coverage starts

If you are already enrolled under this plan and have the following life events, you may be able to add the following new dependents:

- A **spouse**: If you marry, or enter into a similar relationship, you can put your **spouse** on your plan.
  - We must receive your completed enrollment information not more than 31 days after the date of your marriage or the date you enter into a similar legal relationship.
- A newborn child: Your newborn is covered on your plan for the first 31 days after birth.
  - To keep your newborn covered, we must receive your completed enrollment information. You must provide the information within 31 days of birth.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for **covered dependents**.
  - If you miss this deadline, you cannot enroll your newborn until the next annual enrollment period.
- An adopted child: A child that you and/or your **spouse** adopt, or a child that is placed with you and/or your **spouse** for adoption, is covered on your plan for the first 31 days after the adoption is final or after the child is placed with you.
  - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the:
    - Adoption is complete, or
    - Date child is placed with you if the child has not been adopted yet
  - If you miss this deadline, you cannot enroll your adopted child until the next annual enrollment period.
- A stepchild: You may put a child of your **spouse** on your plan.
  - To add your stepchild to your plan, you must complete your enrollment information and send it to us within 31 days after the date of your marriage or the date you enter into a similar legal relationship.
  - If you miss this deadline, you cannot enroll your stepchild until the next annual enrollment period.
  - If you meet this deadline, ask the **policyholder** when coverage starts for your stepchild.
- A foster child: You may put a child that you and/or your **spouse** foster on your plan.
  - To add your foster child to your plan, we must receive your completed enrollment information within 31 days after the date of placement.
  - If you miss this deadline, you cannot enroll your foster child until the next annual enrollment period.
  - If you meet this deadline, ask the **policyholder** when coverage starts for your foster child.
- A court ordered dependent: You may put an eligible **spouse** or minor child on your plan when you must provide health coverage as the result of a qualified medical support order, legal guardianship court order, or other court order.
  - To add your court ordered dependent to your plan, we must receive your completed enrollment information.
  - Ask the **policyholder** when coverage starts for your court ordered dependent.

Important note: A **covered person** cannot be covered under this certificate as:

- Both an **employee** and a **covered dependent** or
- A dependent of more than one **employee**

Premium

A note on how we use "you" and "your" in this section:

- When we say "you" and "your", we mean the **employee** only.

Premium payments

The **policyholder** makes **premium** payments to us. However, the **policyholder** will no longer make **premium** payments if you port coverage as described in the *Portability* section. Under portability, you are required to make **premium** payments.

We require that you make **premium** payments. In this section, we explain how the payments are made.

- If payments are made through a payroll deduction with the **policyholder**, then the **policyholder** will forward your payment to us.

Our right to change premium rates

We have the right to change our **premium** rates. We will give the **policyholder** at least 60 days prior written notice of any change. The notice will include the date the change will take place.

Refund of unearned premium

If coverage under this certificate for a **covered person** terminates for any reason, we will promptly refund any unearned **premium** with respect to such person.

Premium waiver

If, as a result of an of your covered critical illness, cancer (invasive), carcinoma in situ (non-invasive) or skin cancer 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**.

If you are still eligible for coverage under this certificate at the end of the waiver period, your coverage can be continued if you resume **premium** payments.

Before we waive your **premium**, you must complete and submit the Premium Waiver Request Form stating that you have missed 30 continuous days of work due to treatment of or recovery from your critical illness, cancer (invasive), carcinoma in situ (non-invasive) or skin cancer. When we receive your notice, we will waive your **premium**.

If you return to work, then you miss another 30 continuous days due to treatment of or recovery from the same critical illness, cancer (invasive), carcinoma in situ (non-invasive) or skin cancer, we will waive the **premium** beginning on the next **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 when your **covered dependents** are **diagnosed** with a critical illness, cancer (invasive), carcinoma in situ (non-invasive) or skin cancer.

Schedule of benefits

Employee

Face amount	$10,000
Dollar benefit amount	Flat dollar amount as shown in the grid below

Covered dependent spouse

Face amount	50% of the Employee face amount
Dollar benefit amount	50% of the Employee dollar benefit amount

Covered dependent children

Face amount	50% of the Employee face amount
Dollar benefit amount	50% of the Employee dollar benefit amount

Benefit	**Percentage of face amount**
Critical illnesses	
Alzheimer's disease	25%
Amyotrophic lateral sclerosis (ALS)	25%
Benign brain or spinal cord tumor	100%
Coma (non-induced)	100%
Coronary artery condition requiring bypass surgery	25%
End-stage renal or kidney failure	100%
Heart attack (myocardial infarction)	100%
Infectious diseases	
Cholera	25%
Coronavirus	100%
Creutzfeldt-Jakob disease	25%
Diphtheria	25%
Ebola	25%
Encephalitis	25%
Hepatitis – occupational	25%
Human immunodeficiency virus (HIV) - occupational	25%

Benefit	**Percentage of face amount**
Critical illnesses (**continued**)	
Infectious diseases (continued)	
Legionnaire's disease	25%
Lyme disease	25%
Malaria	25%
Meningitis - amoebic, bacterial, fungal, parasitic, viral	25%
Methicillin-resistant staphylococcus aureus (MRSA)	25%
Necrotizing fasciitis	25%
Osteomyelitis	25%
Pneumonia	25%
Poliomyelitis	25%
Rabies	25%
Rocky mountain spotted fever (RMSF)	25%
Septic shock and severe sepsis	25%
Tetanus	25%
Tuberculosis (TB)	25%
Tularemia	25%
Typhoid fever	25%
Variant influenza virus (swine flu in humans)	25%
Maximum infectious disease **diagnosis** per **plan year**	2
Loss of hearing	100%
Loss of sight (blindness)	100%
Loss of speech	100%
Lupus	25%
Major organ failure	100%
Multiple sclerosis	25%

Benefit	**Percentage of face amount**
Critical illnesses (**continued**)	
Muscular dystrophy	25%
Paralysis	
Quadriplegia	100%
Triplegia	75%
Paraplegia	50%
Hemiplegia	50%
Diplegia	50%
Monoplegia	25%
Parkinson's disease	25%
Persistent vegetative state (PVS)	100%
Primary sclerosing cholangitis (PSC)	25%
Stroke	100%
Sudden cardiac arrest	25%
Maximum sudden cardiac arrest **diagnosis**	once per lifetime
Third degree burns	100%
Transient ischemic attack (TIA)	25%
Maximum TIA **diagnosis**	once per lifetime

Benefit	**Percentage of face amount/ Employee dollar benefit amount**
Cancer	
Cancer (invasive)	100%
Carcinoma in situ (non-invasive)	25%
Skin cancer	$1,000
Maximum **diagnosis**	once per lifetime

The following benefits pay a flat dollar amount. The dollar amount is not based on the Percentage of face amount/Employee dollar benefit amount shown above.

Benefit	**Dollar benefit**
Additional benefits	
Health screening	$50 per screening
Maximum screenings per **plan year**	1

Benefits under your plan

In this section we help you understand your benefits under this plan

Critical illness benefits

Critical illness benefits are payable if you are **diagnosed** with a critical illness. Covered benefits must meet all of these requirements:

- The **diagnosis** occurs on or after your **effective date of coverage** and while your coverage under the certificate is in force.
- The critical illness **diagnosed** is not excluded by name or specific description in this certificate.
- The **diagnosis** is given or received in the United States or its territories.

If you are **diagnosed** with two or more critical illnesses on the same day, only the **diagnosis** with the highest amount is payable.

If you are **diagnosed** with and receive a benefit from us for a critical illness, and then you are **diagnosed** again with the *same* critical illness (a recurrence), a benefit may or may not be payable for the recurrence. See the *Recurrence critical illness diagnosis* benefit for details.

If you are **diagnosed** with and receive a benefit from us for a critical illness, and then you are subsequently **diagnosed** with a *different* critical illness, a benefit may or may not be payable for the subsequent **diagnosis**. See the *Subsequent critical illness diagnosis* benefit for details.

Alzheimer's disease

We will pay the *Alzheimer's disease* benefit amount shown in the *Schedule of benefits* if:

- You are **diagnosed** with Alzheimer's disease, and
- You have the inability to independently perform 3 or more of the **activities of daily living**.

Alzheimer's disease means an irreversible, progressive brain disorder that destroys memory and thinking skills.

The *Alzheimer's disease* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Amyotrophic lateral sclerosis (**ALS**)

We will pay the *Amyotrophic lateral sclerosis (ALS)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with ALS and your symptoms include:

- The inability to perform 3 or more **activities of daily living**, or
- The need for either a feeding tube or non-invasive ventilation.

ALS, sometimes called Lou Gehrig's disease, means a disease characterized by the progressive degeneration of motor neurons as evidenced by permanent neurological defect with persisting clinical signs and symptoms.

The *ALS* benefit does not include other motor neuron diseases.

The *ALS* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Benign brain or spinal cord tumor

We will pay the *Benign brain or spinal cord tumor* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with a benign brain or spinal cord tumor as confirmed by the examination of tissue (biopsy or surgical excision) or specific neurological exam.

Benign brain tumor means a non-cancerous brain tumor or cyst located in the brain, cranial nerves, or meninges within the skull.

The *Benign brain tumor* benefit does not include:

- Angiomas or aneurysms
- Germinomas
- Pituitary adenomas
- Tumors of the skull

Benign spinal cord tumor means the presence of a non-cancerous spinal cord tumor.

The *Benign spinal cord tumor* benefit does not include these tumors:

- Brain
- Peripheral nerves
- Vertebrae

The *Benign brain or spinal cord tumor* benefit does not include any such tumor resulting from:

- Cowden disease
- Neurofibromatosis I or II
- Tuberous sclerosis
- Von Hippel Lindau disease

Coma (**non-induced**)

We will pay the *Coma (non-induced)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** as being in a non-induced coma.

A coma (non-induced) is a continuous state of profound unconsciousness characterized lasting for a period of 14 or more consecutive days characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance.

The *Coma (non-induced)* benefit does not include:

- A medically induced coma, or
- Persistent vegetative state.

Coronary artery condition requiring bypass surgery

We will pay the *Coronary artery condition requiring bypass surgery* benefit amount shown in the *Schedule of benefits* if:

- You are **diagnosed** with a coronary artery condition requiring bypass surgery, and
- The cardiologist performs coronary artery bypass surgery.

  If you are too ill to undergo surgery, but otherwise qualify under this provision, the requirement that surgery be performed is waived.

A coronary artery condition requiring bypass surgery means the narrowing or blockage of one or more coronary arteries, for which surgery is required and is performed in which the patient is placed on a cardiac pulmonary bypass machine and a bypass graft is performed.

The *Coronary artery condition requiring bypass surgery* benefit does not include:

- Balloon angioplasty
- Laser relief
- Stents
- Other nonsurgical procedures

End-stage renal or kidney failure

We will pay the *End-stage renal or kidney failure* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with:

- End-stage renal or kidney failure and your **physician** recommends that you undergo regular hemodialysis or peritoneal dialysis at least weekly, or
- Kidney failure, and
  - 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).

    The transplant list requirement will be waived if:
    - You receive the transplant prior to placement on a national transplant list, or
    - You are too ill for a transplant, but otherwise meet the criteria to be placed on a national transplant list

End-stage renal failure means irreversible failure of both kidneys.

Kidney failure means irreversible failure of one or both kidneys.

The *End-stage renal or kidney failure* benefit is not payable:

- When end-stage renal or kidney failure is caused by a traumatic event, including surgical traumas
- For acute renal failure

Heart attack (**myocardial infarction**)

We will pay the *Heart attack (myocardial infarction)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with a heart attack (myocardial infarction) based on:

- A new electrocardiogram (EKG or ECG) findings consistent with myocardial infarction, and
- Elevation of cardiac enzymes above standard laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used).

Confirming diagnostic data from one or more of the following test results, or other diagnostic tests as may be determined, may also be required in support of a **diagnosis** of myocardial infarction:

- Cardiac catheterization
- Clinical picture of myocardial infarction
- PECT
- Stress echo results
- Thallium

Heart attack (myocardial infarction) means the death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries.

The *Heart attack (myocardial infarction)* benefit does not include:

- Angina
- Atherosclerosis
- Congestive heart failure
- Coronary artery disease or any other dysfunction of the cardiovascular system
- Established (old) myocardial infarction
- Heart attacks that occur during clinical procedures
- Sudden cardiac arrest

Infectious diseases

- **Cholera**

  We will pay the *Cholera* benefit amount shown on the *Schedule of benefits* if you are **diagnosed** with cholera based on a positive stool sample.

  Cholera means an infection caused by the bacterium vibrio cholerae, typically contracted from infected water supplies.

- **Coronavirus**

  We will pay the *Coronavirus* benefit amount shown in the *Schedule of benefits* if:
  - You are **diagnosed** with:
    - Coronavirus strain SARS-CoV or SARS-CoV-1
    - Coronavirus strain SARS-CoV-2
    - Coronavirus strain MERS-CoV
    - Multi-system inflammatory syndrome in children (MIS-C) or adults (MIS-A), and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

  Coronaviruses (CoV) are a large family of viruses that cause illness in people such as:
  - SARS-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.

- **Creutzfeldt-Jakob disease**

  We will pay the *Creutzfeldt-Jakob disease* benefit amount shown in the *Schedule of benefits* if:
  - Based on neuropathologic and/or immunodiagnostic testing of brain tissue, you are **diagnosed** with these forms of Creutzfeldt-Jakob disease (CJD):
    - Acquired CJD:
      - Iatrogenic (iCJD)
      - Variant (vCJD), sometimes called “mad cow disease”
    - Genetic CJD (gCJD), sometimes called familial CJD
    - Sporadic CJD (sCJD), and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

  CJD means a degenerative brain disorder caused by an abnormal infectious protein in the brain called a prion.

  Acquired CJD forms:
  - iCJD means acquired by undergoing certain medical procedures or taking growth hormone.
  - vCJD means acquired by having a blood or plasma transfusion, or consumption of beef infected with a specific prion called bovine spongiform encephalopathy.

  gCJD is inherited and sCJD occurs for no known reason.

  The *Creutzfeldt-Jakob disease* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

- **Diphtheria**
  We will pay the *Diphtheria* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with diphtheria based on a positive culture test.

  Diphtheria means an infection caused by the bacterium corynebacterium diphtheriae.

- **Ebola**
  We will pay the *Ebola* benefit amount shown in the *Schedule of benefits* if:
  - You are **diagnosed** with Ebola, and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

  Ebola means a virus that causes severe bleeding, organ failure, and can lead to death.

- **Encephalitis**
  We will pay the *Encephalitis* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with encephalitis.

  Encephalitis means a bacterial or viral acute inflammation of the brain resulting in permanent neurological damage.

  The *Encephalitis* benefit does not include encephalitis resulting from any human immuno-deficiency virus (HIV) infection or other ancillary infections resulting from the HIV infection.

- **Hepatitis – occupational**
  We will pay the *Hepatitis – occupational* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with occupational hepatitis based on a positive test result for hepatitis B, C, or D.

  Occupational hepatitis means hepatitis B, C, or D resulting from an **accident** which exposed you to hepatitis B, C, or D due to **accidental** exposure by contaminated body fluids. Such exposure must occur during the normal course of duties for the occupation which you regularly perform and for which you receive remuneration.

  To prove occupational exposure, these conditions must all be met:
  - The incident must be reported to the **policyholder** within 48 hours of the **accident** and you must seek immediate medical attention.
  - You must provide proof of a negative hepatitis B, C, or D test, performed by a state certified and licensed laboratory within 5 days of exposure.
  - You must provide proof of a positive hepatitis B, C, or D test, performed by a state certified and licensed laboratory, within 180 days after exposure.

  Occupational hepatitis does not include infection due to:
  - Drug use
  - Sexual transmission, or
  - Other hepatitis infection determined to not to be **accidental**

  The *Hepatitis – occupational* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

- **Human immunodeficiency virus (HIV) - occupational**
  - We will pay the *Human immunodeficiency virus (HIV) – occupational* benefit amount shown in the *Schedule of benefits* if:
  - You are **diagnosed** with occupational HIV based on a positive antibody test for HIV subsequent to a prior negative test for the same condition with a lapse of between 180 days between the two tests.

  HIV means the presence of HIV or antibodies to the HIV which:
  - Is caused by an **accidental** needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid, and
  - Occurs while you were following your normal occupational duties and is reported by you in accordance with the established occupational procedures for such accidents.

  The *HIV – occupational* benefit does not include infection due to sexual transmission.

  You must have undergone a blood test within 5 days of the **accident** that indicates the absence of HIV or antibodies to the HIV and the **accident** follow-up must have included a further blood test within 180 days that indicated the presence of HIV or antibodies to the HIV.

  The *HIV - occupational* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

- **Legionnaire's disease**
  We will pay the *Legionnaire's disease* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with having pneumonia and such **diagnosis** is based on a finding of the legionella bacteria.

  Your **diagnosis** must be supported by specialized laboratory tests searching for the legionella bacteria, involving culture of your sputum, lung biopsy specimen, respiratory secretions or detecting the organism in urine.

  Legionnaire's disease means a lung infection (pneumonia) caused by legionella bacteria.

- **Lyme disease**
  We will pay the *Lyme disease* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with Lyme disease.

  Lyme disease is caused by infection with the bacterium Borrelia burgdorferi.

- **Malaria**
  We will pay the *Malaria* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with malaria based on a blood test.

  Malaria means a mosquito-borne infectious disease evidenced by the presence of the sporozoan plasmodium.

- **Meningitis**
  We will pay the *Meningitis* benefit amount shown on the *Schedule of benefits* if you are **diagnosed** with these forms of meningitis: amoebic, bacterial**,** fungal, parasitic, or viral.

  Amoebic meningitis means an infection of the brain caused by the Naegleria fowleri amoeba.

  Bacterial meningitis means the infection meningitis evidenced by the presence of bacteria in the cerebrospinal fluid.

  Fungal meningitis means an infection caused by certain fungi that spread from somewhere in the body to the brain and spinal cord.

  Parasitic meningitis means an infection caused by certain parasites.

  Viral meningitis means an inflammation of the lining of the brain and spinal cord caused by a virus.

  The *Meningitis* benefit does not include non-infectious meningitis.

- **Methicillin-resistant staphylococcus aureus** (**MRSA**)
  We will pay the *Methicillin-resistant staphylococcus aureus (MRSA)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with MRSA based on a laboratory test.

  MRSA means a type of antibiotic-resistant bacteria.

- **Necrotizing fasciitis**
  We will pay the *Necrotizing fasciitis* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with necrotizing fasciitis and your **physician** determines that surgery is recommended.

  If you are too ill to undergo the recommended surgery, but otherwise qualify under this provision, the requirement that surgery be recommended is waived.

  Necrotizing fasciitis, sometimes called flesh-eating disease or flesh-eating bacteria syndrome, means a rare, quickly progressing infection of the deeper layers of the skin and subcutaneous tissues and requiring surgery.

- **Osteomyelitis**
  We will pay the *Osteomyelitis* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with osteomyelitis.

  Osteomyelitis means an infection of the bone or bone marrow that typically results from a bacterial infection and may result in the death of bone tissue.

- **Pneumonia**
  We will pay *Pneumonia* benefit amount if:
  - You **diagnosed** with bacteria or viral pneumonia, and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

    The **stay** requirement is waived for viral pneumonia.

  Bacterial pneumonia means a lung infection caused by a bacterial infection.

  Viral pneumonia means a lung infection caused by a viral infection.

- **Poliomyelitis**
  We will pay the *Poliomyelitis* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with poliomyelitis.

  Poliomyelitis means a contagious viral illness resulting from poliovirus type 1, 2, or 3 that is characterized by fever, paralysis and atrophy of skeletal muscles. It often results in permanent disability and deformity and is marked by inflammation of nerve cells in the anterior gray matter in each lateral half of the spinal cord.

  The *Poliomyelitis* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

- **Rabies**
  We will pay the Rabies benefit amount shown in the Schedule of benefits if you are **diagnosed** with rabies supported by clinical confirmation through isolation of the associated antibodies.

  Rabies means an acute viral disease of the central nervous system caused by a virus in the Lyssavirus family that is transmitted through saliva from the bite of an infected animal.

- **Rocky mountain spotted fever** (**RMSF**)
  We will pay the *Rocky mountain spotted fever (RMSF)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with RMSF.

  RMSF means a tick-borne disease caused by the bacterium Rickettsia rickettsii and evidenced by clinical symptoms with either a tick bite or exposure to an area known to harbor ticks. Symptoms include sudden onset of high fever, chills, headache, severe weakness, muscle pain, and rash.

- **Septic shock and severe sepsis**
  We will pay the *Septic shock and severe sepsis* benefit amount shown in the *Schedule of benefits* if:
  - You are **diagnosed** with septic shock or severe sepsis, and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

  Septic shock means that you have severe sepsis and persistent low blood pressure after fluid treatment and the need for vasoactive prescription drugs.

  Severe sepsis means that you have the presence of sepsis and a new organ dysfunction associated with sepsis.

  The *Septic shock and severe sepsis* benefit does not include:
  - Non-severe sepsis
  - Post-sepsis syndrome

- **Tetanus**
  We will pay the *Tetanus* benefit amount shown in the Schedule of benefits if you are **diagnosed** with tetanus by a finding of clostridium tetani bacteria in a clinical specimen taken from you.

  Tetanus means infection with tetanus as evidenced by clinical symptoms and a medical history.

- **Tuberculosis** (**TB**)
  We will pay the *Tuberculosis (TB)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with TB based on skin tests, chest X-rays, and sputum analysis (smear or culture).

  TB means an infectious disease caused by mycobacterium tuberculosis bacteria and primarily affecting the lungs.

- **Tularemia**
  We will pay the *Tularemia* benefit amount shown in the *Schedule of benefits* if:
  - You are **diagnosed** with these forms of tularemia: glandular, intestinal, oculoglandular, oropharyngeal, pneumonic, ulceroglandular, typhoidal, and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

  Tularemia, sometimes called rabbit fever, means an infectious disease that typically attacks the skin, eyes, lymph nodes, and lungs.

- **Typhoid fever**
  We will pay the *Typhoid fever* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with typhoid fever based on the result of a stool or blood test conducted by a **physician**.

  Typhoid fever means an infectious disease evidenced by the presence of salmonellae typhi bacteria.

- **Variant influenza virus** (**swine flu in humans**)
  We will pay the *Variant influenza virus* benefit amount shown in the *Schedule of benefits* if:
  - You are **diagnosed** with variant influenza virus subtypes H1N1v, H1N2v, or H3N2v, and
  - As a direct result of such **diagnosis**, you:
    - Have a **stay** in a **hospital**, **rehabilitation unit**, or **skilled nursing facility** for at least 5 consecutive days, or
    - Die before having met the **stay** requirement.

  Variant influenza virus means swine influenza type A virus that is detected in a person.

Loss of hearing

We will pay the *Loss of hearing* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with loss of hearing which has continued 90 consecutive days.

Loss of hearing means deafness in both ears, such that it cannot be corrected to any functional degree by any procedure, aid, or device.

The *Loss of hearing* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Loss of sight (blindness)

We will pay the *Loss of sight (blindness)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with loss of sight (blindness) which has continued 90 consecutive days.

Loss of sight (blindness) means total and irrecoverable loss of sight in both eyes such that it cannot be restored to any functional degree by any procedure, aid, or device.

The *Loss of sight (blindness)* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Loss of speech

We will pay the *Loss of speech* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with loss of speech which has continued for 90 consecutive days.

Loss of speech means loss of one's ability to communicate through speech, such that it cannot be corrected to any functional degree by any procedure, aid, or device.

The *Loss of speech* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Lupus
We will pay the *Lupus* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with lupus.

Lupus means systemic lupus erythematosus, indicated by at least 4 of the following:

- Malar rash: butterfly-shaped rash across cheeks and nose
- Discoid (skin) rash: raised red patches
- Photosensitivity: skin rash as result of unusual reaction to sunlight
- Ulcers of the nose or mouth
- Arthritis (nonerosive) in two or more joints, along with tenderness, swelling, or effusion
- Inflammation of the lining around the heart (pericarditis) and/or lungs (pleuritis)
- Seizures and/or psychosis
- Excessive protein in the urine, or cellular casts in the urine
- Hemolytic anemia, low white blood cell count, or low platelet count
- Antibodies to double stranded DNA, antibodies to Sm, or antibodies to phospholipids such as cardiolipin
- Antinuclear antibodies (ANA): a positive test in the absence of drugs known to induce positive results

The *Lupus* benefit does not include:

- Discoid lupus
- Drug-induced lupus

The *Lupus* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Major organ failure

We will pay the *Major organ failure* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with major organ failure.

Major organ failure means you have irreversible failure of your heart, liver, one or both lungs, or pancreas as determined by a **physician** that complete replacement of such organ with an entire organ is necessary and you are placed on a national transplant list, such as UNOS (United Network for Organ Sharing).

The transplant list requirement will be waived if:

- You die before you were placed on the list.
- You receive the transplant prior to placement on a national transplant list.
- You are too ill for a transplant, but otherwise meet the criteria to be placed on a national transplant list.
- A **physician** determines that a partial replacement of your liver with a liver or liver tissue from a live donor is necessary.

If you are **diagnosed** with kidney failure, see the *End-stage renal or kidney failure* benefit.

Multiple sclerosis (MS)

We will pay the *Multiple sclerosis (MS)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with MS.

MS means at least one of the following:

- Two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination.
- Well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination.
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least 1 month apart.

The *MS* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Muscular dystrophy

We will pay the *Muscular dystrophy* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with muscular dystrophy.

Muscular dystrophy means 1 of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue.

The *Muscular dystrophy* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Paralysis

We will pay the applicable *Paralysis* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with these types of *Paralysis* and your **physician** confirms the paralysis continued for a period of 60 consecutive days:

- Quadriplegia affects both arms and both legs.
- Triplegia affects one side of the body, such as the arm and leg of the same side of the body, plus the one arm or one leg on the opposite side of the body.
- Paraplegia affects both legs and sometimes parts of the trunk.
- Diplegia affects the same area on both sides of the body, such as both arms.
- Hemiplegia affects one side of the body, such as the leg and arm of the same side of the body.
- Monoplegia affects one limb only, such as one arm or one leg.

Parkinson's disease

We will pay the *Parkinson's disease* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with Parkinson's disease by a **physician** trained in the **diagnosis** of the disease.

Parkinson's disease means a chronic, progressive neurodegenerative disorder characterized by 2 or more of these symptoms:

- Bradykinesia
- Gait disturbance
- Rest tremor
- Rigidity

The *Parkinson's disease* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Persistent vegetative state (PVS)

We will pay the *Persistent vegetative state (PVS)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with PVS.

PVS means a state of severe unconsciousness characterized by no evidence of awareness of self or environment, and no purposeful response to external stimuli.

The *PVS* benefit does not include coma.

Primary sclerosing cholangitis (PSC)

We will pay the *Primary sclerosing cholangitis (PSC)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with PSC.

PCS, sometimes called Walter Payton's disease, is a disease of the bile ducts that causes inflammation and obliterative fibrosis of bile ducts inside and/or outside of the liver.

The *PSC* benefit is not subject to the *Recurrence critical illness diagnosis* benefit.

Stroke

We will pay the *Stroke* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with stroke as evidenced by:

- A clinical picture of permanent neurological damage provided from a computed tomography (CT or CAT) scan, and/or
- A magnetic resonance imaging (MRI) or such other diagnostic tests as may be required.

Stroke means an acute or sub-acute cerebral vascular incident producing permanent, neurological impairment and resulting in paralysis or other measurable objective neurological defect persisting for more than 24 hours.
The *Stroke* benefit does not include:

- Transient ischemic attacks (TIA)
- Attacks of vertebrobasilar ischemia

If you receive a TIA benefit, then you are **diagnosed** with stroke, we will reduce the *Stroke* benefit amount payable by the amount paid under the *TIA* benefit.

Sudden cardiac arrest

We will pay the *Sudden cardiac arrest* benefit amount shown in the *Schedule of benefits* if:

- You are **diagnosed** with sudden cardiac arrest, and
- Your **physician** certifies that the pumping action of your heart failed due to sudden cardiac arrest.

Sudden cardiac arrest means the sudden, unexpected loss of heart function in which the heart, abruptly and without warning, stops working due to an internal electrical system malfunction of the heart. Sudden cardiac arrest includes:

- Cardiovascular collapse
- Cardiac arrest
- Sudden cardiac death
- Ventricular Fibrillation (VFib)
- Ventricular Flutter (VF)

The *Sudden cardiac arrest* benefit does not include:

- Sudden cardiac arrest when caused by, or contributed to by, a heart attack (myocardial infarction)
- Heart attack (myocardial infarction)

Third degree burns

We will pay the *Third degree burns* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with third degree burns.

Third degree burns, also called full-thickness burns, means an area of tissue damage in which there is destruction of the entire epidermis (outer layer of skin) and the dermal (second layer of skin) that is caused by heat, electricity, radiation, or chemicals.

Transient ischemic attack (**TIA**)

We will pay the *Transient ischemic attack (TIA)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with a TIA.

TIA means an abrupt loss of brain function due to the temporary blockage or reduction of blood supply to the brain lasting less than 24 hours with no residual signs, symptoms, deficits or abnormalities that are revealed or shown on neuroimaging studies. TIA must meet all of these requirements:

- New ischemic event with no cerebral tissue damage and reversible.
- Impairment and no cerebral tissue damage as confirmed by clinical diagnosis.
- Documentation of recommended treatment of stroke prevention.
- The impairment must be focal and confined to an area of the brain perfused by a specific artery.

The *TIA* benefit does not include:

- Attacks of vertebrobasilar ischemia
- Stroke

Cancer benefits:

Cancer benefits are payable when you are **diagnosed** as having cancer (invasive), carcinoma in situ (non-invasive), or skin cancer. Covered benefits must meet all of these requirements:

- The **diagnosis** occurs on or after your **effective date of coverage** and while your coverage under the certificate is in force.
- The cancer **diagnosed** is not excluded by name or specific description in this certificate.
- The **diagnosis** is given or received, in the United States or its territories.
- The **diagnosis** is either a **pathological diagnosis** or **clinical diagnosis**. We may require additional information from your attending **physician** or **hospital**.

This benefit is payable if the required **pathological diagnosis** or **clinical diagnosis** occurs post-mortem.

If you are **diagnosed** with two or more cancer types in the same day, only the **diagnosis** with the highest amount is payable.

Cancer (invasive)

We will pay the *Cancer (invasive)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with cancer (invasive).

Cancer (invasive) is the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells within the area where cancer first starts. Cancer (invasive) includes metastatic cancer.

Metastatic cancer is the spread of cancer cells, often by way of the lymph system or bloodstream, from the primary site of origin (where it started), into different areas of the body.

The following are not cancer (invasive):

- Locally advanced cancer (the spread of a cancer within the same organ)
- Pre-malignant conditions or conditions with malignant potential
- Carcinoma in situ (non-invasive)
- Skin cancer

If you are **diagnosed** with and receive a benefit from us for cancer (invasive) and then are later **diagnosed** with cancer (invasive) again, a benefit may or may not be payable for the recurrence. See the *Recurrence cancer (invasive) diagnosis* benefit for details.

Carcinoma in situ (non-invasive)

We will pay the *Carcinoma in situ (non-invasive)* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with carcinoma in situ (non-invasive).

Carcinoma in situ (non-invasive) means cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.

Carcinoma in situ (non-invasive) does not include skin cancer as defined in this certificate.

If you are **diagnosed** with and receive a benefit from us for carcinoma in situ (non-invasive) and are later **diagnosed** with carcinoma in situ (non-invasive) again, a benefit may or may not be payable for the recurrence. See the *Recurrence carcinoma in situ (non-invasive) diagnosis* benefit for details.

Skin cancer
We will pay the *Skin cancer* benefit amount shown in the *Schedule of benefits* if you are **diagnosed** with skin cancer.

Skin cancer means melanoma of Clark's Level I or II (Breslow depth of less than .75mm), basal cell carcinoma, or squamous cell carcinoma of the skin. For the purposes of this definition:

- Clark's level measures how deep the tumor has penetrated into the layers of the skin.
- Breslow depth refers to how deeply tumor cells have invaded.

The *Skin cancer* benefit is not subject to recurrence.

Additional benefits

Health screening

We will pay the *Health screening* benefit amount shown on the *Schedule of benefits* when you receive any of the following health screenings, and all of these requirements are met:

- The date of service is on or after your **effective date of coverage** and while your coverage under the certificate is in force.
- The screening must be given or received, in the United States or its territories.
- You incur a charge due to the screening.

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

Echocardiogram (ECHO)	Two-hour post-load plasma glucose test
Endoscopy	Ultrasound for cancer detection
Eye exam	Ultrasound screening for abdominal aortic aneurysms
Fasting blood glucose test	Virtual colonoscopy
Fasting plasma glucose test	

Recurrence and subsequent diagnosis

Recurrence critical illness diagnosis

If you are **diagnosed** with and receive a benefit from us for a critical illness, and then you are diagnosed again with the *same* critical illness (a recurrence), 100% of the applicable *Critical illness* benefit as shown on the *Schedule of benefits* is payable for the recurring critical illness **diagnosed**, if all of these requirements are met:

- The date of **diagnosis** of the recurring critical illness is more than 180 days after the previous date of **diagnosis** for the same critical illness for which a benefit was paid.
- The date of **diagnosis** for the recurrence is while your coverage is in force.
- The recurring critical illness is not excluded by name or specific description in this certificate.

These benefits are excluded from the *Recurrence critical illness diagnosis* benefit:

Addison's disease (adrenal hypofunction)

Amyotrophic lateral sclerosis (ALS)

Alzheimer's disease

Childhood conditions

Crohn's disease

Diabetes

Hemophilia

Huntington's disease

Infectious disease

- Creutzfeldt-Jakob disease
- Hepatitis – occupational
- Human immunodeficiency virus (HIV) - occupational
- Poliomyelitis

Loss of sight (blindness)

Loss of hearing

Loss of speech

Lupus

Multiple sclerosis

Muscular dystrophy

Myasthenia gravis

Parkinson's disease

Primary sclerosing cholangitis (PSC)

Rheumatoid arthritis (RA)

Systemic sclerosis (scleroderma)

Ulcerative colitis (UC)

Subsequent critical illness diagnosis

If you are **diagnosed** with and receive a benefit from us for a critical illness and are later **diagnosed** with a *different* critical illness, 100% of the applicable *Critical illness* benefit as shown in the *Schedule of benefits* is payable, if all of these requirements are met:

- The date of **diagnosis** of the subsequent critical illness is more than 30 days after the previous date of **diagnosis** for a critical illness for which a benefit was paid.
- The subsequent date of **diagnosis** is while your coverage under this certificate is in force.
- The subsequent critical illness is not excluded by name or specific description in this certificate.

Recurrence cancer (invasive) diagnosis

If you are **diagnosed** with and receive a benefit from us for cancer (invasive), and then you are **diagnosed** with any kind of cancer (invasive) again, 100% of the *Cancer* benefit for cancer (invasive) as shown on the *Schedule of benefits* for the cancer (invasive) diagnosed is payable, if all of these requirements are met:

- The date of **diagnosis** for cancer (invasive) of the subsequent cancer (invasive) **diagnosis** is more than 180 days after the previous date of **diagnosis** for cancer (invasive) for which a benefit was paid.
- You have not received treatment for the cancer (invasive) for which a benefit was paid during the 180 days between the dates of **diagnosis** for cancer (invasive). As used here, treatment does not include **maintenance drug therapy** or routine follow-up visits to your **physician** to confirm the cancer (invasive) has not returned.
- The subsequent date of **diagnosis** for cancer (invasive) is while your coverage under this certificate is in force.
- The subsequent cancer (invasive) is not excluded by name or specific description in this certificate.

Recurrence carcinoma in situ (non-invasive) diagnosis

If you are **diagnosed** with and receive a benefit for carcinoma in situ (non-invasive) and then are **diagnosed** with any kind of carcinoma in situ (non-invasive) again, 100% of the *Cancer* benefit for carcinoma in situ (non-invasive) shown on the *Schedule of benefits* for the carcinoma in situ (non-invasive) **diagnosed** is payable, if all of these requirements are met:

- The date of **diagnosis** for carcinoma in situ (non-invasive) of the subsequent carcinoma in situ (non-invasive) **diagnosis** is more than 180 days after the previous date of **diagnosis** for carcinoma in situ (non-invasive) for which a benefit was paid.
- You have not received treatment for the initial carcinoma in situ (non-invasive) for which a benefit was paid during the 180 days between the dates of **diagnosis** for carcinoma in situ (non-invasive). As used here, treatment does not include **maintenance drug therapy** or routine follow-up visits to your **physician** to confirm the initial carcinoma in situ (non-invasive) has not returned.
- The subsequent date of **diagnosis** for carcinoma in situ (non-invasive) is while your coverage under this certificate is in force.
- The subsequent carcinoma in situ (non-invasive) is not excluded by name or specific description in this certificate.

What your plan doesn't cover – exclusions

Exclusions

We call **diagnoses** that are not covered "exclusions." In this section, we tell you about exclusions. And, just a reminder, you'll find benefit maximums in the *Schedule of benefits* section.

Benefits will not be paid for a **diagnosis** related to the following:

Act of war, riot, war

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

This exclusion does not apply to the *Posttraumatic stress disorder* benefit.

Assault, felony, illegal occupation

Assault, felony, illegal occupation, or other criminal act.

Care provided by immediate family members or any household member

Self-harm, suicide

Except when resulting from a **diagnosed** disorder, benefits will not be paid:

- In connection with suicide or attempt at suicide, intentionally self-inflicted injury, or any attempt at self-inflicted injury.
- For any form of intentional asphyxiation.

Substance abuse and use

Except when resulting from a **diagnosed** disorder, 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**.

Claim decisions and appeal procedures for when you disagree

When a claim comes in, we review it and decide if a benefit is payable or not. In this section, we explain the claim decision process and what you can do if you think we got it wrong.

Claim decisions

Action	Requirement	Timeframe
Notice of claim	When you have a loss, you must let us know so that we can begin the claim payment process. When you let us know you have a loss, this is called a *Notice of claim*. You or your representative must give us written *Notice of claim.* When you give us your *Notice of claim*, you should include your name and **policy** number. The *Notice of claim* should be mailed to us at the company address appearing on the face page of this certificate or to one of our agents.	Your *Notice of claim* must be given to us within 20 days after a loss occurs or starts, or as soon as reasonably possible.
Claim forms	When we receive your *Notice of claim*, we will provide you with a form for sending us your proof of loss. This form is called a *Claim form*.	If we do not provide you with the *Claim form* within 15 days, you will be considered to have complied with the requirements and you can give us a written statement of what happened. This statement should include the type and extent of the loss incurred.

Action	Requirement	Timeframe
Submitting your *Claim form* and *Proof of loss* When you receive a **diagnosis** for a critical illness or cancer, you will be charged. The information you receive for that **diagnosis** is your *Proof of loss*.	To give us your *Claim form*, or written statement, and *Proof of loss*, you can choose from one of these two options: • Use the online claim process by logging into www.myaetnasupplemental.com • Complete the *Claim form* and submit it to us with any required information by fax or the postal service.	You must send us your *Claim form*, or written statement, and *Proof of loss* within 90 days after the loss. If it was not reasonably possible to send us the required information, we will not reduce or deny the claim for this reason. However, your *Claim form*, or written statement, and *Proof of loss* must be filed as soon as reasonably possible. Except in the absence of legal capacity, your *Claim form*, or written statement, and *Proof of loss* must be given no later than one year from the time specified above.
Claim decision	We will review your *Claim form*, or written statement, and *Proof of loss* and promptly decide to either: • Pay benefits • Request additional information, or • deny payment	If a benefit is payable, it will be paid no later than 60 days after the date the required written proof is received. All benefits are payable to you. If we need additional information, you have 45 days from the date of request to send us the additional information. If your claim is denied entirely or in part, this is called an "adverse claim decision." If we make an adverse claim decision, we will tell you in writing in 30 days. If you disagree, you can ask us to re-review the adverse claim decision. This is called an appeal. See the *Appeal procedures for when you disagree* section below.

Appeal procedures for when you disagree

If you want to appeal, send it to us within 180 calendar days from the time you receive the adverse claim decision. You can appeal by either:

- Calling us toll-free at 800-607-3366
- Sending us a written appeal to the address on the notice of adverse claim decision

When you send us a written appeal, be sure to include:

- Your name
- The **policyholder's** name
- A copy of the adverse claim decision
- Your reasons for making the appeal
- Any other details you would like us to know

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by calling us toll-free at 800-607-3366. The form will tell you where to send it to us.

When we receive your appeal, it will be handled by someone who was not involved in making the adverse claim decision.

Timeframe for deciding your appeal

We will give you an appeal decision within 30 calendar days of our receipt of your request for an appeal.

Exhaustion of appeals process

We recommend that you complete the appeal process with us before you can take these actions:

- Contact the Texas Department of Insurance to request an investigation of an appeal.
- File a complaint or appeal with the Texas Department of Insurance.
- Pursue arbitration, litigation or other type of administrative proceeding.

Do you have a complaint?

If you are not happy about a **provider** or an operational issue, you may want to complain. You can call us toll-free at 800-607-3366 or write Member Services to tell us about your complaint.

When you complain in writing, you should include:

- A description of the issue
- Copies of any records or documents that you think are important

We will review the information and provide you with a written response within 30 calendar days of receiving the complaint**.** We will let you know if we need more details to make a decision.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing an appeal or complaint.

Coordination of benefits

This plan does not coordinate benefits with any other plan. That means it pays benefits regardless of any other coverage you may have.

When coverage ends

A note on how we use "you" and "your" in this section:

- When we say "you" and "your", we mean the **employee** only.

When will your coverage end?

Your coverage under this certificate will end, subject to the *Portability* section, on the earliest of the following dates:

- The end of the month on or following the date you cease to be a member of an eligible class.
- The end of the month on or following the date the eligible class to which you are a member is no longer an eligible class for coverage under the **policy**.
- The end of the month on or following the date we receive your written request for termination of coverage.
- The payment due date, if any required **premium** has not been paid by the end of the grace period.
- The date of your death.
- The date the **policy** ends.

If your coverage ends, your claim that existed on the date coverage ends will not be affected.

When will coverage end for dependents?

Your **covered dependent's** coverage under this certificate will end, subject to the *Portability* section, on the earliest of the following dates:

- The end of the month on or following the date your coverage ends.
- The end of the month on or following the date the **policy** ends coverage for all dependents.
- The end of the month on or following the date your **covered dependent** becomes covered under this plan as an **employee**.
- The end of the month on or following the date your **covered dependent** is no longer eligible as a dependent.

Portability

If your employment ends and as a result your coverage under the **policy** ends, we will provide portability coverage. Such coverage will be available to you and any of your **covered dependents**.

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

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

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

A grace period of 30 days after the **premium** due date will be allowed for the payment of each **premium**. We will not pay benefits under this certificate in the absence of payment of current **premium**, subject to this grace period.

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

- The date of your death
- The end of the portability grace period following the date you fail to pay any required **premium**
- The end of the month on or following the date you are again covered under the **policy**
- The date coverage under this portability provision is cancelled by us for any reason upon 31 days advanced notice
- The date your class of coverage ends
- With respect to any **covered dependents**:
  - The date your coverage ends
  - The date your **covered dependent** ceases to be an eligible dependent under the **policy**

If you die, your surviving **covered dependent spouse** may elect portability to continue coverage for all your **covered dependents**. All the portability requirements that apply to you will apply to your **covered dependent spouse**.

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

Once portability coverage ends, it cannot start again.

General provisions – other things you should know

Administrative provisions

Transfer of your rights
You may not transfer your rights under this certificate to a person you name.

How you and we will interpret this certificate
We prepared this certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws.

Your coverage can change
Your coverage is defined by the **policy**. This document may have amendments and riders too. We, the **policyholder**, or the law may change your plan. Only we may waive a requirement of your plan. No other person, including the **policyholder**, can do this without our approval.

Legal action
You are encouraged to complete the appeal process before you take any legal action against us for any expense or bill. You cannot take any action until 61 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

Physical examinations, evaluations and autopsy
At our expense, we have the right to have a **physician** of our choice examine you. We also have the right to require an autopsy unless prohibited by law. This will be done at all reasonable times while a claim for benefits is pending or under review.

Records of services
You should keep complete records of the **care** you receive because we may need them to pay a claim. Records that you should keep are:

- Names of **physicians** and others who give you **care**
- Dates your expenses are incurred
- Copies of all bills and receipts

Your health information
We will protect your health information. We will use it and share it with others to help us process your claims. We need your consent to distribute your information. You can get a free copy of our Notice of Privacy Practices at www.aetna.com.

When you accept coverage under this certificate, you agree to let your **providers** share your information with us. We will need information about your physical and mental condition and care.

Discount arrangements

We can offer you discounts on goods or services. These discount arrangements are not insurance. Sometimes, other companies provide these discounted goods and services. These companies are called third party service providers.

We don't pay the third party service providers for the goods and services they offer. The third party service provider is responsible for the goods or services they deliver. You are responsible for paying for the discounted goods or services. We have the right to change or end the arrangements at any time.

Contact us for information on the discounts available.

Mistakes and intentional deception

Honest mistakes

You or the **policyholder** may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years before we learned of it.

Any statement you or the **policyholder** make is considered a representation and not a warranty.

Intentional deception

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious effects on your coverage. Examples of serious effects include:

- Loss of coverage going forward
- Denial of benefits
- Recovery of amounts we already paid
- Reduced benefits

We also may report fraud to law enforcement.

Some money issues

Assignments of your coverage
Coverage may not be assigned.

Benefits unpaid at death
Benefits unpaid at death may be paid, at our option, to either your beneficiary or estate. If benefits are payable to your estate or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000 to someone related to you or your beneficiary by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Change of beneficiary
We will use the most recently signed or electronic beneficiary designation on file with the **policyholder** or us. You can change your beneficiary information at any time by completing a beneficiary designation form. A beneficiary change will be effective on the date you sign the beneficiary designation form, provided it's on file with the **policyholder** or us or if mailed, postmarked prior to your death.

Financial sanctions exclusions
If benefits provided under this certificate violate or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay group benefits if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Recovery of overpayments
If we overpay benefits, we can:

- Require you or the person we paid to return the money
- Stop paying benefits until the money is paid back
- Take legal action to get the amount owed
- Reduce the amount of a benefit owed by the amount of the overpayment

Unpaid premium
If you owe past-due **premiums** for your coverage under the **policy**, we can recover them by offsetting what you owe against what we would otherwise pay under the **policy**.

Glossary

Aetna
Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Accident
A sudden, unexpected event, which occurs on or after the effective date of coverage for the **covered person** and while this certificate is in force, that is the direct cause of an **accidental injury** to a **covered person**.

Accidental injury
An injury to a **covered person** that is directly caused by an **accident** and is the direct cause of an injury or loss sustained on or after the **covered person's** effective date of coverage and while this certificate is in force, which is independent of **sickness** and not excluded under the **policy**.

Active work, actively at work, active at work, available to work
An **employee** is considered to be **actively at work** or performing **active work** on any of the **policyholder's** scheduled work days if on that day, the **employee** is **available to work** or performing the regular duties of their job on a full time basis for the normally scheduled number of work hours.

In addition, the **employee** is considered to be **actively at work** on the following days:
- Any day which is not one of the **policyholder's** scheduled work days if you were **actively at work** on the preceding scheduled work day, or
- A normal vacation day as long as the **employee** is not taking a vacation day to use, or get paid for, as a sick day.

Activities of daily living
Activities used to measure the ability of a person to independently care for oneself.
Such activities include:
- Taking medication
- Meal preparation
- Eating
- Bathing
- Personal grooming
- Dressing, and
- Toileting/Continence

Care
Medical treatment, health care services or supplies, or attention received by a **physician**.

Covered dependent
The **employee's spouse**, and any children who are covered under this certificate.

Covered person
An **employee** or an **employee's** dependent for whom all of the following applies:
- The person is eligible for coverage as defined in this certificate.
- The person has enrolled for coverage and paid any required **premium**.
- The person's coverage has not ended.

Diagnosis/diagnosed/diagnoses

A **physician**, specializing in a particular field of medicine, where applicable, has definitively identified your **sickness** or irregularity. Such **diagnosis** must:

- Be based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by your medical records, and
- Meet all diagnostic requirements stated in this certificate for the particular critical illness, cancer (invasive), carcinoma in situ (non-invasive), or skin cancer being **diagnosed**.

Domestic partner or domestic partnership

The **employee's domestic partner** who meets the rules set by the **policyholder**.

The **employee's** and their **domestic partner** will need to complete and sign a Declaration of Domestic Partnership. Contact the **policyholder** for the form.

An eligible **domestic partner** is a person who certifies as of the date of enrollment that he or she:

- Is your sole **domestic partner** and intends to remain so indefinitely
- Is not married or is legally separated from anyone else
- Is not registered as a member of another **domestic partnership** within the past 6 months
- Is of the age of consent in your state of residence
- Is not a blood relative to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
- Has cohabitated and resided with you in the same residence for the past 6 months and intends to cohabitate and reside with you indefinitely
- Is engaged with you in a committed relationship of mutual caring and support, and is jointly responsible for your common welfare and living expenses
- Is not in the relationship solely for the purpose of obtaining the benefits of coverage
- Can show interdependence with you by sending at least three of the following:
    - Common ownership of a motor vehicle
    - Driver's license with a common address
    - Proof of joint bank accounts or credit accounts
    - Proof of designation as the primary beneficiary for life insurance or retirement benefits or primary beneficiary designation under your will
    - Assignment of a durable property power of attorney or health care power of attorney

Effective date of coverage

The date the **employee** and their eligible dependents coverage begins under this certificate.

Employee

A person listed as an **employee** on the books of the **policyholder** who is currently in **active service**.

Hospital

An institution licensed as a **hospital** by applicable laws and accredited as a **hospital** by The Joint Commission.

Hospital does not include a:

- Convalescent facility
- Extended care facility
- Facility for the aged
- Hospice facility
- Intermediate care facility
- Mental disorder treatment facility
- Nursing facility
- Psychiatric hospital
- Rehabilitation unit
- Rest facility
- Skilled nursing facility
- Substance abuse treatment facility

Immediate family member or household member
A person who is related to the **covered person** in any of the following ways: **spouse**, child (including a legally adopted child, foster child, grandchildren, stepchild, son-in-law and daughter-in-law), parents (including stepparent, mother-in-law and father-in-law), brother or sister (including stepbrother, stepsister, brother-in-law or sister-in-law), or who resides in your household.

Physician
A person who:

- Is a doctor of medicine or osteopathy
- Is licensed or certified to provide **care** under the laws of the state where he or she practices
- Provides **care** within the scope of his or her license or certificate, and
- Is not an **immediate family member or household member**.

A **physician** also includes a person who is licensed, certified or otherwise authorized by law to provide **care**, such as podiatrists, chiropractors, nurses, and physical therapists.

Plan year
The period from September 1st through August 31 of the following year.

Policy
The **policy** consists of several documents taken together. These documents are:

- The **policyholder's** application
- The **policy**
- This certificate
- Any amendments and riders to the **policy** or this certificate

These documents are the entire contract between us and the **policyholder**.

Policyholder
Boyd ISD and entities associated with it for purpose of coverage under the **policy**.

Premium
The amount you and/or the **policyholder** are required to pay to **Aetna** to continue coverage.

Provider
A **physician**, **hospital**, or other entity or person licensed or certified under applicable state and federal law to provide health care services to you. If state law does not specifically provide for licensure or certification, the entity must meet all Medicare accreditation standards (even if it does not participate in Medicare).

Rehabilitative services
The combined and coordinated use of medical, social, educational, and vocational measures for training or retraining if you are disabled by illness.

Rehabilitation unit
A free-standing facility or part of a **hospital** that provides **rehabilitative services**.

Sickness
A disease, bodily infirmity, illness, infection or any other physical condition that affects the **covered person** and is wholly independent of an **accident**.

Spouse

Any individual who, under applicable state law is recognized as a **spouse**. **Spouse** includes any individual of either gender who is in a registered **domestic partnership**, a reciprocal beneficiary relationship or other relationship allowed by the state. **Spouse** does not include any person who is insured as an **employee**.

Stay

A period of not less than 23 hours during which you are confined as an inpatient in a:

- **Hospital**
- **Rehabilitation unit**
- **Skilled nursing facility**

Stay excludes:

- Any period of such a confinement due to custodial care or personal needs that do not require medical skills or training.
- A period of observation in an observation unit or in the emergency room unless this leads to a **stay**.

Glossary - Cancer

Clinical diagnosis

A **diagnosis** based on the study of symptoms. Also:

- A **pathological diagnosis** cannot be made because it is medically inappropriate or life-threatening
- There must be medical evidence supporting the **diagnosis**, and
- The **diagnosis** is made by your treating **physician**.

Maintenance drug therapy

Ongoing treatment, such as hormone therapy (HT), immunotherapy or chemoprevention, which may be given to help keep cancer (invasive) or carcinoma in situ (non-invasive) from coming back after it has disappeared following the primary treatment.

Pathological diagnosis

Diagnosis based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of **diagnosis** must be done by a **pathologist** whose **diagnosis** of malignancy is in keeping with the standards established by the American Board of Pathology.

Pathologist

A **physician** who is licensed to practice medicine and who is also licensed to practice pathologic anatomy by the American Board of Pathology. A **pathologist** also means an osteopathic pathologist who is certified by the Osteopathic Board of Pathology.

Confidentiality Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number or visit our Internet site at www.aetna.com.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be subject to prior written agreement between **Aetna** and your Employer.

If your Employer grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue Indemnity Benefits for you and your eligible dependents. Your Employer may also allow you to continue other coverage for which you are covered under the group contract on the day before the approved FMLA leave starts.

At the time you request FMLA leave, you must agree to make any contributions required by your Employer to continue coverage. Your Employer must continue to make premium payments.

If any coverage your Employer allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so.
- The date your Employer determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues as to your eligible class. However, coverage facility indemnity expenses will be available to you under another plan sponsored by your Employer.

Any coverage being continued for a dependent will not be continued beyond the date it would otherwise terminate.

If Medical Indemnity Benefits terminate because your approved FMLA leave is deemed terminated by your Employer, you may, on the date of such termination, be eligible for Continuation under Federal Law on the same terms as though your employment terminated, other than for gross misconduct, on such date. If the group contract provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined dependent), you (or your eligible dependents) may be eligible for such continuation on the date your Employer determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new dependent while your coverage is continued during an approved FMLA leave, the dependent will be eligible for the continued coverage on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for your Employer following the date your Employer determines the approved FMLA leave is terminated, your coverage under the group contract will be in force as though you had continued in active employment rather than going on an approved FMLA leave provided you make request for such coverage within 31 days of the date your Employer determines the approved FMLA leave to be terminated. If you do not make such request within 31 days, coverage will again be effective under the group contract only if and when Aetna gives its written consent.