Financial help when you have a serious illness

Aetna Critical Illness Plan

A smart way to help you with your expenses

Recovering from a critical illness can be hard — and expensive.

Most medical plans aren't designed to cover out-of-pocket costs like utility bills, transportation to doctor appointments or alternative treatments. Unfortunately, these expenses can come at a time when you're missing work and your paycheck.

An Aetna Critical Illness Plan pays you cash to help you pay for health care costs and other expenses when you are diagnosed with a covered condition. This insurance plan covers conditions such as **heart attack**, **stroke**, **major organ failure** and **end-stage renal failure**.

While medical plans typically cover a serious illness, they don't cover the additional expenses that come with it.
The Aetna Critical Illness Plan can help you.

Cash benefits to help pay your bills

When you are diagnosed with a critical illness that's covered under your Aetna Critical Illness Plan, send us your claim and we will mail you a check. You can use the money to pay for:

- Everyday expenses like rent, child care or grocery bills
- Doctors' bills, coinsurance or to help cover your medical plan's deductible

It's up to you.

Why is critical illness coverage important?

It **pays you cash** to help you pay for health care costs and other expenses when you are diagnosed with a covered condition.

Consider the statistics:

Approximately 63% of Americans have no emergency savings[1]

and ...

Someone in the U.S. has a stroke every 40 seconds.[2]

Someone in the U.S. has a heart attack every 34 seconds.[3]

It's convenient

Premiums are easy to pay through payroll deduction. Your benefits payment will be sent directly to you.

It's attainable

Your coverage is guaranteed. We don't ask you any questions about your health.

[1]Fottrell Quentin. Most Americans are one paycheck away from the street. MarketWatch. Article online. January 31, 2016. Available at:http://www.marketwatch.com/story/most-americans-are-one-paycheck-away-from-the-street-2016-01-06. Accessed March 30, 2017.

[2]American Heart Association. Impact of Stroke. Article online. June 6, 2016. Available at: www.strokeassociation.org/STROKEORG/AboutStroke/Impact-of-Stroke-Stroke-statistics_UCM_310728_Article.jsp#.V-GYTMtTFiw. Accessed September 21, 2016.

[3]American Heart Association. Answers by Heart. Cardiovascular conditions. Article online. August 31, 2016. Available at: www.heart.org/HEARTORG/Conditions/More/ToolsForYourHeartHealth/Answers-by-Heart-Fact-Sheets-Cardiovascular-Conditions_UCM_300475_Article.jsp#.V-GcHctTFiw. Accessed September 21, 2016.

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Aetna's simplified claims process

If you are an Aetna medical plan member, we can retrieve your medical information needed to process claims under your Critical Illness Plan. **Here's how it works.**

Covered critical illness

Submit your claim using the online claims form

Our system matches this claim to the medical claim to retrieve the necessary medical information

Your critical illness plan claim is processed

Payments are sent directly to you

Not an Aetna medical plan member?

Just upload your medical paperwork when submitting your claim.

Submitting claims is easy

1. Go to **myaetnasupplemental.com**.
2. Click the "Create a new claim" button, answer a few quick questions, and submit.

Your payment for covered services will be on the way.
That's all there is to it!

Claims can be completed online at **myaetnasupplemental.com** *or printed and mailed to:*
Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079.

The Aetna Critical Illness Plan is offered and/or underwritten by Aetna Life Insurance Company (Aetna).

This plan provides limited benefits. The benefit payments are not intended to cover the full cost of medical care. Members are responsible for making sure the providers' bills get paid. These benefits are paid in addition to any other health coverage members may have.

This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. Aetna does not provide care or guarantee access to health services. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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

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BENEFIT SUMMARY

BARNES GROUP INC

802402

Aetna Critical Illness Plus with Cancer

THIS IS NOT A MEDICARE SUPPLEMENT (MEDIGAP) PLAN. If you are or will become eligible for Medicare, review the free Guide to Health Insurance for People with Medicare available at www.medicare.gov.

Insurance plans are underwritten by Aetna Life Insurance Company.

The benefits in the table below will be paid when you are diagnosed with a covered Critical Illness . Unless otherwise indicated, all benefits and limitations are per covered person.

Face Amounts

Covered Benefit	Low	Mid	High
Employee Face Amount	$10,000	$20,000	$30,000
Spouse Face Amount	50% of Employee Face Amount		
Child(ren) Face Amount	50% of Employee Face Amount		

Covered Benefit	Percent of Face Amount:	Percent of Face Amount:
Subsequent Critical Illness Diagnosis Benefit The Subsequent diagnosis benefit is payable if the insured person has been diagnosed with and received a benefit for a critical illness and is subsequently diagnosed with a different critical illness.	100%	100%
Recurrence Critical Illness Diagnosis Benefit If an insured person has been initially diagnosed with and received a benefit under this plan for a critical illness and then is diagnosed with the same critical illness again at least 180 days later, we will pay the stated percentage of the benefit as shown in the Schedule of Benefits for the recurring critical illness diagnosed. No benefit payable if the recurrence occurs less than 180 days later.	100%	100%
Recurrence Cancer (invasive) Diagnosis Benefit If an insured person has been initially diagnosed with and received a benefit for cancer (invasive) under this plan and is then diagnosed with any kind of cancer (invasive) again at least 180 days later, we will pay the stated percentage of the Cancer Benefit for Cancer (invasive) as shown on the Schedule of Benefits for the cancer (invasive) diagnosed. No benefit payable if the recurrence occurs less than 180 days later.	100%	100%
Recurrence Carcinoma in Situ Diagnosis Benefit (non-invasive) If an insured person has been initially diagnosed with and received a benefit for carcinoma in situ (non-invasive) under this plan and is then diagnosed with any kind of carcinoma in situ (non-invasive) again at least 180 days later, we will pay the stated percentage of the carcinoma in situ (non-invasive) as shown on the Schedule of Benefits for the carcinoma in situ (non-invasive) diagnosed. No benefit payable if the recurrence occurs less than 180 days later.	100%	100%

Critical Illness Conditions

Covered Benefit	Percent of Face Amount (Employee):	Percent of Face Amount (Employee):
Heart Attack (Myocardial Infarction) Pays a benefit when you are diagnosed with a Heart attack (Myocardial Infarction) resulting from a blockage of one or more coronary arteries.	100%	100%
Stroke Pays a benefit when you are diagnosed with a Stroke resulting in paralysis or other measurable objective neurological defect persisting for at least 30 days.	100%	100%
Coronary Artery Condition Requiring Bypass Surgery Pays a benefit when you are diagnosed with a Coronary artery condition requiring bypass surgery.	25%	25%
Major Organ Failure Pays a benefit when you are diagnosed with a Major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the insured person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.	100%	100%
End-Stage Renal Failure Pays a benefit when you are diagnosed with End stage renal failure, and the insured person has to undergo regular hemodialysis or peritoneal dialysis at least weekly.	100%	100%
Paralysis Pays a benefit when you are diagnosed with Paralysis, resulting in paraplegia or quadriplegia (complete, total and permanent loss of use of two or more limbs) confirmed by the insured person's attending physician. The paralysis has to continue for a period of 60 consecutive days;	100%	100%
Loss of Sight (Blindness) Pays a benefit when you are diagnosed with Loss of sight (blindness) that is total and irrecoverable loss of sight in both eyes. Loss of sight (blindness), has to continue for a period of 90 consecutive days.	100%	100%
Loss of Speech Pays a benefit when you are diagnosed with Loss of speech that cannot be corrected to any functional degree by any procedure, aid or device. Loss of speech has to continue for a period of 90 consecutive days.	100%	100%

Loss of Hearing Pays a benefit when you are diagnosed with Loss of hearing in both ears that cannot be corrected to any functional degree by any procedure, aid or device. Loss of hearing has to continue for a period of 90 consecutive days.	100%	100%
Occupational HIV Pays a benefit when you are diagnosed with Occupational HIV. The date of 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.	100%	100%
Coma Pays a benefit when you are diagnosed with Coma, characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance (a medically induced coms is not covered). The Coma must last for a period of 14 or more consecutive days.	100%	100%
Benign Brain Tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%	100%
Third-Degree Burns Pays a benefit when you are diagnosed with a Third degree burn that covers more than 10% of total body surface (also called full-thickness burn).	100%	100%
Alzheimer's Disease Pays a benefit when you are diagnosed with Alzheimer’s disease, diagnosis of the disease by a psychiatrist or neurologist.	25%	25%
Parkinson's Disease Pays a benefit when you are diagnosed with Parkinson’s disease by a psychiatrist or neurologist.	25%	25%
Lupus Pays a benefit when you are diagnosed with Lupus by a physician.	25%	25%
Multiple Sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	25%	25%
Muscular Dystrophy Pays a benefit when you are diagnosed with Muscular dystrophy by a physician.	25%	25%

Cancer Benefits

Covered Benefit	Percent of Face Amount (Employee):	Percent of Face Amount (Employee):
Cancer (invasive) Pays a benefit when you are diagnosed with Cancer (invasive) that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.	100%	100%
Carcinoma in Situ (non-invasive) Pays a benefit when you are diagnosed with Carcinoma in situ that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of this Certificate.	25%	25%
Skin Cancer Pays a benefit when you are diagnosed with Skin Cancer (melanoma of Clark's Level I or II Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin. Skin cancer benefit provides coverage for invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic.	$1,000	$1,000

Cancer is not a Critical Illness under this plan

Additional Plan Benefits

*Covered Health Screenings:	
Health Screening Pays a lump sum benefit for each day you receive any of the approved health screening tests. *Maximum 1 day per plan year*	$50

- Lipoprotein profile (serum plus HDL, LDL and triglycerides)
- Fasting blood glucose test
- Digital rectal exams (DRE)
- Carotid Doppler Ultrasound
- Electrocardiogram (EKG, ECG)
- Echocardiogram (ECHO)
- Chest x-ray (CXR)
- Thermography
- Ultrasound screening for abdominal aortic aneurysms
- Bone marrow screening
- Adult and child immunizations
- HPV vaccine (Human Papillomavirus)
- Bone mass density measurement (DEXA, DXA)
- Hemoccult stool analysis
- Doppler screenings for peripheral vascular disease (also known as arteriosclerosis)
- Prostate Specific Antigen (PSA) Test
- Flexible sigmoidoscopy
- Colonoscopy
- Virtual colonoscopy
- Carcinoembryonic Antigen (CEA)
- Cancer Antigen (CA) Test 15-3 (breast cancer)
- Mammography
- Breast Ultrasound
- Cancer Antigen (CA) Test 125 (ovarian cancer)
- Pap smears
- Cytologic Screening
- ThinPrep Pap Test
- Skin cancer screening
- Serum protein electrophoresis (blood test for myeloma)

Critical Illness: Exclusions and Limitations

This plan has exclusions and limitations. Refer to the actual booklet certificate and schedule of benefits to determine which services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, the plan may contain exceptions to this list based on state mandates or the plan design purchased.

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

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

Also, no indemnity will be paid for loss caused by the voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his physician for the insured.

Note – If any critical illness is diagnosed outside the country and is subsequently confirmed through a diagnosis in the United States, including its territories, a benefit is payable for the critical illness diagnosed.

Portability

Your plan includes a Portability option which allows you to keep your existing coverage by making direct payments to the carrier. You may exercise this option, if your employment ceases for any reason. Refer to your Certificate for additional Portability provisions.

Questions and Answers about the Critical Illness Plan

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

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

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

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

Can I have more than one *Critical Illness* Plan?

No, you are not allowed to have more than one Aetna Critical Illness Plan.

What does Face Amount mean?

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

To whom are benefits paid?

Benefits are paid to you, the member.

Is my Aetna *Critical Illness* policy compatible with a Health Savings Account (HSA)?

Yes, Aetna Critical Illness policies are compatible with Health Savings Accounts.

How do I submit a claim?

*Go to **myaetnasupplemental.com** and either "Log In" or "Register", depending on if you've set up your account. Click the "Create a new claim" button and answer a few quick questions. You can even save your claim to finish later. You can also print/mail in form(s) to: Aetna Voluntary Plans, PO Box 14079, Lexington, KY 40512-4079, or you can ask us to mail you a printed form.*

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

*Please call us. We want you to understand these benefits before you decide to enroll. You may reach one of our Customer Service representatives **Monday through Friday, 8 a.m. to 6 p.m.,** by calling **1-800-607-3366**. We're here to answer questions before and after you enroll.*

What should I do in case of an emergency?

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

What happens if I lose my employment, can I take the *Critical Illness* Plan with me?

Should you lose your job, you are able to continue coverage under the Portability provision. You will need to pay premiums directly to Aetna.

Important information about your benefits

THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

In order for benefits to be payable, the date of diagnosis must occur while coverage for the insured person is in force; you must be diagnosed while your coverage is in effect.

This plan does not count as Minimum Essential Coverage under the Affordable Care Act.

Complaints and appeals

Please tell us if you are not satisfied with a response you received from us or with how we do business. Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. You can also e-mail Member Services through the secure member website. If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information. Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs). We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

These parties are required to keep your information private as required by law. Some of the ways in which we may use your information include: Paying claims, making decisions about what the plan covers, coordination of payments with other insurers, quality assessment, activities to improve our plans and audits.

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

If you'd like a copy of our privacy notice, call **1-800-607-3366** or visit us at **www.aetna.com.**

If you require language assistance, please call Member Services at 1-800-607-3366 and an Aetna representative will connect you with an interpreter. If you're deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna

telephone number you're calling.

Si usted necesita asistencia lingüística, por favor llame al Servicios al Miembro a 1-800-607-3366, y un representante de Aetna le conectará con un intérprete. Si usted es sordo o tiene problemas de audición, use su TTY y marcar 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

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

Plans are underwritten by Aetna Life Insurance Company (Aetna). This material is for information only and is not an offer or invitation to contract. Each insurer has sole financial responsibility for its own products. Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

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

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

A Shopper's Guide to Cancer Insurance

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About the NAIC …

The National Association of Insurance Commissioners (NAIC) is the oldest association of state government officials. Its members consist of the chief insurance regulators in all 50 states, the District of Columbia and five U.S. territories. The primary responsibility of state insurance regulators is to protect the interests of insurance consumers, and the NAIC helps regulators fulfill that obligation in a number of different ways. This guide is one example of work done by the NAIC to assist states in educating and protecting consumers.

Another way the NAIC lends support to state regulators is by providing a forum for the development of uniform public policy when uniformity is appropriate. It does this through a series of model laws, regulations and guidelines, developed for the states' use. States that choose to do so may adopt the models intact or modify them to meet the needs of their marketplace and consumers.

The NAIC's mission is to assist state insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient and cost effective manner, consistent with the wishes of its members:

- Protect the public interest;
- Promote competitive markets;
- Facilitate the fair and equitable treatment of insurance consumers;
- Promote the reliability, solvency and financial solidity of insurance institutions; and
- Support and improve state regulation of insurance.

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A Shopper's Guide to

CANCER INSURANCE

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National Association of Insurance Commissioners

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National Association of Insurance Commissioners
Insurance Products & Services Division
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Introduction

Cancer insurance provides benefits only if you get cancer. No policy will cover you for cancer diagnosed before you applied for the policy. Examples of other specified-disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified-disease policies.

Cancer Insurance is Not a Substitute for Comprehensive Coverage

Cancer treatment accounts for about 10 percent of all U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid, either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1 million. Major medical policies will cover any accident or sickness, including cancer. They cost more than cancer policies because they cover more, but they are generally considered a better buy.

Should You Buy Cancer Insurance? Many People Do Not Need it

If you are considering cancer insurance, ask yourself three questions:

- Is my current coverage adequate for these costs?
- How much will treatment cost if I do get cancer?
- How likely am I to contract the disease?

If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need. Low-income people who are Medicaid recipients do not need any more insurance. If you think you might qualify, contact your local social service agency.

- **Duplicate Coverage is Expensive and Unnecessary.**
  Buy basic coverage first, such as a major medical policy. Make sure any cancer policy will meet any needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy might contain a coordination of benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your major medical insurance, as well as the cancer policy.

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- **Some Cancer Expenses Might Not be Covered, Even by a Cancer Policy.**
  Medical costs of cancer treatment vary. On average, hospitalization accounts for 78 percent of such costs and physician services account for about 13 percent. The remainder goes for other professional services, drugs and nursing home care. Cancer patients often face large, non-medical expenses that are not usually covered by cancer insurance. Examples include home care, transportation and rehabilitation costs.

- **Do Not be Misled by Emotions.**
  While three in 10 Americans will get cancer over a lifetime, seven in 10 will not. In any one year, only one American in 250 will get cancer. The odds are against you receiving any benefits from a cancer policy. Be sure you know what conditions must be met before the policy will start to pay your bills.

Caution: Limitations of Cancer Insurance

Cancer policies sold today vary widely in cost and coverage. If you decide to purchase a cancer policy, contact different companies and agents, and compare the policies before you buy. The following are some common limitations:

- **Some policies pay only for hospital care.**
  Today cancer treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 13 days, a policy that pays only when you are hospitalized has limited value.

- **Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days.**
  However, because the average stay in a hospital for a cancer patient is 13 days, large dollar amounts for extended benefits have very little value for most patients.

- **Many cancer insurance policies have fixed dollar limits.**
  For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it might have fixed payments, such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount, such as $5,000 or $10,000.

- **No policy will cover cancer diagnosed before you applied for the policy.**
  Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

- **Most cancer insurance does not cover cancer-related illnesses.**
  Cancer or its treatment might lead to other physical problems, such as infection, diabetes or pneumonia.

- **Many policies contain time limits.**
  Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

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Non-Discrimination Notice

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-772-9682.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: 711, Fax: 859-425-3379, CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Availability of Language Assistance Services

TTY: 711

For language assistance in your language call 1-888-772-9682 at no cost. (English)

Para obtener asistencia lingüística en su idioma, llame sin cargo al 1-888-772-9682. (Spanish)

欲取得以您的語言提供的語言協助，請撥打1-888-772-9682，無需付費。(Chinese)

Pour une assistance linguistique dans votre langue, appeler le 1-888-772-9682 sans frais. (French)

Para sa tulong sa inyong wika, tumawag sa 1-888-772-9682 nang walang bayad. (Tagalog)

Hilfe oder Informationen in deutscher Sprache erhalten Sie kostenlos unter der Nummer 1-888-772-9682. (German)

للمساعدة اللغوية بلغتك الرجاء الاتصال على الرقم المجاني 1-888-772-9682. (Arabic)

Pou jwenn asistans nan lang pa w, rele nimewo 1-888-772-9682 gratis. (French Creole)

Per ricevere assistenza nella sua lingua, può chiamare gratuitamente il numero 1-888-772-9682. (Italian)

日本語で援助をご希望の方は 1-888-772-9682（フリーダイアル）までお電話ください。(Japanese)

본인의 언어로 통역 서비스를 받고 싶으시면 비용 부담 없이 1-888-772-9682번으로 전화해 주십시오. (Korean)

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Aby uzyskać pomoc w swoim języku, zadzwoń bezpłatnie pod numer 1-888-772-9682. (Polish)

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Чтобы получить помощь с переводом на ваш язык, позвоните по бесплатному номеру 1-888-772-9682. (Russian)

Để được hỗ trợ ngôn ngữ bằng ngôn ngữ của bạn, hãy gọi miễn phí đến số 1-888-772-9682. (Vietnamese)