



I've got this

Aetna Fixed Indemnity Plan Helps pay for the costs of everyday medical expenses

Extra benefits when you need them

Do you have security in knowing you have help handling your medical expenses?

You can with the **Aetna Fixed Indemnity Plan**.

Here's how the plan works

When you see an in-network provider, you get the benefit of Aetna discounts for lower out-of-pocket costs. And we pay the provider a fixed dollar amount for your covered services.

Please keep in mind this plan does not pay the full cost of medical care. You are responsible for making sure your doctor gets paid.

However, the plan pays regardless of any other insurance you may have.

¹Johnson, Angela. 76% of Americans are living paycheck-to-paycheck. CNNMoney. June 24, 2013. Available at: money.cnn.com/2013/06/24/pf/emergency-savings. Accessed July 11, 2017.

The Aetna Fixed Benefits Plan is underwritten by Aetna Life Insurance Company (Aetna).

Coverage when it counts

As a society, we aren't always prepared for medical expenses. In fact, fewer than 1 in 4 of us have enough money in our savings accounts to cover at least six months of expenses or a medical emergency.¹

So this plan helps pay the costs associated with common medical expenses like:

- Doctor visits
- Hospital stays
- Prescriptions

The result? You can be healthier, happier and more focused on enjoying life.



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Convenient features

- Guaranteed issue, with no doctor exam
- Freedom to see any licensed doctor
- Discounts for staying in network
- Simple payroll deduction
- Reasonable rates

Our DocFind® online directory helps you locate in-network doctors and medical specialists in your area:

www.aetna.com/dse/custom/avp.

Call your customer service representative for more information.

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

This policy alone does not meet Massachusetts Minimum Creditable Coverage standards.

This plan provides LIMITED BENEFITS. Benefits provided are supplemental and are not intended to cover all medical expenses. This plan pays you fixed dollar amounts regardless of the amount that the provider charges. 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. If the provider participates in your underlying health plan's network, the provider may bill you for the rate the provider has negotiated with the health plan and the Aetna discounted rate cannot be guaranteed. This disclosure provides a very brief description of the important features of the benefits being considered. It is not an insurance contract and only the actual policy provisions will control. **THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

This material is for information only. Health insurance plans contain exclusions and limitations and are subject to United States economic and trade sanctions. Refer to the actual policy and Booklet-Certificate to determine which health care services are covered and to what extent. Providers are independent contractors and are not agents of Aetna. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. 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.

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 and limitations:** All medical or hospital services not specifically covered in, or which are limited or excluded in, the plan documents; cosmetic surgery, including breast reduction; custodial care; infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies, donor egg retrieval and reversal of sterilization; non-medically necessary, and experimental or investigational, services and supplies. No benefit is paid for or in conjunction with the following stays or visits or services: Those received outside the United States; those for education or job training, whether or not given in a facility that also provides medical or psychiatric treatment.

Policy forms issued in Idaho and Oklahoma include: AL VOL HPOL-Hosp; GR-96172, GR-96173.

Policy forms issued in Missouri include: AL VOL HPOL-Hosp 01, GR 96172 01.



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Benefit summary



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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. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. 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.

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.

This policy, alone, does not meet Massachusetts Minimum Creditable Coverage standards.

Aetna will pay benefits only for services provided while coverage is in force, and only for medically necessary, **covered** services. These benefits may be modified where necessary to meet state mandated benefit requirements.

If you or your spouse have a health saving account, please consult your tax advisor before you enroll about whether the Fixed Indemnity plan may affect it.

Here's how the plan can help you:

You can lower your medical expenses by seeing a participating provider in the Aetna Open Choice® PPO network. To locate a participating provider, call toll-free **1-888-772-9682** or visit **www.aetna.com/dse/custom/avp**. If your provider participates in your comprehensive medical plan's network, the medical plan's negotiated rate with that provider applies.

Unless otherwise indicated, all benefits and limitations are per covered person.

Covered benefit for inpatient stays

Unless otherwise stated, all inpatient daily stays begin on day two and count toward the plan year maximum.

Hospital stay — admission

Pays a lump sum benefit for the first day of your stay in a non-ICU room of a hospital. **2nd admission requires 30 day separation** period from the first stay. \$200

Maximum stays per plan year 2

Hospital stay — intensive care unit (ICU) — admission

Pays a lump sum benefit for the initial day of your stay in an ICU room of a hospital. **2nd admission requires 30 day separation** period from the first stay. \$400

Maximum stays per plan year 2

Hospital stay — daily

Pays a daily benefit beginning on day 2 for each day of your stay in a non-ICU room of a hospital. \$200

Maximum days per plan year 365

Hospital stay — ICU daily

Pays a daily benefit beginning on day 2 for each day of your stay in an ICU room of a hospital. \$400

Maximum days per plan year 365

Newborn routine care

Pays a lump sum benefit on the birth of your newborn with an inpatient stay. \$100

Maximum days per plan year 1

Observation unit

Pays a lump sum benefit for the initial day of your observation. \$100

Maximum stays per plan year 1

Substance abuse stay — daily

Pays a daily benefit beginning on day 2 for each day you have a stay in a substance abuse treatment facility. \$200

Maximum days per plan year— shared with the hospital stay benefit max 365

Covered benefit for inpatient stays

Unless otherwise stated, all inpatient daily stays begin on day two and count toward the plan year maximum.

Mental disorder stay — daily

Pays a daily benefit for each day you have a stay in a mental disorder treatment facility. \$200

*Maximum **days** per plan year — shared with the hospital stay benefit max* 365

Rehabilitation unit stay — daily

Pays a daily benefit beginning on day 2 for each day of your stay in a rehabilitation unit immediately after your hospital stay. \$200

*Maximum **days** per plan year — shared with the hospital stay benefit max* 365

Skilled nursing facility stay — daily

Pays a daily benefit beginning on day 2 for each day you have a stay in a skilled nursing facility. \$200

*Maximum **days** per plan year — shared with the hospital stay benefit max* 365

Hospice care — daily

Pays a daily benefit beginning on day 2 for each day you have a stay in a hospice facility or each day you receive hospice care. \$200

*Maximum **days** per plan year — shared with the hospital stay benefit max* 365

Covered benefits for surgery

Inpatient surgery

Pays a daily benefit for each day you have an inpatient surgical procedure during your stay. \$200

*Maximum **days** per plan year* 1

Outpatient surgery — hospital outpatient or ambulatory surgical center

Pays a daily benefit for each day you have an outpatient surgical procedure performed by a physician. \$200

*Maximum **days** per plan year* 1

Outpatient surgery — doctor's office, urgent care facility or hospital emergency room

Pays a daily benefit for each day you have an outpatient surgical procedure performed by a physician. \$25

*Maximum **days** per plan year* 1

Covered benefits for doctor's visits

Doctor visits — office / urgent care facility

Pays a daily benefit for each day you visit a physician.

\$50

*Maximum **days** per plan year*

5

Doctor visits — walk-in-clinic / telemedicine visit

Pays a daily benefit for each day you visit a physician.

\$25

*Maximum **days** per plan year*

5

Prescription drugs

Pays a daily benefit for each day you have a prescription filled by a licensed pharmacist on an outpatient basis.

\$20

*Maximum **days** per plan year*

12

Covered benefits for outpatient services

Ambulance — ground

Pays a daily benefit for when you are transported by a licensed professional ambulance company by a ground ambulance to or from a hospital, or between medical facilities. \$100

Maximum days per plan year 1

Ambulance — air

Pays a daily benefit for when you are transported by a licensed professional ambulance company by Air ambulance to or from a hospital, or between medical facilities. \$500

Maximum days per plan year 1

Emergency room

Pays a daily benefit for each day you receive care in a hospital emergency room for an emergency medical condition. \$100

Maximum days per plan year 2

Equipment and supplies

Pays a daily benefit for each day on which equipment and supplies are purchased and for any associated maintenance and repair. \$20

Maximum days per plan year 5

X-ray and lab

Pays a daily benefit for each day on which you have an X-ray or lab. \$25

Maximum days per plan year 3

Medical imaging

Pays a daily benefit for each day on which you have a covered medical imaging test. \$150

Maximum days per plan year 1

Additional covered benefits

Accidental injury treatment

Pays a benefit when you are treated in a doctor's office, hospital emergency room or walk-in clinic for an accidental injury. \$100

Maximum days per plan year 1

Lodging

Pays for one motel / hotel room for a companion to accompany you for each day of a stay. \$100

Your stay must be more than **50 miles** from your home.

Maximum days per plan year 10

Transportation

Pays a benefit for each day on which you travel from your residence more than **50 miles** one way on doctor's advice. \$100

Maximum days per plan year 1

Prescription drugs

We will pay the prescription drugs benefit amount shown in the schedule of benefits section of your certificate for each day you have a prescription filled. Prescription drugs must be dispensed by a licensed pharmacist on an outpatient basis.

The prescription drugs benefit amount will not be paid for:

- Immunization agents, biological sera, blood or blood plasma
- Any contraceptive method, device, material, or medicine
- Prescription drugs, medicine, or insulin used by, or administered to, you while you are confined as an inpatient to any facility or institution
- Prescription drugs and medicine related to infertility
- Therapeutic devices or appliances

Exclusions and limitations

This plan has exclusions and limitations. Refer to the actual policy and booklet certificate to determine which health care 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. Benefits will not be paid for any service for an illness or accidental injury related to the following:

1. Certain competitive or recreational activities, including but not limited to: ballooning, bungee jumping, parachuting, skydiving
2. Any semi—professional or professional competitive athletic contest, including officiating or coaching, for which you receive any payment
3. Act of war, riot, war
4. Operating, learning to operate or serving as a pilot or crew member of any aircraft, whether motorized or not
5. Assault, felony, illegal occupation, or other criminal act
6. Care provided by a spouse, parent, child, sibling or any other household member
7. Cosmetic services and plastic surgery, with certain exceptions
8. Custodial care
9. Intentional self-harm or suicide, except when resulting from a diagnosed disorder
10. Violating any cellular device use laws of the state in which the accident occurred, while operating a motor vehicle
11. Care or services received outside the United States or its territories
12. Experimental or investigational drugs, devices, treatments, or procedures
13. Education, training or retraining services or testing
14. Accidental injury sustained while intoxicated or under the influence of any drug intoxicant
15. Exams except as specifically provided in the Benefits under your plan section of the certificate
16. Dental and orthodontic care and treatment
17. Family planning services
18. Any care, prescription drugs, and medicines related to infertility
19. Nutritional supplements, including but not limited to: food items, infant formulas, vitamins
20. Outpatient cognitive rehabilitation, physical therapy, occupational therapy, or speech therapy for any reason
21. Vision—related care