Supplemental Plans Bundle

Accident | Critical Illness | Hospital Indemnity

MESSA

800-336-0013 | TTY: 888-445-5614 | messa.org

Table of Contents

This Certificate explains the insurance benefits issued to members of the Michigan Education Special Services Association.

The Policy under which this Certificate is issued may be amended or cancelled at any time as stated in its provisions. Only an officer of Aetna Life Insurance Company may approve a change and it must be done in writing. Such action may be taken without the consent of or notice to any person who claims rights or benefits under the Policy.

THIS CERTIFICATE IS NOT MEDICARE SUPPLEMENT COVERAGE.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

This plan provides limited benefits. 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.

This plan does not count as minimum essential coverage under the Affordable Care Act.

Cancellation during the first 30 days if you are Medicare eligible:
You may cancel this policy at any time during a period of 30 days after it is effective. You must provide a written request for cancellation to your employer and will receive a prompt refund of any premium paid.

Cancellation after 30 days if you are Medicare eligible:
You may cancel this policy after the first 30 days it is effective by giving written notice to your employer effective upon receipt or on a later date as may be specified in the notice. Your employer will promptly refund to you any excess of paid premium. Ending the policy under this paragraph is without prejudice to any claim originating before the effective date of cancellation.

Eligibility

The following individuals are eligible to become members of the Michigan Education Special Services Association and may apply for coverage:

- Any active, associate, service associate, retiree, or student member of the Michigan Education Association as defined in the MEA bylaws
- Any member of a bargaining unit in an educational agency in which a local association of MEA is the recognized bargaining agent and has negotiated MESSA benefits for its members
- Any administrator employed by an educational agency in which a local association of the MEA is a recognized bargaining agent and has negotiated MESSA benefits for its members
- Any retiree eligible for benefits under Section 91 of The Public School Employee Retirement Act of 1979, being MCLA 38.1391, as amended
- Any other eligible individual as defined in the Michigan Education Special Services Association bylaws as amended

Enrollment

An application is required if you are:

- Enrolling for the first time;
- Changing coverages for yourself or your dependents;
- Covering dependent children over age 26; or
- Changing employers.

If you miss the enrollment period, you will not be able to participate in this plan until the next annual enrollment period. If you do not enroll for coverage when you first become eligible, but wish to do so later, your employer will provide the information on when and how enrollment can be done.

Newborns are automatically covered for 31 days after live birth provided payment of premium is received. To continue coverage after 31 days, you will need to notify your employer within the 31-day enrollment period.

You must notify your employer or group if there is a change in your family such as a birth, divorce, death, etc. We must receive notice from your employer or group within 31 days of the change so that any contract changes take effect as of the date of the event. Any change in rates resulting from contract changes will take effect as of the effective date of the contract change.

If a dependent becomes ineligible for coverage under your contract, as in the case of a divorce, that dependent may be eligible for his or her own contract. However, we must be notified within 31 days of the change in order to provide continuous coverage.

Eligible Dependents

You, your spouse (this does not include the person who marries a member who has coverage as a surviving spouse) and your children listed on your contract are eligible. You will need to complete an application for coverage.

Children are covered through the end of the month or calendar year in which they turn 26 years of age, based on employer guidelines and subject to the following conditions:

- The subscriber continues to be covered under this certificate
- The children are related to the subscriber by birth, marriage, legal adoption or legal guardianship or you are responsible for the child under a qualified medical support order or other court order, regardless of where the child resides

Note: Your child's spouse is not covered under this certificate. Your grandchildren may be covered under limited circumstances.

Disabled, unmarried children may remain on your contract beyond the end of the calendar year in which they turn age 26 if all of the following apply:

- They are diagnosed as totally and permanently disabled due to a physical disability or developmental disability.
- They depend on your for support and maintenance.
- They are incapable of self-sustaining employment by reason of their disabilities. (Under no circumstances will mental illness be considered a cause of incapacity. Neither will it be considered as a basis for continued coverage.)

Please contact MESSA to obtain the appropriate form to continue coverage. Included with those forms will be a required physician's certification.

When Your Coverage is Effective

The following information details the guidelines for your effective date of coverage:

- If you are a new employee and enroll for coverage within 31 days following the date you became eligible (your date of employment or the day following completion of the eligibility waiting period, whichever is later), your coverage will be effective on the date you became eligible. This date is verified by your employer.
- During open enrollment, the effective date of coverage for all new applications and coverage changes will be that date approved by MESSA and verified by your employer.
- If your application is submitted at any other time, your coverage will be effective on the first day of the month following approval of your application by MESSA.
- Each dependent will be eligible for coverage on the later of the date on which your coverage begins or the date he/she becomes an eligible dependent if enrolled within 31 days. If your application for dependent coverage is submitted at any other time, coverage will be effective on the first day of the month following approval of your application by MESSA.

Termination

Your coverage ends on the date specified when the first of the following events occurs:

Termination of Employment

Coverage will end on the last day of the month in which you terminate employment.

Nonpayment of Contributions

Coverage will end on the last day of the month preceding the month for which the required contribution has not been remitted to MESSA.

Termination of Employer's Participation

Coverage will end on the last day of any month in which your employer ceases to participate.

Member's Loss of Eligibility

Coverage will end on the last day of the month in which a member no longer meets the eligibility criteria.

Dependent's Loss of Eligibility

Coverage will end on the date a dependent no longer meets the eligibility criteria.

Termination of the Policy

Death

Age Out

For the Critical Illness Plan only, coverage terminates when the member or dependent reaches 80 years old.

Portability

If your employment ends and, as a result, your coverage under the policy ends, Aetna 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 Aetna along with payment of the first premium for the portability coverage not later than 30 calendar days after your coverage under the policy terminates. Portability coverage will be effective on the day after benefits under the policy terminates.

The benefits, terms and conditions of portability coverage will be the same as those provided under the Policy on the date your coverage terminated. 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 or terminated by us for any reason upon 31 days advanced notice
- The date your class of coverage is terminated

With respect to any covered dependents:

- The date your coverage terminates
- The date you and your spouse divorce
- The date your covered dependent ceases to be an eligible dependent under the policy

Once portability coverage ends, it cannot start again.

MESSA Accident, Critical Illness and Hospital Indemnity Bundled Plan

Accident Plan

Accidents happen when you least expect them, but MESSA's Accident Plan can help you be more financially prepared. It pays you cash benefits when you are faced with a covered accidental injury on or off the job to help you stay on top of your bills while you recover.

To be a covered benefit, the care and other services you receive must be due to an accidental injury, must be advised by a physician and you must have been billed accordingly. The care and services must be on or after your effective date of coverage and must be given or received in the United States or its territories.

Each benefit is payable once per accident, unless stated otherwise.

Initial Care

Covered Benefit	Benefit Amounts
Ambulance	
If both air and ground transportation take place on the same date for the same accidental injury, only the benefit with the higher amount is payable.	
— Ground ambulance	$300
» Must take place within 24 hours of your accidental injury and must be transported by a licensed professional ambulance company by ground to or from a hospital or between medical facilities	
— Air ambulance	
» Must take place within 48 hours of your accidental injury and must be transported by a licensed professional air ambulance company by air to or from a hospital or between medical facilities	$1,500
Maximum trips per accident, air and ground combined	1

Initial Treatment	
— Emergency room/hospital	$150
— Physician's office/urgent care facility	$150
— Walk-in clinic/telemedicine	$50
Maximum visits per accident, combined for all places of service	1
Maximum visits per plan year, combined for all places of service	3
The initial exam and treatment must be received within 72 hours after accidental injury. If two or more visits occur on the same day for the same accidental injury, only the benefit with the highest amount is payable. This benefit is not payable for speech, occupational, or physical therapy or cognitive rehabilitation.	

X-ray/lab Must be performed in a licensed facility within 30 days after accidental injury	$50

Medical imaging The test must be ordered by a physician and performed in a medical facility on an inpatient or outpatient basis within 180 days after accidental injury. Medical imaging tests include only the following: — Positron Emission Tomography (PET) — Computed Tomography Scan (CT) — Computed Axial Tomography (CAT) — Magnetic Resonance (MR) or Magnetic Resonance Imaging (MRI) — Electroencephalogram (EEG)	$150

Follow-up Care

Follow-up care must be received within 365 days after the accidental injury. If two or more visits occur on the same day for the same injury, only the benefit with the highest amount will be payable.

Covered Benefit	Benefit Amounts
Accident follow-up	
— Emergency room/hospital	$50
— Physician's office/urgent care facility	$50
— Walk-in clinic/telemedicine	$25
Maximum visits per accident, combined for all places of service	3
Maximum visits per plan year, combined for all places of service	9

Appliances Requires a prescription and must be purchased within 90 days after the accidental injury.	
— Major	$200
» Back brace, body jacket, knee scooter, wheelchair, motorized scooter or wheelchair	
— Minor	$100
» Brace, cane, crutches, walker, walking boot, other medical device to aid your physical movement	

Chiropractic treatment and alternative therapy (acupuncture, biofeedback and electrical stimulation)	$25
Maximum visits per accident	10
Maximum visits per plan year	30
Treatment must begin within 90 days after accidental injury and must be completed within 365 days after accidental injury. If visits occur on the same day, only the benefit with the highest amount is payable.	
This benefit is not payable for: — Physical therapy — Massage therapy — Treatment of chronic conditions — Treatment unrelated to your accidental injury	

Pain management (epidural anesthesia)	$100
Must be administered within 60 days after accidental injury	

Prescription drugs	$10
Must be dispensed by a licensed pharmacist on an outpatient basis within 10 days after accidental injury.	

Prosthetic device/artificial limb	
Benefits for hearing aids, dental aids (including false teeth), eyeglasses, cosmetic prostheses such as hair wigs, or for joint replacement such as an artificial hip or knee are not payable.	
— One limb	$750
— Multiple limbs	$1,500
Maximum benefit per accident	1
Payable when an arm, hand, leg, foot or an eye is lost due to an accidental injury. Must receive the prosthetic device(s) or artificial limb(s) within 365 days after accidental injury.	
— Repair or replace	25%
Maximum benefit per plan year	1
Must receive the replacement or repaired prosthetic device or artificial limb within 180 days after accidental injury.	

Therapy services (speech, occupational or physical therapy, or cognitive rehabilitation)	$25
Maximum visits per accident	10
The therapy must be: — Prescribed by a physician — Rendered by a physician, speech, occupational or physical therapist, and — Performed in an office setting or in a hospital on an inpatient or outpatient basis. The therapy must begin within 90 days after accidental injury and must be completed within 365 days after accidental injury. We will pay either the *Therapy services* benefit or the applicable *Accident follow-up* benefit if those visits occur on the same date for the same accidental injury. When the visits occur on the same date, only the benefit with the highest amount is payable.	

Hospital Care

Covered Benefit	Benefit Amounts
Hospital stay – admission (initial day)	
— Non-ICU admission (stay must begin within 180 days after accidental injury)	$1,000
— ICU admission (stay must begin within 30 days after accidental injury)	$2,000
If admitted to both Non-ICU and ICU, only the benefit with the higher amount is payable. Two or more separate stays count as one stay if they are due to the same accident and are separated by less than 90 days; otherwise, they count as separate stays. This benefit is not payable for stays due to PTSD.	

Hospital stay – daily (benefits begin on day two)	
— Non-ICU daily (stay must begin within 180 days after accidental injury)	$200
— ICU daily (stay must begin within 30 days after accidental injury)	$400
— Step-down intensive care unit daily (stay must begin within 10 days after your ICU stay for the same accidental injury)	$300
Maximum days per accident (combined for all stays due to the same accident) If you have multiple stays, only the benefit with the higher amount is payable. Two or more separate stays count as one stay if they are due to the same accident and are separated by less than 90 days; otherwise, they count as separate stays. This benefit is not payable for stays due to PTSD.	365

Rehabilitation unit stay – daily Maximum days per accident Must be transferred to a rehabilitation unit within 24 hours after a stay in a hospital due to an accidental injury. If you have a stay in a non-ICU room of a hospital, an ICU room, a step down intensive care unit, and/or a rehabilitation unit on the same day, only the benefit with the highest amount is payable.	$100 30
Observation unit The initial day of observation must begin within 72 hours after your accident. If your period of observation leads to a hospital stay then: — The *Observation unit* benefit amount will not be paid. — The applicable *Hospital stay – admission* and *Hospital stay – daily* benefit amounts are payable. We will pay either the *Observation unit* benefit or the applicable *Initial treatment* benefit for the initial treatment of an accidental injury, whichever is higher. This benefit is not payable for pre-operative and post-operative care.	$100

Surgical Care

Covered Benefit	Benefit Amounts
Blood/plasma/platelets Transfusion must take place within 90 days after the accidental injury	$400
Eye injury — Surgical repair — Removal of foreign object The eye injury must require surgery or the removal of a foreign object by a physician within 90 days after accidental injury. An exam with anesthesia is not surgery. If you require surgery and the removal of a foreign object by a physician on the same day for the same accidental injury, only the benefit with the higher amount is payable.	 $300 $150
Surgery (without repair) — Arthroscopic or exploratory » Payable if surgery is performed and no repair is done, or if torn knee cartilage is shaved (debridement), within 60 days after accidental injury	$150

Surgery (with repair)	
— Cranial, open abdominal or thoracic	$1,500
» Payable if your physician recommends surgery within 72 hours after your accidental injury and cranial, open abdominal or thoracic surgery is performed within 30 days after accidental injury	
— Hernia	$250
» Payable if a physician diagnoses hernia within 30 days after accidental injury and repairs it through surgery within 60 days after accidental injury	
— Ruptured disc	$750
» Payable if a physician diagnoses ruptured disc within 60 days after accidental injury and repairs it through surgery within 180 days after accidental injury	
— Tendon/ligament/rotator cuff	
» Single repair	$750
» Multiple repairs	$1,500
» Payable if a physician diagnoses tear, rupture or sever within 60 days after accidental injury and repairs it through surgery within 180 days after accidental injury	
— Torn knee cartilage	$750
» Payable if a physician diagnoses torn knee cartilage within 60 days after accidental injury and repairs it through surgery within 180 days after accidental injury	
— Non-Specified	
» Inpatient	$250
» Outpatient	$250
» Payable if you undergo inpatient or outpatient surgery with repair that is not otherwise included as a Surgery benefit and the surgery is performed within 180 days after accidental injury	
Receiving stitches to repair a laceration is not payable under this benefit.	
When multiple surgeries, including surgery for fractures and dislocations, are performed on the same date for the same accidental injury, only the benefit with the highest amount is payable. When multiple surgeries are performed for the same accidental injury, we will pay for each surgery, but no more than two surgeries with the highest amount.	
Maximum benefits per accident, combined for all surgery (with and without repair)	2

Transportation/Lodging Assistance

Covered Benefit	Benefit Amounts
Lodging Maximum days per accident This benefit is payable within 90 days after accidental injury. Payable only for motel/hotel stays during the period of time you have a hospital stay and the hospital must be more than 50 miles from your residence, measured by the most direct route.	$200 30
Transportation This benefit is payable within 90 days after accidental injury when you must travel by taxi, plane, train, bus, or personal car from your residence more than 50 miles one way on physician's advice for treatment of an accidental injury. This benefit will be paid for travel due to: — A hospital stay — Outpatient surgery — A physician's office visit Mileage will be measured for the most direct route from your residence to the facility where treatment is received. This benefit is not payable if you are transported by ground ambulance or air ambulance.	$300

Dislocations and Fractures

A physician must diagnose the dislocation or fracture within 90 days after accidental injury and correct it by open reduction or closed reduction within 90 days after accidental injury.

If we pay the applicable *Dislocation* benefit for a dislocation, we will not pay a benefit for subsequent dislocations of the same joint.

We will pay either the applicable *Dislocation* benefit or the *Surgery - Arthroscopic or exploratory* benefit amount if treatment occurs on the same date for the same accidental injury. When treatment occurs on the same date, only the benefit with the higher amount is payable.

If you:

- Sustain more than one dislocation, we will pay for each dislocation, but no more than three times the *Dislocation* benefit for the joint involved with the highest benefit amount.
- Receive reduction by a physician without anesthesia, we will pay 25% of the applicable *Dislocation* benefit amount shown in the *Schedule of benefits* for a closed reduction of the joint involved.
- Are diagnosed with a partial dislocation, we will pay 25% of the applicable *Dislocation* benefit amount shown in the *Schedule of benefits* for a closed reduction of the joint involved. A partial dislocation is a dislocation in which the joint is not completely separated.
- Sustain multiple fractures to the same bone during the same accidental injury, we will pay only one *Fracture* benefit.
- Sustain a fracture of more than one bone, we will pay for each fracture, but no more than three times the applicable *Fracture* benefit for the bone involved with the highest benefit amount.
- Are diagnosed with a chip fracture, we will pay 25% of the applicable *Fracture* benefit amount shown in the *Schedule of benefits* for the closed

reduction for the bone involved. A chip fracture is a fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

- Sustain a dislocation and a fracture as a result of the same accident, both benefits are payable. However, we will pay no more than three times the amount for the joint or bone involved with the highest amount.

Covered Benefit	Benefit Amounts
*Dislocations – closed reduction**	
**Open reduction pays twice the amount of the closed reduction value*	
— Hip	$3,000
— Knee	$1,500
— Ankle – bone or bones of the foot (other than toes)	$750
— Collarbone (sternoclavicular)	$600
— Lower jaw	$600
— Shoulder (glenohumeral)	$600
— Elbow	$600
— Wrist	$600
— Bone of bones of the hand (other than fingers)	$600
— Collarbone (acromioclavicular and separation)	$150
— Rib	$150
— One toe or one finger	$150
— Partial dislocation	25%
Maximum dislocations per accident	3
*Fractures – closed reduction**	
**Open fracture pays twice the amount of the closed fracture value*	
— Skull (except bones of the face or nose), depressed	$4,125
— Skull (except bones of the face or nose), non-depressed	$4,125
— Hip, thigh (femur)	$1,725
— Vertebrae, body of (excluding vertebral processes)	$1,125
— Pelvis (inc. ilium, ischium, pubis, acetabulum except coccyx)	$1,125
— Leg (tibia and/or fibula malleolus)	$1,125
— Bones of the face or nose (except mandible or maxilla)	$600
— Upper jaw, maxilla (except alveolar process)	$600
— Upper arm between elbow and shoulder (humerus)	$600
— Lower jaw, mandible (except alveolar process)	$600
— Collarbone (clavicle, sternum)	$600
— Shoulder blade (scapula)	$600
— Vertebral process	$600
— Forearm (radius and/or ulna)	$450

*Fractures – closed reduction** **continued***	
**Open fracture pays twice the amount of the closed fracture value*	
— Kneecap (patella)	$450
— Hand/foot (except fingers/toes)	$450
— Ankle/wrist	$450
— Rib	$225
— Coccyx	$225
— Finger, toe	$225
— Chip fracture	25%
Maximum fractures per accident	3

Paralysis Benefits

Covered Benefit	Benefit Amounts
Home and vehicle alteration To be payable, you must have sustained an accidental injury that resulted in your dismemberment or paralysis. The following conditions must also be met: — Your physician must prescribe that you have your primary home or vehicle altered to maintain an independent lifestyle — The installation is done by a licensed contractor who is not you or your immediate family member, and — You must provide a written receipt for the alteration within 365 day after the covered accidental injury Payable home alterations include: — Permanent or portable outdoor wheelchair ramps — Adding or changing a sidewalk or driveway for wheelchair access — Motorized platform and staircase lifts — Reinforced ceilings for lifting equipment — Recessed/flushed baseboards — Roll-in, level access/wet area shower — Alterations to create an open floor plan or to widen the doorway(s) of your home — Lowering your existing counters, sinks, and electrical switches — Purchase and installation of lifting equipment — Purchase and installation of in-home light and vibration alerting systems for the deaf and blind	$1,000

Home and vehicle alteration ***continued***	
Payable motor vehicle alterations include: — Electronic control consoles — Power door operators — Raised roof and door openings — Power transfer seat bases — Modifications to the steering and braking systems — Floor modifications for driving from a wheelchair — A mounted wheelchair or scooter loader or lift — Adaptive control devices to help you control the accelerator, foot brake, turn signals, dimmer switch, steering wheel, and/or parking brake This benefit is also payable for the purchase of a motor vehicle with adaptive equipment. This benefit is not payable for purchase or installation of: — Mobility handles and chairs, transfer chairs and benches, except for lifting equipment — Repair, maintenance, and replacement parts for your home or vehicle device — Alterations to any work vehicle — Alterations to any boat or motorcycle — Home security system — Non-slip surfaces — Portable chairs — Routine home maintenance — Spa, hot tub, or jacuzzi — Seat-back cushions — Transfer toilets or toilet seat extenders — Grab bars/rails	

Paralysis (complete, total and permanent loss)	
— Quadriplegia	$10,000
— Triplegia	$7,500
— Paraplegia	$5,000
— Hemiplegia	$5,000
— Diplegia	$5,000
— Monoplegia	$2,500
A physician must: — Diagnose paralysis within 60 days after accidental injury — Confirm the paralysis continued for a period of 90 consecutive days, and — Expect it to be permanent	

Other Accidental Injuries

Covered Benefit	Benefit Amounts
Animal bite treatment	
— Tetanus shot	$100
— Anti-venom shot	$200
— Rabies shot	$300
Treatment must take place within 30 days after your accidental injury. If you receive more than one type of shot, only the benefit with the highest amount is payable. This benefit is not payable for: — Stings — Human bites — Mosquito, tick, or bed bug bites — Animal bites if you are trespassing — Any bacterial, viral or microorganism infection or infestation or any condition resulting from insect, arachnid, or other arthropod bites or stings	
Brain injury	
— Concussion/mild traumatic brain injury	$150
» Diagnosis must be made within 72 hours after accidental injury	
— Moderate/severe traumatic brain injury	$450
» Diagnosis must be made within 30 days after accidental injury If you receive the Concussion/Mild traumatic brain injury benefit, then you are diagnosed with a moderate or severe traumatic brain injury, the Moderate/Severe traumatic brain injury benefit amount payable will be reduced by the amount paid under the Concussion/Mild traumatic brain injury benefit.	
Burn	
— Second-degree burn, greater than 5% of total body surface	$1,000
— Third-degree burn, less than 5% of total body surface	$1,500
— Third-degree burn, 5-10% of total body surface	$6,000
— Third-degree burn, greater than 10% of total body surface	$18,000
Treatment must be received by a physician within 72 hours after accidental injury. If you sustain more than one burn classification, only the benefit with the highest amount is payable.	
Burn skin graft Must be received within 365 days after accidental injury	50% of burn

Coma/persistent vegetative state (PVS) Only the benefit with the highest amount is payable: — Coma (non-induced; period of at least 14 consecutive days due to accidental injury) — PVS (period of at least 30 consecutive days due to accidental injury) — Coma (induced) Maximum days per accident	 $10,000 $10,000 $250/day 10
Dental treatment — Extractions — Crown The dental services must begin within 60 days after accidental injury. This benefit is not payable for an injury caused by biting or chewing.	 $75 $225
Gunshot wound Gunshot wound must be sustained by a conventional firearm due to an accidental injury. A physician must treat your gunshot wound within 24 hours after your accidental injury. If you receive the *Gunshot wound* benefit and then die, we will reduce the benefit payable by the amount paid under the *Gunshot wound* benefit.	$1,500
Laceration — Without stitches — With stitches, less than 7.5 centimeters — With stitches, 7.6 – 20.0 centimeters — With stitches, greater than 20.0 centimeters A physician must repair the laceration within 72 hours after your accidental injury. If the laceration is severe enough to require stitches but the physician chooses to repair it in another way, we will pay the benefit amount that corresponds to "with stitches". If you sustain more than one repair classification, only the benefit with the highest amount is payable. Receiving stitches to repair a laceration is not payable under the *Surgery – Non-specified* benefit.	 $25 $75 $300 $600
Post-traumatic stress disorder Maximum diagnoses per lifetime Must receive the diagnosis of PTSD within 365 days after accidental injury. This benefit is payable for the diagnosis only. Benefits are not payable for treatment of PTSD.	$500 1

Service dog Maximum service dogs per your lifetime Requires physician recommendation that you would benefit from a service dog due to an accidental injury and a service dog is placed with you. You must: — Be a covered person when the service dog is placed with you. — Purchase the service dog from an organization accredited by Assistance Dogs International (ADI) or the International Guide Dog Federation (IGDF). — Provide proof of purchase. The service dog must be placed with you within 365 days after accidental injury.	$1,500 1

Waiver of Premium

If, as a result of an accidental injury, 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 six months of coverage. During such absence, you must remain employed. The premium waiver does not apply to your covered dependents.

Organized Sports Rider (child only)

If while a covered dependent is playing as a registered member of an organized sporting activity, they sustain an accidental injury, benefits payable will be increased by 25%, except for the excluded benefits below:

- Burn skin graft
- Animal bite
- Burn
- Gunshot wound
- Service dog

Exclusions

Benefits will not be paid for any care, service or supply for an accidental injury related to the following:

Activities and contests

- Competitive or recreational activities:
  - Ballooning
  - Boarding (including the use of self-balancing boards or hover boards)
  - Bungee jumping
  - Gliding (including sailplaning or sail gliding, hang gliding, paragliding)
  - Mountaineering using ropes and/or other equipment
  - Parachuting
  - Paramotoring
  - Parasailing or parakiting
  - Parascending
  - Racing a motor-driven vehicle
  - Scuba diving
  - Skydiving
- Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment.

Aircraft (pilot and crew member)

Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by, for, or under the direction of, any military authority.

Bacterial infections
Bacterial infections that are not caused by a cut or a wound from an accidental injury.

Care provided by immediate family members or any household member

Elective or cosmetic surgery
Surgery, (cosmetic or plastic), drugs or supplies to alter, improve or enhance the shape or appearance of the body, even for psychological or emotional reasons.

Felony and illegal occupation
Any loss to which a contributing cause was your commission of or attempt to commit a felony, or to which a contributing cause was your engagement in an illegal occupation or other willful criminal activity.

Nutritional supplements
Vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition

Riot, war
If you engage in willful criminal activity, at the level of a misdemeanor or a felony, any illness or accidental injury associated with riot or war will be excluded.

Substance abuse and use
Any accidental injury sustained while you were engaging in an illegal occupation or committing, or attempting to commit, a felony and you were:

- Legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accidental injury occurred
- Under the influence of a stimulant, depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by you.

Violation of cellular device use laws
Violating any cellular device use laws, of the state in which the accident occurred, while operating a motor vehicle.

BACK

Critical Illness Plan

No one is truly ready to receive a diagnosis of a serious illness, but MESSA's Critical Illness Plan pays cash benefits when you are diagnosed with a covered illness or condition after your coverage effective date. This can help you relieve some financial stress so you can focus on recovery.

Face Amounts

Covered Benefit	Benefit Amounts
Employee face amount	$10,000
Spouse face amount	50% of employee face amount
Child(ren) face amount	50% of employee face amount

Plan Features

Feature	% of Face Amount
Subsequent critical illness diagnosis benefit Diagnosis of a different critical illness	100% after 0 days
Recurrence of critical illness diagnosis benefit Diagnosis of the same critical illness	100% after 180 days
Recurrence cancer (invasive) diagnosis benefit Must not have received treatment for the initial cancer for which a benefit was paid during the 180 days between the dates of diagnosis. As used here, "treatment" does not include maintenance drug therapy or routine follow-up visits to confirm the initial cancer has not returned.	100% after 180 days
Recurrence carcinoma in situ diagnosis benefit (non-invasive) Must not have received treatment for the initial cancer for which a benefit was paid during the 180 days between the dates of diagnosis. As used here, "treatment" does not include maintenance drug therapy or routine follow-up visits to confirm the initial cancer has not returned.	100% after 180 days

Critical Illness Conditions

Unless otherwise noted, the date of diagnosis is the date a physician performs, diagnoses or confirms that the critical illness occurred. If the date of diagnosis of two or more critical illnesses is the same day, only the diagnosis with the highest benefit will be paid.

Covered Benefit	% of Face Amount
Heart attack (myocardial infarction)	100%
Stroke	100%
Coronary artery condition requiring bypass surgery	25%
Major organ failure Date of diagnosis is the date the member is placed on the United Network of Organ Sharing (UNOS) list for transplantation	100%
End-stage renal failure Date of diagnosis is the date that regular hemodialysis or peritoneal dialysis begins	100%
Paralysis Date of diagnosis is the date a physician confirms the paralysis continued for a period of 60 consecutive days	100%
Loss of sight (blindness) Date of diagnosis is the date a physician confirms the loss of sight (blindness) has continued for a period of 90 consecutive days	100%
Loss of speech Date of diagnosis is the date a physician confirms the loss of speech has continued for a period of 90 consecutive days	100%
Loss of hearing Date of diagnosis is the date a physician confirms the loss of hearing has continued for a period of 90 consecutive days	100%
Occupational Human Immunodeficiency Virus (HIV) Date of diagnosis is 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%
Coma	100%
Benign brain tumor	100%

Third-degree burns	100%
Alzheimer's disease	25%
Parkinson's disease	25%
Lupus	25%
Multiple sclerosis	25%
Muscular dystrophy	25%

Additional Critical Illness Conditions

Covered Benefit	% of Face Amount
Acute respiratory distress syndrome	50%

Cancer Benefits

Cancer (invasive), carcinoma in situ or skin cancer must be diagnosed by either pathological diagnosis or clinical diagnosis and additional information from the attending physician and hospital may be required.

If the required diagnosis can only be made post-mortem, the benefit will be paid retroactively beginning with the date of terminal hospital confinement for not less than 45 days before the date of death.

Date of diagnosis means the date the tissue specimen, blood samples or titer(s) are taken upon which an insured person receives diagnosis of cancer (invasive), carcinoma in situ or skin cancer. If the date of diagnosis of two or more cancer diagnoses is the same day, only the diagnosis with the highest benefit will be paid.

Covered Benefit	Benefit Amount
Cancer (invasive)	100%
Carcinoma in Situ (non-invasive)	25%
Skin Cancer Maximum benefit per lifetime	$1,000 1

Additional Plan Benefits

Covered Benefit	Benefit Amount
Health screening	$50
Maximum pay per plan year	1
Covered health screenings include: — Lipoprotein profile (serum plus HDL, LDL and triglycerides) — Skin cancer screening — Doppler screenings for peripheral vascular disease (also known as arteriosclerosis) — Serum protein electrophoresis (blood test for myeloma) — Fasting blood glucose test — Prostate Specific Antigen (PSA) Test — Carotid Doppler Ultrasound — Flexible sigmoidoscopy — Electrocardiogram (EKG, ECG) — Digital rectal exams (DRE) — Echocardiogram (ECHO) — Hemoccult stool analysis — Chest x-ray (CXR) — Colonoscopy — Thermography — Virtual colonoscopy — Ultrasound screening for abdominal aortic aneurysms — Carcinoembryonic Antigen (CEA) — Bone marrow screening — Cancer Antigen (CA) Test 15-3 (breast cancer) — Adult and child immunizations — Mammography — HPV vaccine (Human Papillomavirus) — Breast Ultrasound — Bone mass density measurement (DEXA, DXA) — Cancer Antigen (CA) Test 125 (ovarian cancer) — Pap smears — Cytological Screening — ThinPrep Pap Test — COVID-19 testing	

Exclusions

Benefits 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:

- 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);
- The insured person 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 insured person; except when resulting from a diagnosed disorder in the most current version of the DSM while engaging in an assault, felony, illegal occupation or other criminal act;
- Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection.

MESSA Hospital Indemnity Plans

MESSA's Hospital Indemnity Plan pays benefits when you have a hospital stay due to an illness, injury, surgery or childbirth. The plan pays a lump-sum benefit for admission and a daily benefit for a covered hospital stay. You can use benefits to help pay out-of-pocket medical costs or personal expenses, providing an extra layer of financial protection when you need it.

To be a covered benefit, your stay and other services must be medically necessary and you must have been billed accordingly. The initial day of your stay and other services must be on or after your effective date of coverage and must be given or received in the United States or its territories. Care to prevent illnesses is covered to the same extent as treatment of an illness.

This plan has a shared maximum number of days for all stays. This means that each day of your stay in a hospital, mental disorder treatment facility, rehabilitation unit and substance abuse treatment facility are all counted against the total.

Inpatient Stays

Covered Benefit	Benefit Amounts
Hospital stay – admission Provides a lump sum benefit for the initial day of your stay in a hospital due to an illness, accidental injury or labor and delivery. If you have an accidental injury, you must be admitted to a non-intensive care unit within 180 days of your accident or to an intensive care until within 30 days of your accident for this benefit to be payable. There is a maximum of one stay per plan year.	$1,000
Hospital stay – daily Pays a daily benefit, beginning on day two of your stay in a non-ICU room of a hospital due to an illness, accidental injury or labor and delivery. If you have an accidental injury, your stay must begin within 180 days after your accident. There is a maximum of 30 days per plan year.	$100
Hospital stay – ICU daily Pays a daily benefit, beginning on day two of your stay in an ICU room of a hospital due to an illness, accidental injury or labor and delivery. If you have an accidental injury, your stay must begin within 30 days after your accident. There is a maximum of 30 days per plan year.	$200

Newborn routine care Provides a lump-sum benefit after the birth of your newborn. This will not pay for an outpatient birth. If, after delivery, your newborn has a stay in the hospital for routine post-natal care until the newborn is discharged, then: — The *Newborn routine care* benefit amount is payable once for the duration of the newborn's stay. — The *Hospital stay – admission* and the *Hospital stay – daily* benefit amounts are not payable for the newborn. If, after delivery, your newborn has a stay in the ICU before being discharged from the hospital, then: — The applicable *Hospital stay – admission* and the *Hospital stay – ICU daily* benefit amounts are payable. — The *Newborn routine care* benefit amount is not payable, even if the newborn also had a stay in the hospital nursery before or after the stay in the ICU. If the birth mother is covered under this plan, the benefits and maximums associated with the birth mother's hospital stay are the same as those for an illness and the *Hospital stay – admission (initial day)* and *Hospital stay – daily* benefits would apply.	$100
Observation unit Provides a lump sum benefit for the initial day of your stay in an observation unit as the result of an illness or accidental injury. There is a maximum of one day per plan year. If you have an accidental injury, the initial day of observation must begin within 72 hours after your accident. If your period of observation leads to a hospital stay, then: — The *Observation unit* benefit amount will not be paid. — The applicable *Hospital stay – admission* and *Hospital stay – daily* benefit amounts are payable.	$100
Substance abuse stay – daily Pays a daily benefit for each day you have a stay in a hospital or substance abuse treatment facility for the treatment of substance abuse. There is a maximum of 30 days per plan year.	$100
Mental disorder stay – daily Pays a daily benefit for each day you have a stay in a hospital or mental disorder treatment facility for the treatment of mental disorders. There is a maximum of 30 days per plan year.	$100

Rehabilitation unit stay – daily Pays a benefit each day of your stay in a rehabilitation unit immediately after your hospital stay due to an illness or accidental injury. You must be transferred to the rehabilitation unit within 72 hours after your hospital stay. There is a maximum of 30 days per plan year.	$50

Waiver of Premium

If, as a result of an accidental injury, 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. The premium waiver does not apply to your covered dependents.

Exclusions

Benefits will not be paid for any stay or other service for an illness or accidental injury related to the following:

Activities and contests

- Competitive or recreational activities:
  - Ballooning
  - Boarding (including the use of self-balancing boards or hover boards)
  - Bungee jumping
  - Gliding (including sailplaning or sail gliding, hang gliding, paragliding)
  - Mountaineering using ropes and/or other equipment
  - Parachuting
  - Paramotoring
  - Parasailing or parakiting
  - Parascending
  - Racing a motor-driven vehicle
  - Scuba diving
  - Skydiving
- Any semi-professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment.

Aircraft (pilot and crew member)

Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not. This includes boarding or alighting in any vehicle or device while being used for any test or experimental purposes or while being operated by, for, or under the direction of, any military authority.

Care provided by family members

Care provided by a:

- Spouse
- Parent (including stepparent, mother-in-law and father-in-law)
- Child (including a legally adopted child, foster child, grandchildren, stepchild, son-in-law and daughter-in-law)
- Sibling (including brother, sister, stepbrother, stepsister, brother-in-law or sister-in-law)
- Any household member

Cosmetic services and plastic surgery

Surgery (cosmetic or plastic) to alter, improve or enhance the shape or appearance of the body, even for psychological or emotional reasons, except to the extent needed to:

- Improve the function of a part of the body that is not a tooth or structure that supports the teeth
- Repair of an accidental injury that occurs while you are covered under this Plan

This exclusion does not apply to reconstructive surgery in these events:

- When a necessary mastectomy is performed and:
  - Your surgery reconstructs the affected breast.
  - Your surgery makes a healthy breast look like the reconstructed breast.
- When you have a gross anatomical defect present at birth and:
  - Your surgery corrects a severe facial disfigurement or major functional impairment of a body part.
  - Your surgery improves function.
- When you had an illness that resulted in severe facial disfigurement or major functional

impairment of a body part and your surgery improves function.

Custodial care
Examples are:

- Institutional care. This includes room and board for rest cures, adult day care and convalescent care.
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods.
- Any services that a person without medical or paramedical training can perform or could be trained to perform.

Dental and orthodontic care and treatment

- Routine/general dental care
- Dental conditions or problems related to:
  - Bridges
  - Cavities
  - Crowns
  - Gum care
  - False teeth and dentures
  - Implants
  - Replacement teeth
  - Root canal
  - Wisdom teeth, impacted or not
- Orthodontics

Educational services
Education, training or retraining services or testing. This includes special education, remedial education, job training, and job hardening programs.

Exams
Except as otherwise provided, benefits will not be paid for:

- Routine physical, eye, dental, and hearing exams
- Preventive services and supplies
- Any health exams needed:
  - Because a third party requires the exam. Examples are, exams to get or keep a job, or exams required under a labor agreement or other contract
  - To buy insurance or to get or keep a license
  - To travel
  - To go to a school, camp, or sporting event
  - To join in a sport or other recreational activity

Experimental or investigational
Experimental or investigational drugs, devices, treatments, or procedures.

Family planning services

- A voluntary abortion
- Complications resulting from a voluntary sterilization procedure
- Any follow-up after a voluntary sterilization procedure
- Any contraceptive methods, devices, material or sterilization procedures
- The reversal of voluntary sterilization procedures, including any related follow-up care

Felony and illegal occupation
Any loss to which a contributing cause was your commission of or attempt to commit a felony, or to which a contributing cause was your engagement in an illegal occupation or other willful criminal activity.

Hospice services
Except as otherwise provided, benefits will not be paid for:

- Hospice facility stays
- Hospice care
- Funeral arrangements
- Pastoral counseling

- Financial or legal counseling, including estate planning and the drafting of a will
- Homemaker or caretaker services which are solely related to care received in your home
- Homemaker or caretaker services which are not solely related to your care which include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Infertility

Any care, prescription drugs, and medicines related to:

- In vitro fertilization
- Zygote or gamete intrafallopian transfer
- Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection or ovum microsurgery)

Nutritional supplements

Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition

Outpatient rehabilitation and therapy services

Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason.

Riot, war

If you engage in willful criminal activity, at the level of a misdemeanor or a felony, any illness or accidental injury associated with riot or war will be excluded.

Substance abuse and use

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

- Any accidental injury sustained while you were engaging in an illegal occupation or committing, or attempting to commit, a felony and you were:
- Legally intoxicated or under the influence of alcohol as defined by the jurisdiction in which the accidental injury occurred
- Under the influence of a stimulant, depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by you.

Violation of cellular device use laws

Violating any cellular device use laws, of the state in which the accident occurred, while operating a motor vehicle.

Vision

Vision-related care

Claim Decisions and Appeal Procedures

Note: as used in this section, "us" and "we" refer to Aetna.

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.

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 can give us a written statement of what happened. This statement should include the type and extent of the loss incurred.
Submitting your Claim form and Proof of loss When you have a stay or receive care for your injury, you will be charged. The information you receive for that stay or other service 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 **aetnavoluntaryforms.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 immediately. All benefits are payable to you. If we need additional info, 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 888-772-9682
- 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 888-772-9682. 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 60 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 Michigan Department of Insurance to request an investigation of an appeal.
- File a complaint or appeal with the Michigan 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 888-772-9682, 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.

Administrative Provisions

Note: As used in this section, "us" and "we" refer to Aetna.

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. Also, you are bound by our interpretation of this certificate when we administer your coverage, so long as we use reasonable discretion.

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 60 days after we receive written submission of claim.

No legal action can be brought to recover payment under any benefit after three 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 **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.

Workers' Compensation

The policy is not a Workers' Compensation policy. It does not satisfy any requirement for coverage by Workers' Compensation insurance.

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 two 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.

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 **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 that is directly caused by a sudden, unforeseen trauma and that:

- Is caused by an identifiable event that is definite as to a time and place
- Occurs on or after your effective date of coverage
- Occurs while this certificate is in force
- Is independent of illness

Ambulatory surgical center
A facility specifically licensed as a freestanding ambulatory surgical facility by applicable state and federal laws to provide outpatient surgery services. If state law does not specifically provide for licensure as an ambulatory surgical facility, the facility must meet all Medicare accreditation standards (even if it does not participate in Medicare).

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

Adverse benefit determination (decision)
A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a benefit. Such adverse benefit determination may be based on the insured person's eligibility for coverage or coverage determinations, including plan exclusions.

Alzheimer's disease
A diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, three or more of the activities of daily living.

Appeal
An oral or written request to us to reconsider an adverse benefit determination.

Behavioral health provider
An individual professional who is licensed or certified to provide diagnostic and/or therapeutic services for mental disorders and substance abuse under the laws of the jurisdiction where he or she practices.

Benign brain tumor
Being diagnosed with a brain tumor that is not cancerous. Benign brain tumor does not include:

- Tumors of the skull;
- Pituitary adenomas; or
- Germanomas

Cancer (invasive)
A disease 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.

The following are not cancer (invasive) for purposes of this policy:

- Pre-malignant conditions or conditions with malignant potential;
- Carcinoma in situ;
- Skin cancer

Carcinoma in situ
Means cancer 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 policy.

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

Chiropractic visits
An office visit for the manipulative (adjustive) treatment, or other physical treatment for any condition caused by or related to biomechanical, nerve conduction, or disorders of the spine.

Clinical 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 insured person must be receiving cancer treatment by a physician.

Closed reduction
A manipulative, non-surgical, repair of a fracture or dislocation.

Coma (non-induced)
A continuous state of profound unconsciousness 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.

Coma (induced)
A temporary coma (state of profound unconsciousness) brought on by a controlled dose of medicine administered by a physician at a hospital.

Common carrier
Commercial airlines, train, bus, boat, ferry or ship, subway or streetcar, operated on a regularly scheduled basis between pre-determined ports or cities. Taxis and privately chartered vehicles are not common carriers.

Coronary artery condition requiring bypass surgery
Being diagnosed with 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 bypass graft(s) are performed. This excludes conditions corrected by procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other nonsurgical procedures.

Cosmetic
Services, drugs, or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered dependent
The employee's spouse, civil union partner, or domestic partner, 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.

Critical illness
The insured person is diagnosed as having a heart attack (myocardial infarction), stroke, Coronary artery condition requiring bypass surgery, major organ failure, end stage renal failure, as being in a coma, as having paralysis, occupational HIV, a benign brain tumor, loss of sight (blindness), loss of hearing, loss of speech, third degree burns, Alzheimer's disease, Parkinson's disease, lupus, multiple sclerosis, and muscular dystrophy.

Custodial care
Services and supplies mainly intended to help meet your activities of daily living or other personal needs. Care may be custodial care even if it prescribed by a physician or given by trained medical personnel.

Diagnosis/diagnosed
A physician, specializing in a particular field of medicine, where applicable, has definitively identified your Accidental injury or illness. 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 the policy for the particular accidental injury or illness being diagnosed.

Dislocation
A completely separated joint.

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

Emergency medical condition
A recent and severe medical condition, illness, or accidental injury that would lead a prudent layperson to reasonably believe that the condition, illness, or accidental injury is of a severe nature. And that if immediate care is not received, it could result in:

- Placing your health in serious danger
- Serious loss to bodily function
- Serious loss of function to a body part or organ
- Serious danger to the health of a fetus

Emergency room
A specified area within a hospital that is designated for the emergency care of accidental injuries. This area must:

- Be staffed and equipped to handle trauma;
- Be supervised and provide care by a physician;
- Provide care seven days per week, 24 hours per day.

End-stage renal failure
Irreversible failure of both kidneys requiring an insured person to undergo regular hemodialysis or peritoneal dialysis at least weekly.

Epidural anesthesia
A form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to an accidental injury and does not include epidural steroid injections or treatment for childbirth.

Experimental or investigational
A drug, device, procedure, or treatment that we find is experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or accidental injury involved
- The needed approval by the U.S. Food and Drug Administration (FDA) has not been given for marketing
- A national medical or dental society or regulatory agency has stated in writing that it is experimental or investigational or suitable mainly for research purposes
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services
- Written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Fracture
A break, rupture or crack in a bone that can be diagnosed by X-ray.

Health professional
A person who is licensed, certified or otherwise authorized by law to provide care, such as physicians, podiatrists, chiropractors, nurses, and physical therapists.

Heart attack
The death of a portion of the heart muscle (myocardium) resulting from a blockage of one or more coronary arteries. Diagnosis of a heart attack requires all three of the following criteria:

- Clinical picture of myocardial infarction;
- 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:

- Thallium;
- PECT;
- Stress echo results; or
- Cardiac catheterization.

Home health care agency
An agency licensed, certified or otherwise authorized by applicable laws to provide home health care services such as skilled nursing and other therapeutic services.

Home health care plan
A plan of services prescribed by a physician or other health professional to be provided in your home. The services are usually provided after you're discharged from a hospital or if you are homebound.

Hospice care
Care designed to give supportive care to people in the final phase of a terminal illness focused on comfort and quality of life, rather than cure.

Hospice facility
An institution specifically licensed, certified or otherwise authorized by applicable state and federal laws to provide hospice care.

Hospital
An institution licensed as a hospital or birthing center 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 facilities

Illness
Poor health resulting from disease of the body or mind. Illness includes pregnancy.

Immediate family member
A person who is related to the insured 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), and brother or sister (including stepbrother, stepsister, brother-in-law or sister-in-law).

Intensive care unit (ICU)
Is an area of the hospital that:

- Is for patients who:
  - Are critically ill or injured, and
  - Need intensive, comprehensive observation and care.
- Is separate from:
  - The surgical recovery room

  - Rooms, beds, and wards customarily used for patients not requiring intensive care.
- Is equipped with special lifesaving equipment for the care of the critically ill or injured.
- Is under close observation by specially trained staff assigned exclusively to the ICU on a 24 hour basis.
- Has a physician assigned to the ICU on a full-time basis.

An intensive care unit that meets the definition above may include hospital units with the following names:

- Burn unit
- Coronary care unit or CCU
- Intensive care nursery or ICN
- Intensive care unit or ICU
- Neonatal Intensive care unit or NICU
- Pulmonary care unit or PCU
- Transplant unit

An ICU excludes any type of facility not meeting the definition ICU, including:

- Private monitored rooms
- Surgical recovery rooms
- Observation rooms
- Step down intensive care unit

Laceration
A cut or tear in skin or flesh.

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

Loss of sight (blindness)
Total and irrecoverable loss of sight in both eyes.

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

Lupus
A diagnosis by a physician of systemic lupus erythematosus, indicated by at least four 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.

Lupus does not include discoid lupus or drug-induced lupus.

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 from coming back after it has disappeared following the primary treatment.

Major organ failure
Diagnosis of 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.

Mental disorder
An illness commonly understood to be a mental disorder, whether or not it has a physiological or organic basis, and for which treatment is generally provided by or under the direction of a behavioral health provider such as a psychiatrist, a psychologist or a psychiatric social worker. Mental disorders include disorders related to substance abuse or use.

Mental disorder treatment facility
A licensed institution that:

- Mainly provides a program to diagnose, evaluate, and treat mental disorders
- Is not mainly a school or a custodial, recreational, or training institution
- Provides infirmary-level medical services
- Is staffed and supervised full-time by a psychiatrist who is responsible for patient care
- Has a psychiatrist present during the whole treatment day
- At all times:
  - Provides psychiatric social work and nursing services
  - Provides skilled nursing services by licensed nurses who are supervised by a full-time registered nurse (R.N.)
  - Provides, or arranges with a hospital in the area, for any other required care
  - Maintains a written treatment plan, supervised by a psychiatrist, for each patient based on medical, psychological, and social needs
  - Makes charges

Multiple sclerosis (MS)
A diagnosis by a physician of 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 six months, confirmed by MRI of the nervous system,
- Showing multiple lesions of demyelination; or
- A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Muscular dystrophy
A diagnosis by a physician of one of a group of muscle diseases characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue.

Necessary
Care that we decide a provider using prudent clinical judgment, would give to you to prevent, evaluate, diagnose, or treat an illness or accidental injury or its symptoms, and that we decide are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your illness or accidental injury
- Not primarily for the convenience of the patient, physician, or other provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your illness or accidental injury

Generally accepted standards of medical practice means:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community
- Consistent with the standards set forth in policy issues involving clinical judgment

Observation unit
A specified area or room within a hospital where a patient can be monitored by a physician and which:

- Is under the direct supervision of a physician or registered nurse (R.N.)
- Is staffed by nurses assigned specifically to that unit.
- Provides care seven days per week, 24 hours per day.

Occupational human immunodeficiency virus (HIV)

The presence of HIV or antibodies to the HIV virus 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 the insured person was following his or her normal occupational duties and is reported by the insured person in accordance with the established occupational procedures for such accidents.

The insured person must have undergone a blood test within five days of the accident that indicates the absence of HIV or antibodies to the HIV virus 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 virus.

Occupational injury

An accidental injury that arises out of (or in the course of) any activity in connection with the covered person's employment or self-employment whether or not on a full-time basis or results in any way from an accidental injury that does.

Open reduction

The surgical repair of a fracture or dislocation.

Paralysis

The complete, total and permanent loss of voluntary movement in muscles due to an accidental injury.

- 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

A chronic, progressive neurodegenerative disorder characterized by any combination of four cardinal signs: rest tremor, rigidity, bradykinesia and gait disturbance diagnosed by a physician trained in the diagnosis of Parkinson's disease.

Pathological 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.

Persistent vegetative state (PVS)

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

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, and
- Provides care within the scope of his or her license or certificate

A physician also includes a health professional.

Plan year
The period from January 1 through December 31.

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 Aetna and the policyholder.

Policyholder
Michigan Education Special Services Association and entities associated with it for purpose of coverage under the policy.

Post-traumatic stress disorder (PTSD)
This is a mental health disorder that can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical harm occurred or was threatened. PTSD must meet the criteria in the current Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

Prescriber
Any provider acting within the scope of his or her license, who has the legal authority to write an order for outpatient prescription drugs.

Prescription
A written order for the dispensing of a prescription drug by a prescriber.

Prescription drug
An U.S. Food and Drug Administration approved drug or biological which can only be dispensed by prescription.

Provider
A physician or other health professional, hospital, skilled nursing facility, 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).

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

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

Room and board
A facility's charge for your overnight stay and other services and supplies expressed as a daily or weekly rate.

Second degree burns
Also called partial-thickness burns, means the epidermis (outer layer of skin) has been burned through and part of the dermal (second layer of skin) has been burned by heat, electricity, radiation, friction or chemicals. For the purpose of this plan, second degree burns do not include burns that result from the skins exposure to the sun.

Service dog
Under the Americans with Disabilities Act (ADA), a service dog is any dog individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. The task(s) performed by the dog must be directly related to your disability. Deterring crime and providing emotional support, a sense of well-being, comfort, or companionship do not constitute work or tasks.

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

Skilled nursing facility
A facility specifically licensed as a skilled nursing facility by applicable state and federal laws to provide skilled nursing care.

Skilled nursing facilities also include rehabilitation hospitals, and portions of a rehabilitation hospital and a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions that provide only:

- Ambulatory care
- Custodial care
- Minimal care
- Part-time care services

It does not include institutions that primarily provide for the care and treatment of mental disorders or substance abuse.

Skilled nursing services
Services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) within the scope of his or her license.

Skin Cancer
Melanoma of Clark's Level I or II (Breslow less than .75mm); basal cell carcinoma; or squamous cell carcinoma of the skin.

Stay
A period during which you are confined as an inpatient in a:

- Hospital
- Mental disorder treatment facility
- Rehabilitation unit
- Substance abuse treatment 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
- Newborn routine care
- Any period of such a confinement in a:
  - Hospice facility
  - Skilled nursing facility

Step down intensive care unit
Any of the following units of a hospital:

- A progressive care unit
- A sub-acute intensive care unit
- An intermediate care unit
- An intermediate intensive care step down unit
- A pre- or post-intensive care unit

A step down intensive care unit is not an ICU.

Stroke
An acute or sub-acute cerebral vascular incident producing permanent, neurological impairment and resulting in paralysis or other measurable objective neurological defect persisting for at least 30 days. Diagnosis of a stroke must be 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 does not include transient, ischemic attacks and attacks of vertebrobasilar ischemia.

Substance abuse
A physical or psychological dependency, or both, on a controlled substance or alcohol agent. These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. This term does not include conditions that you cannot attribute to a mental disorder that are a focus of attention or treatment, or an addiction to nicotine products, food, or caffeine.

Substance abuse treatment facility
A licensed institution that:

- Mainly provides a program to diagnose, evaluate, and treat substance abuse
- Maintains a written treatment, supervised by a physician, for each patient based on medical, psychological, and social needs
- Provides, or arranges with a hospital in the area, for any other required care
- Provides, on the premises, at all times:
  - Detoxification services and an effective treatment program
  - Infirmary-level medical services
  - Supervision by a staff of physicians
  - Skilled nursing services by licensed nurses who are supervised by a full-time registered nurse (R.N.)
  - Makes charges

Surgical procedure or surgery
Cutting into the skin or other organ to:

- Implant mechanical or electronic devices
- Make a diagnosis
- Redirect channels
- Remove an obstruction, diseased tissue, or diseased organ(s)
- Repair an area that has been injured or affected by trauma, overuse, or disease
- Repair an area to restore proper function
- Reposition structures to their normal position
- Take a biopsy of tissue
- Transplant tissue or whole organs

Under this plan, these procedures are not a surgical procedure:

- Laceration
- Venipuncture (drawing blood)
- Lumbar puncture
- Epidural steroid injections
- Removal of skin tags
- Foreign body removal from the ear, eye, or other cavity unless cutting of the skin is required
- Episiotomy during routine vaginal delivery
- Endoscopy/colonoscopy without biopsy
- A biopsy of tissue

Telemedicine
A telephone or internet-based consult with a provider through an authorized internet service vendor who conducts telemedicine consultations.

Terminal illness
A medical prognosis that you are not likely to live more than 12 months.

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 covers more than 10% of total body surface and that is caused by heat, electricity, radiation or chemicals.

Urgent Care facility
A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.

Urgent condition
An illness or accidental injury that requires prompt medical attention. An urgent condition is not an emergency medical condition.

Walk-in clinic
A free-standing health care facility that is not an emergency room or the outpatient department of a hospital.

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 **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 Supplemental 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.

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

If Supplemental 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.

1475 Kendale Blvd., P.O. Box 2560 | East Lansing, MI 48826-2560 | 800-336-0013 | TTY: 888-445-5614 | messa.org

Rev. 08/31/23 Pr. 08/23