



PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per plan year)	\$1,500	Individual	\$3,000	Individual
	\$3,000	Family	\$6,000	Family

All covered expenses including prescription drugs accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Once family deductible is met, all family members will be considered as having met their deductible for the remainder of the calendar year. There is no individual deductible to satisfy within the family deductible.

Member Coinsurance	10%	30%
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Applies to all expenses unless otherwise stated.

Coinsurance Limit (per plan year)	\$3,000	Individual	\$6,000	Individual
	\$6,000	Family	\$12,000	Family

All covered expenses including deductible and prescription drugs accumulate toward both the preferred and non-preferred Coinsurance Limit.

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. There is no individual payment limit to satisfy within the family payment limit.

Lifetime Maximum	\$3,000,000 per member's lifetime.	\$3,000,000 per member's lifetime.
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All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Lifetime

Primary Care Physician Selection	Not applicable	Not applicable
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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, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.

PREVENTIVE CARE	PREFERRED CARE		NON-PREFERRED CARE	
Routine Adult Physical Exams	100%, deductible waived		Not Covered	

1 exam per calendar year for members age 18 to age 65; 1 exam per calendar year for adults age 65 and older.

Routine Well Child Exams/Immunizations	100%, deductible waived		Not Covered	
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7 exams from birth to 12 months, 6 exams 13 months to 23 months; 2 exams 24 months through 35 months, 2 visits for 36 months through 47 months, 1 per 12 months thereafter to age 18.

Routine Gynecological Care Exams	100%, deductible waived		Not Covered	
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Included Pap smear and related lab fees

Routine Mammograms	100%, deductible waived		Not Covered	
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One per calendar year

Routine Digital Rectal Exam / Prostate-specific Antigen Test	100%, deductible waived		Not Covered	
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For covered males age 40 and over

Colorectal Cancer Screening	100%, deductible waived		Not Covered	
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For all members age 50 and over.

PHYSICIAN SERVICES	PREFERRED CARE		NON-PREFERRED CARE	
Office Visits to Non-Specialist (non-surgical)	35%		35%	

Includes services of an internist, general physician, family practitioner or pediatrician.

Specialist Office Visits (non-surgical)	35%		35%	
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Maternity OB Visits	35%		35%	
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Allergy Testing	35%		35%	
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Allergy Injections	35%		35%	
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DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Diagnostic Laboratory and X-ray	10%	30%
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing		
Diagnostic X-ray for Complex Imaging Services	10%	30%
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	10%	30%
Emergency Room	10%	10%
Ambulance	10%	10%
HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	10%	30%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	10%	30%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Hospital Expenses (including surgery)	10%	30%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	10%	30%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	35%	35%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	10%	30%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	35%	35%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	10%	30%
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	10%	30%
Unlimited visits Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	10%	30%
Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	10%	30%
Up to a maximum benefit of \$5,000 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient	10%	30%
Outpatient Short-Term Rehabilitation	35%	40%
Includes speech, physical, and occupational therapy. Limited to 60 visits per calendar year.		
Massage Therapy (By a licensed massage therapist)	35%	35%
Combined 60 visit maximum with all other Outpatient Short-Term Rehab.		



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Spinal Manipulation Therapy Limited to 24 visits per calendar year	35%	40%
Durable Medical Equipment	35%	35%
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	10%	30%
Transplants	10% Preferred coverage is provided at an IOE contracted facility only	30% Non-Preferred coverage is provided at a Non-IOE facility.
FAMILY PLANNING		
	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Voluntary Sterilization Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY		
	PREFERRED CARE	NON-PREFERRED CARE
The full cost of the drug is applied to the deductible before benefits are considered for payment under the pharmacy plan.		
Retail	Member coinsurance: 10% after the deductible	Not Covered
Mail Order	Member coinsurance: 10% after the deductible	Not Covered
Pharmacy Managed Self Injectables (PMSI) First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®		
No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.		
Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Diabetic supplies. Precert for growth hormones included		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 19 or to age 25 if in school (or an approved dependent as determined by Michigan Tech.)	
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived	



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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 by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; 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;

Nonmedically necessary services or supplies; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. 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. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.