Aetna Critical Illness Plan

Be prepared for what happens next
Critical illness insurance coverage can keep you focused on your health when it matters most. This extra coverage can help ease some financial worries during a difficult time.

What is the Critical Illness Plan?
The Aetna Critical Illness Plan pays benefits when a doctor diagnoses you with a covered serious illness or condition, like heart attack, stroke, cancer and more*. You can use the benefits to help pay out-of-pocket medical costs or towards personal expenses.

How is this different from a major medical plan?
Medical plans help pay providers for services and treatment. But, they don't cover unexpected costs that can come with a serious illness.

The Aetna Critical Illness Plan pays benefits directly to **you**, giving you extra cash when you need it most. It can help fill in the gaps, making it a great companion to your major medical plan.

How can you use the cash benefits?
It's completely up to you. You can use the money any way you want, like:

- Deductibles or copays
- Mortgage or rent
- Groceries or utility bills

...or for anything else you choose.

Easy to use
Online tools make it easy to manage your plan. File a claim in about 90 seconds or less if you have a diagnosis for a covered illness. And, benefits get paid directly to you by check or direct deposit.

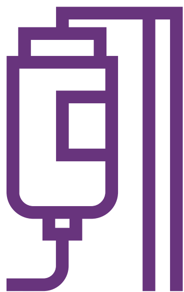
*Refer to your plan documents to see all covered illnesses under the plan.

The Aetna Critical Illness Plan is underwritten by Aetna Life Insurance Company (Aetna).

Aetna.com
57.03.502.1 (02/21)

Did you know?

Someone in the U.S. has a heart attack **every 40 seconds**[1]. A hospital stay for a heart attack, on average, costs **$20,246**[2].



Having less to worry about

Dan* knows that heart disease runs in his family. And when a heart attack struck, he was thankful he had the Aetna Critical Illness plan.

He filed his claim easily online and benefits were deposited directly into his bank account. As an Aetna medical member, he didn't need to upload any medical bills.

He was able to use the money to help pay his out-of-pocket medical costs and other bills such as his children's daycare tuition.

A Simplified Claims Experience™

Just register on the **My Aetna Supplemental** app or on the member portal at **Myaetnasupplemental.com** to view plan documents, submit and track claims, and sign up for direct deposit. Aetna Medical members can also access the portal from **Aetna.com**.

Filing a claim is easy! Click "Report New Claim" and answer a few quick questions. Filing claims is even easier for Aetna Medical Plan members. **Aetna Easy File™** uses information from your medical claim to process your Critical Illness Plan claim. That's less paperwork for you. Don't have Aetna Medical? No problem; just upload or take a picture of your medical bill.

You can also print and mail a paper claim form to Aetna Voluntary Plans.

[1]Centers for Disease Control and Prevention. Heart attack. August 18, 2017. Available at: cdc.gov/heartdisease/heart_attack.htm. Accessed May 8, 2018.
[2]Michaels M. The 35 most expensive reasons you might have to visit a hospital in the US — and how much it costs if you do. Business Insider. March 1, 2018. Available at: businessinsider.com/most-expensive-health-conditionshospital-costs-2018-2. Accessed April 26, 2018.
*This is a fictional example of how the plan could work.

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

This insurance plan provides limited benefits. It pays fixed dollar benefits for covered services without regard to the health care provider's actual charges. The benefits payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have. This material is for information only. Insurance plans contain exclusions and limitations. Not all health services are covered, and coverage is subject to applicable laws and regulations, including economic and trade sanctions. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features, rates, eligibility and availability may vary by location and are subject to change. For more information about Aetna plans, refer to **Aetna.com.**

Policy forms issued in Oklahoma include: GR-96843, AL HCOC-VOL CI 01, AL HPOL-VOL CI 01.
Policy forms issued in Missouri include: GR-96844 01, AL HCOC-VOL CI 01, AL HPOL-VOL CI 01.

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AETNA LIFE INSURANCE COMPANY

CRITICAL ILLNESS/SPECIFIED DISEASE

OUTLINE OF COVERAGE

Read Your Certificate Carefully. This outline of coverage provides a very brief description of some important features of your certificate. This is not the insurance contract and only the actual certificate provisions will control. The certificate itself sets forth, in detail, the rights and obligations of both you and Aetna. It is, therefore, important that you Read Your Certificate Carefully!

1. **Specified Disease Coverage.** This category of coverage is designed to provide, to persons insured, benefits ONLY when certain losses occur as a result of specified diseases. Benefits are not provided for basic hospital, basic medical-surgical, or major-medical expenses.

Some notes on how we use words:

- Some words appear in **bold** type. **We** define them in the Glossary section of **your** certificate.
- When we say "**we,**" we mean **Aetna**.
- When we say "**you**" and "**your,**" **we** mean the **employee**.

2. **Benefits.** Refer to the Schedule of Benefits and Benefits sections of the certificate for details about when benefits are payable, what your benefits are and if any **waiting periods** apply.

3. **Exceptions, Reductions and Limitations.**

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

   - 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);
   - Engaging in felony crimes;
   - Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection.

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

4. **Eligibility, Termination and Portability**. Refer to the Eligibility, Termination of Coverage and Portability Provision sections of the certificate for information about eligibility for coverage, termination of coverage and portability.

5. **Premium or Contribution**. The cost of the coverage is included within the premium or contribution paid by **you** and/or **your employer** for the plan.

BENEFIT SUMMARY

Sonos, Inc.

802256

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	High
Employee Face Amount	$15,000	$30,000
Spouse Face Amount	50% of Employee Face Amount	50% of Employee Face Amount
Child(ren) Face Amount	50% of Employee Face Amount	50% of Employee Face Amount

Critical Illness Conditions

Covered Benefit	Percent of Face Amount:
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%
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%
Coronary Artery Condition Requiring Bypass Surgery Pays a benefit when you are diagnosed with a Coronary artery condition requiring bypass surgery.	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%
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%
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%
Loss of Sight (Blindness) Pays a benefit when you are diagnosed with Loss of sight (blindness) that is total and irrecoverable loss of sight in both eyes. Loss of sight (blindness), has to continue for a period of 90 consecutive days.	100%
Loss of Speech Pays a benefit when you are diagnosed with Loss of speech that cannot be corrected to any functional degree by any procedure, aid or device. Loss of speech has to continue for a period of 90 consecutive days.	100%
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%
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%
Benign Brain Tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%

Covered Benefit	Percent of Face Amount:
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%
Alzheimer's Disease Pays a benefit when you are diagnosed with Alzheimer's disease, diagnosis of the disease by a psychiatrist or neurologist.	25%
Parkinson's Disease Pays a benefit when you are diagnosed with Parkinson's disease by a psychiatrist or neurologist.	25%
Lupus Pays a benefit when you are diagnosed with Lupus by a physician.	25%
Multiple Sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	25%
Muscular Dystrophy Pays a benefit when you are diagnosed with Muscular dystrophy by a physician.	25%
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%
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%

Additional Critical Illness Conditions

Covered Benefit	Percent of Face Amount:
Acute respiratory distress syndrome (ARDS) Pays a benefit when you are diagnosed with Acute respiratory distress syndrome (ARDS) by a physician.	25%

Cancer Benefits

Covered Benefit	Benefit Amount
Cancer (invasive) Pays a benefit when you are diagnosed with Cancer (invasive) that is identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells.	100%
Carcinoma in Situ (non-invasive) Pays a benefit when you are diagnosed with Carcinoma in situ that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue. Skin cancer will not be considered carcinoma in situ for purposes of this Certificate.	25%
Specified Skin Cancer (Lifetime Maximum per Insured) *Skin cancer benefit provides coverage for invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic.	$1,000 (Once per lifetime)
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%
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%

Additional Plan Benefits

Covered Benefit	Benefit Amount
Health Screening	
Pays a lump sum benefit for each day you receive any of the approved health screening tests.	$50

***Covered Health Screenings:**

Maximum 1 day per plan year

- 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/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)
- Any other generally accepted cancer screening test

Note: COVID-19 testing is covered as an eligible health screening benefit

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, cancer (invasive), carcinoma in situ or skin cancer that is diagnosed or for which care was received outside the United States and its territories, or for any loss caused in whole or in part by or resulting in whole or part from the following:

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

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

Portability

Your plan includes a option portability which allows you to keep your existing coverage by making direct payments to the carrier. You may exercise this option portability, if your employment ceases for any reason. Refer to your Certificate for additional 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 DO NOT COUNT AS MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT. THESE PLANS ARE A SUPPLEMENT TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. These plans provide limited benefits. They pay fixed dollar benefits for covered services without regard to the health care provider's actual charges. These benefit payments are not intended to cover the full cost of medical care. You are responsible for making sure the provider's bills get paid. These benefits are paid in addition to any other health coverage you may have.

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

Please review your Cancer buyer's guides:
http://demo.avpenroll.com/media/1591/maine-nh-prod_serv_consumer_guide_cancer.pdf
http://demo.avpenroll.com/media/1590/aetna-utah_ci_buyersguide.pdf

Complaints and appeals

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

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

We protect your privacy

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

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to: your doctors, dentists, pharmacies, hospitals and other caregivers, other insurers, vendors, government departments and third-party administrators (TPAs).

We obtain information from many different sources —particularly you, your employer or benefits plan sponsor if applicable, other insurers, health maintenance organizations or TPAs, and health care providers.

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

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

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

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

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

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

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

1-617-521-7794 or visiting its website at **www.mass.gov/doi.**

Plans are underwritten by Aetna Life Insurance Company (Aetna). This material is for information only and is not an offer or invitation to contract. Each insurer has sole financial responsibility for its own products.

Providers are independent contractors and are not agents of Aetna. Aetna does not provide care or guarantee access to health services. Insurance plans contain exclusions and limitations. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Policies may not be available in all states, and rates and benefits may vary by location. Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, refer to **www.aetna.com**.

Financial Sanctions Exclusions Clause

If coverage provided by this policy violates or will violate any US economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the United States, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit the website below:

http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx

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

Please review the below notice for Aetna Supplemental Health plan members who reside in the state of New Mexico.

ATTENTION NEW MEXICO RESIDENTS
The coverage provided under your benefits plan or policy underwritten by Aetna Life Insurance Company is limited in nature and may not provide financial protection for significant costs that you could incur for the diagnosis or treatment of COVID-19 ("Corona virus") related illness.

If you do not have comprehensive major medical coverage, in addition to the plan or policy issued by our company, you may incur significant uninsured medical expenses associated with the diagnosis and treatment of illness caused by COVID-19.

Major medical plans offer robust consumer protections, and are required to waive all deductibles, co-pays and other cost sharing expenses for the diagnosis or treatment of COVID-19 related illness. Your policy or plan with us is not a major medical plan and does not provide such protections.

If you do not have major medical coverage, you may:

1. Contact a licensed insurance broker or agent to see about major medical coverage availability.

2. To see if you are eligible for a special enrollment period for major medical coverage through the New Mexico Health Insurance Exchange, contact beWellnm toll-free at **1-833-862-3935**.

3. To see if you are eligible for Medicaid coverage and to complete an application, please call the Human Services Department's Medicaid Expansion Hotline toll-free at **1-855-637-6574** or visit **https://www.yes.state.nm.us/yesnm/home/index.**

4. To see if you are eligible for high risk pool coverage, please contact the New Mexico Medical Insurance Pool (the "High Risk Pool") at **1-844-728-7896** or **https://nmmip.org/**". If you are uninsured and have a COVID-19 diagnosis, your condition qualifies you for Pool coverage.

The Centers for Disease Control and the New Mexico Department of Health each have websites with considerable information on COVID-19. Visit each website at **https://www.cdc.gov/** or **http://cv.nmhealth.org/**.

Individuals who have symptoms consistent with COVID-19 should immediately call the NM Department of Health at **1-855-600-3453**.

Proprietary