

BENEFIT SUMMARY



**West Texas Employee Benefit Cooperative
802466**

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

Insurance plans are underwritten by Aetna Life Insurance Company.

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

Face Amounts

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

Plan Features

Critical Illness Conditions

Covered Benefit	Percent of Face Amount (Employee):
Heart Attack (Myocardial Infarction) Pays a benefit when you are diagnosed with a Heart attack (Myocardial Infarction) resulting from a blockage of one or more coronary arteries.	100%
Stroke Pays a benefit when you are diagnosed with a Stroke resulting in paralysis or other measurable objective neurological defect persisting for at least 30 days.	100%
Coronary Artery Condition Requiring Bypass Surgery Pays a benefit when you are diagnosed with a Coronary artery condition requiring bypass surgery.	25%
Major Organ Failure Pays a benefit when you are diagnosed with a Major organ failure of the heart, kidney, liver, lung, or pancreas resulting in the insured person being placed on the UNOS (United Network for Organ Sharing) list for a transplant.	100%

Covered Benefit	Percent of Face Amount (Employee):
End-Stage Renal Failure Pays a benefit when you are diagnosed with End stage renal failure, and the insured person has to undergo regular hemodialysis or peritoneal dialysis at least weekly.	100%
Paralysis Pays a benefit when you are diagnosed with Paralysis, resulting in paraplegia or quadriplegia (complete, total and permanent loss of use of two or more limbs) confirmed by the insured person's attending physician. The paralysis has to continue for a period of 60 consecutive days;	100%
Loss of Sight (Blindness) Pays a benefit when you are diagnosed with Loss of sight (blindness) that is total and irrecoverable loss of sight in both eyes. Loss of sight (blindness), has to continue for a period of 90 consecutive days.	100%
Loss of Speech Pays a benefit when you are diagnosed with Loss of speech that cannot be corrected to any functional degree by any procedure, aid or device. Loss of speech has to continue for a period of 90 consecutive days.	100%
Loss of Hearing Pays a benefit when you are diagnosed with Loss of hearing in both ears that cannot be corrected to any functional degree by any procedure, aid or device. Loss of hearing has to continue for a period of 90 consecutive days.	100%
Occupational HIV Pays a benefit when you are diagnosed with Occupational HIV. The date of a positive antibody test for HIV subsequent to a prior negative test for the same condition with a lapse of between 180 days between the two tests.	100%
Coma Pays a benefit when you are diagnosed with Coma, characterized by the absence of eye opening, verbal response and motor response, and the individual requires intubation for respiratory assistance (a medically induced coms is not covered). The Coma must last for a period of 14 or more consecutive days.	100%
Benign Brain Tumor Pays a benefit when you are diagnosed with a Benign brain tumor by a physician.	100%
Third-Degree Burns Pays a benefit when you are diagnosed with a Third degree burn that covers more than 10% of total body surface (also called full-thickness burn).	100%
Alzheimer's Disease Pays a benefit when you are diagnosed with Alzheimer's disease, diagnosis of the disease by a psychiatrist or neurologist.	25%
Parkinson's Disease Pays a benefit when you are diagnosed with Parkinson's disease by a psychiatrist or neurologist.	25%
Lupus Pays a benefit when you are diagnosed with Lupus by a physician.	25%

Covered Benefit	Percent of Face Amount (Employee):
Multiple Sclerosis Pays a benefit when you are diagnosed with Multiple sclerosis by a physician.	25%
Muscular Dystrophy Pays a benefit when you are diagnosed with Muscular dystrophy by a physician.	25%

Childhood Critical Illness Conditions

Covered Benefit	Percent of Face Amount (Employee):
Cerebral Palsy Pays a benefit when you are diagnosed with Cerebral palsy by a physician. Diagnosis must be made before the insured child reaches the age of 5. Other similar conditions that can be outgrown, are not included in this definition.	100%
Cleft Lip or Cleft Palate Pays a benefit when you are diagnosed with a Cleft Lip or Cleft Palate after live birth by a physician.	100%
Cystic Fibrosis Pays a benefit when you are diagnosed with Cystic fibrosis by a physician. The diagnosis must be confirmed with sweat chloride concentrations greater than 60 mmol/L.	100%
Down Syndrome Pays a benefit when you are diagnosed with Down Syndrome, the first date after live birth and based on the physician's study of the 21st chromosome revealing trisomy 21, translocation, or mosaicism.	100%
Spina Bifida Pays a benefit when you are diagnosed with Spina bifida by a specialist physician and must be associated with neurologic symptoms including motor impairment. Spina bifida does not include spina bifida occulta.	100%

Additional Plan Benefits

Covered Benefit	Percent of Face Amount:
Recurrence Critical Illness Diagnosis Benefit If an insured person has been initially diagnosed with and received a benefit under this plan for a critical illness and then is diagnosed with the same critical illness again at least 180 days later, we will pay the stated percentage of the benefit as shown in the Schedule of Benefits for the recurring critical illness diagnosed. No benefit payable if the recurrence occurs less than 180 days later.	50% after 180 days
Subsequent Critical Illness Diagnosis Benefit Subsequent diagnosis of a different covered Critical Illness is payable at the original amount if it occurs at least 180 days after the previous date of diagnosis for which a benefit was paid. No benefit payable if the subsequent diagnosis occurs less than 180 days later.	100% after 180 days

Critical Illness: Exclusions and Limitations

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

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

1. Suicide or attempt at suicide, intentional self-inflicted injury or sickness, any attempt at intentional self-inflicted injury, injury caused by a self-inflicted act or sickness, while sane or insane; except when resulting from a diagnosed disorder in the most current version of the Diagnostic and Statistical Manual (DSM)
2. Being under the influence of a stimulant (such as amphetamines or pitrates), depressant, hallucinogen, narcotic or any other drug intoxicant, including those prescribed by a physician that are misused by the insured person; except when resulting from a diagnosed disorder in the most current version of the DSM
3. Engaging in an assault, felony, illegal occupation or other criminal act
4. Any act of war, whether declared or not, or voluntary participation in a riot, rebellion or civil insurrection. This exclusion does not apply to the posttraumatic stress disorder (PTSD) benefit.

Portability

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

Questions and Answers about the Critical Illness Plan

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

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

Can I have more than one Critical Illness Plan?

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

What does Face Amount mean?

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

To whom are benefits paid?

Benefits are paid to you, the member.

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

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

How do I submit a claim?

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

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

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

What should I do in case of an emergency?

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

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

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

Important information about your benefits

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

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

Complaints and appeals

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

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

We protect your privacy

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

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

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

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

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

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

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

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

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

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

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

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

Financial Sanctions Exclusions Clause

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

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

