



PLAN DESIGN AND BENEFITS - MI PPO SPLIT COPAY 1.2

| PLAN FEATURES | PREFERRED CARE | NON-PREFERRED CARE |
|---|--|--------------------------------------|
| Deductible (per calendar year) | \$500 Individual \$1,000 Family | \$1,000 Individual \$2,000 Family |
| Unless otherwise indicated, the Deductible must be met prior to benefits being payable. All covered expenses accumulate separately towards the Preferred and Non-Preferred Deductibles. Member cost sharing for certain services (including member cost sharing for prescription drugs), as indicated in the plan, are excluded from charges to meet the Deductible. Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year. No one family member may contribute more than the Individual Deductible amount to the Family Deductible. Deductible credit applies. Deductible carryover does not apply. | | |
| Plan Coinsurance * | 100% | 80% |
| Applies to all expenses unless otherwise stated. | | |
| Payment Limit (per calendar year, excludes deductible) | \$0 Individual \$0 Family | \$4,000 Individual \$8,000 Family |
| All covered expenses accumulate separately towards the Preferred and Non-Preferred Payment Limits. Certain member cost-sharing elements may not apply toward the Payment Limit: DME, mental health, alcohol/drug abuse, infertility and prescription drug expenses; Deductibles; copays (including prescription drug copays); amounts over Recognized Charge; and Non-Preferred pre-certification penalty amounts. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year. No one family member may contribute more than the Individual Payment Limit to the Family Payment Limit. | | |
| Lifetime Maximum | \$5,000,000 per member's lifetime. Preferred Care and Non-Preferred Care combined. | |
| Payment for Non-Preferred Care | Not Applicable | Recognized Charge ** |
| Primary Care Physician Selection | Not Applicable | Not Applicable |
| Certification Requirements: Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, and Hospice Care is required. Benefits will be reduced by \$400 per occurrence if Certification is not obtained. | | |
| Referral Requirement | Not Applicable | Not Applicable |
| PHYSICIAN SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Office Visits to Non-Specialist | \$20 Copay; deductible waived | 80% after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury. | | |
| Specialist Office Visits | \$35 Copay; deductible waived | 80% after deductible |
| Primary Care Physician E-Visits | \$20 copay | Not Covered |
| Specialist Physician E-Visits | \$30 Copay | Not Covered |
| An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit vendor. Register at www.relayhealth.com . | | |
| Walk-In Clinics | \$20 copay | 80% after deductible |
| Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor an outpatient department of a hospital, shall be considered a Walk-in Clinic. | | |
| Maternity OB Visits | 100% after deductible | 80% after deductible |
| Surgery (in office) | 100% after deductible | 80% after deductible |
| Allergy Testing / Treatment | Same as Applicable Office Visit Copay (deductible waived). | 80% after deductible |
| Allergy Injections | When office visit is being charged, Allergy Injection/Serum covered as part of the Applicable Office Visit Copay (deductible waived). No serum cost-share. When no office visit is being charged, Allergy Injection/Serum covered at 100% after deductible. | 80% after deductible |



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| PREVENTIVE CARE | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---------------------------|
| Routine Adult Physical Exams/ Immunizations (Limited to 1 exam every 12 months for members age 18 and older.) | \$20 Copay; deductible waived | Not Covered |
| Well Child Exams / Immunizations (Provides coverage for 7 exams in the first 12 months of life; 2 exams in the 13th – 24th months of life; 1 exam per 12 months thereafter up to age 18.) | \$20 Copay; deductible waived | Not Covered |
| Routine Gynecological Care Exams (Direct access to participating OB/GYN providers. Includes pap smear and related lab fees. Limited to one annual exam and pap smear.) | \$20 Copay; deductible waived | Not Covered |
| Routine Mammograms (Limited to one baseline mammogram for covered females age 35-39 years old; and one annual mammogram for covered females age 40 and over. Preferred Care and Non-Preferred Care combined.) | \$35 Copay; deductible waived | 80% after deductible |
| Routine Digital Rectal Exam / Prostate-Specific Antigen Test (For covered males age 40 and over. Frequency schedule applies.) | Member cost sharing is based on the type of service performed and the place rendered. | Not Covered |
| Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies.) | Member cost sharing is based on the type of service performed and the place rendered. | Not Covered |
| Routine Eye Exams at Specialist (Limited to one routine exam per 24 months. No referral required.) | \$35 Copay; deductible waived | Not Covered |
| Routine Hearing Exams Covered only as part of a routine physical exam. | Paid as part of a routine physical exam. | Not Covered |
| DIAGNOSTIC PROCEDURES | PREFERRED CARE | NON-PREFERRED CARE |
| Outpatient Diagnostic Laboratory and X-ray (except for Complex Imaging Services) - (If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.) | \$35 Copay; deductible waived | 80% after deductible |
| Outpatient Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans) | 100% after deductible | 80% after deductible |



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| EMERGENCY MEDICAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
|--|---|--|
| Urgent Care Provider | \$50 Copay; deductible waived | 80% after deductible |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room (Copay waived if admitted.) | \$125 Copay; deductible waived | Paid as Preferred Care |
| Non-Emergency care in Emergency Room | Not Covered | Not Covered |
| Emergency Ambulance | 100% after deductible | Paid as Preferred Care |
| Non-Emergency Ambulance | 100% after deductible | 80% after deductible |
| HOSPITAL CARE | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Coverage Including maternity (prenatal, delivery and postpartum) | 100% after deductible | 80% after \$500 Copay per admission and calendar year deductible |
| Transplants (If transplant is performed through an Institute of Excellence [®] facility, benefits would be paid at the preferred level. If procedure is not performed through Institutes of Excellence [®] facility, benefits would not be covered.) | 100% after deductible, limited to \$1,000,000 maximum benefit per transplant per lifetime | Not Covered |
| Outpatient Surgery (Provided in an outpatient hospital department or a freestanding surgical facility) | 100% after deductible | 80% after \$250 Copay per visit and calendar year deductible |
| Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy | 100% after deductible | 80% after deductible |
| MENTAL HEALTH SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Mental Illness (Limited to 30 days per member per calendar year for Inpatient Mental Illness, Inpatient Detoxification and Inpatient Rehabilitation combined. Preferred Care and Non-Preferred Care combined.) | 50% after deductible | 50% after \$500 Copay per admission and calendar year deductible |
| Outpatient Mental Illness (Limited to 20 visits per member per calendar year. Preferred Care and Non-Preferred Care combined.) | 50% after deductible | 50% after deductible |
| ALCOHOL/DRUG ABUSE SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
| Inpatient Detoxification (Limited to 30 days per member per calendar year for Inpatient Mental Illness, Inpatient Detoxification and Inpatient Rehabilitation combined. Preferred Care and Non-Preferred Care combined.) | 50% after deductible | 50% after \$500 Copay per admission and calendar year deductible |
| Outpatient Detoxification (Limited to \$3,919 maximum benefit per member per calendar year. Preferred Care and Non-Preferred Care combined.) | 50% after deductible | 50% after deductible |



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| ALCOHOL/DRUG ABUSE SERVICES (CONTINUED) | PREFERRED CARE | NON-PREFERRED CARE |
|--|-------------------------------|--|
| Inpatient Rehabilitation (Limited to 30 days per member per calendar year for Inpatient Mental Illness, Inpatient Detoxification and Inpatient Rehabilitation combined. Preferred Care and Non-Preferred Care combined.) | 50% after deductible | 50% after \$500 Copay per admission and calendar year deductible |
| Outpatient Rehabilitation (Limited to \$3,919 maximum benefit per member per calendar year. Preferred Care and Non-Preferred Care combined.) | 50% after deductible | 50% after deductible |
| OTHER SERVICES AND PLAN DETAILS | PREFERRED CARE | NON-PREFERRED CARE |
| Convalescent Facility (Skilled Nursing Facility) (Limited to 30 days per member per calendar year. Preferred Care and Non-Preferred Care combined.) | 100% after deductible | 80% after deductible |
| Home Health Care (Limited to 60 visits per member per calendar year. One visit per day up to four hours per visit. Preferred Care and Non-Preferred Care combined.) | 100% after deductible | 80% after deductible |
| Infusion Therapy (Provided in the home or physician's office) | \$35 Copay; deductible waived | 80% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies. |
| Infusion Therapy (Provided in an outpatient hospital department or freestanding facility) | 100% after deductible | 80% after deductible; Aetna pays up to \$50 per visit after deductible for nursing services and supplies. |
| Inpatient Hospice Care (Limited to \$10,000 maximum benefit per member per lifetime for Inpatient and Outpatient Hospice Care combined. Preferred Care and Non-Preferred Care combined.) | 100% after deductible | 80% after deductible |
| Outpatient Hospice Care (Limited to \$10,000 maximum benefit per member per lifetime for Inpatient and Outpatient Hospice Care combined. Preferred Care and Non-Preferred Care combined.) | 100% after deductible | 80% after deductible |
| Outpatient Short-Term Rehabilitation (Includes speech, physical and occupational therapy. Limited to 60 visits per member per calendar year for speech, physical and occupational therapy combined. Preferred Care and Non-Preferred Care combined.) | \$35 Copay; deductible waived | 80% after deductible |

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| OTHER SERVICES AND PLAN DETAILS (CONTINUED) | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---|
| Spinal Manipulation Therapy (Chiropractic) (Limited to 20 visits per member per calendar year. Preferred Care and Non-Preferred Care combined.) | \$35 Copay; deductible waived | 80% after deductible |
| Durable Medical Equipment | 100% after deductible | 80% after deductible |
| FAMILY PLANNING | PREFERRED CARE | NON-PREFERRED CARE |
| Infertility Treatment (Covered only for the diagnosis and treatment of the underlying medical condition.) | Member cost sharing is based on the type of service performed and the place rendered. | 80% after deductible |
| Voluntary Sterilization (Including tubal ligation and vasectomy.) | Member cost sharing is based on the type of service performed and the place rendered. | 80% after deductible |
| PHARMACY - PRESCRIPTION DRUG BENEFITS | PARTICIPATING PHARMACIES | NON-PARTICIPATING PHARMACIES |
| Retail Up to a 30-day supply | \$15 Copay for generic drugs, \$35 Copay for brand-name formulary drugs, and \$50 Copay for brand-name non-formulary drugs | 80% of submitted cost after \$15 copay for generic drugs, \$35 copay for brand-name formulary drugs, and \$50 copay for brand-name non-formulary drugs |
| Mail Order 31-90 day supply | \$30 Copay for generic drugs, \$70 Copay for brand-name formulary drugs, and \$100 Copay for brand-name non-formulary drugs | Not Covered |
| Specialty CareRx: First prescription for a self-injectable drug must be filled at a participating retail pharmacy or Aetna Specialty Pharmacy [®] . Subsequent fills must be through Aetna Specialty Pharmacy [®] . | | |
| Mandatory Generic with DAW override (MG w/DAW Override) - The member pays the applicable copay and/or coinsurance only if the physician requires brand. If the member requests brand when a generic is available, the member pays the applicable copay and/or coinsurance plus the difference between the generic price and the brand price. | | |
| Plan includes: Diabetic supplies, contraceptive drugs and devices obtainable from a pharmacy. | | |
| Plan excludes: Lifestyle/performance drugs. | | |
| Pre-certification and 90 day Transition of Care (TOC) for Pre-certification included. | | |

* The dollar amount copayments indicate what the member is required to pay and the percentage copayments indicate what Aetna is required to pay.

** Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

What's Not Covered

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents 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, **your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased.**

- (1) All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents;
- (2) Charges related to any eye surgery mainly to correct refractive errors;
- (3) Cosmetic surgery, including breast reduction;
- (4) Custodial care;
- (5) Dental care and x-rays;
- (6) Donor egg retrieval;
- (7) Experimental and investigational procedures;
- (8) Hearing aids;
- (9) Immunizations for travel or work;
- (10) Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents;
- (11) Nonmedically necessary services or supplies;



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- (12) Orthotics;
- (13) Over-the-counter medications and supplies;
- (14) Reversal of sterilization;
- (15) Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, counseling and prescription drugs;
- (16) Special duty nursing; and
- (17) Treatment of those services for or related to treatment of obesity or for diet or weight control.

This material is for informational purposes only and is not an offer or invitation to contract. An application must be completed to obtain coverage. Rates and benefits vary by location. Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

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

Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as pre-certification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member.

Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

Plans are provided by Aetna Life Insurance Company.

For more information about Aetna plans, refer to www.aetna.com. Information is subject to change.