



PLAN DESIGN AND BENEFITS  
 PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	In Network		Out of Network	
<b>Deductible (per plan year)</b>	\$1,000	Individual	\$2,000	Individual
	\$2,000	Family	\$4,000	Family

All covered expenses, excluding penalties and copays, accumulate toward both the preferred and non-preferred Deductible.

Unless otherwise indicated, the Deductible must be met prior to benefits being payable.

Certain member cost sharing elements may not apply toward the Deductible.

Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.

No individual will be responsible for more than the amount of the single deductible in a calendar year.

<b>Member Coinsurance</b>	10%		30%	
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Applies to all expenses unless otherwise stated.

<b>Coinsurance Limit (per plan year)</b>	\$2,200	Individual	\$4,400	Individual
	\$4,400	Family	\$8,800	Family

All covered expenses accumulate toward both the preferred and non-preferred Coinsurance Limit.

Certain member cost sharing elements may not apply toward the Coinsurance Limit.

Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles (except prescription drug copays, emergency room copays and penalty amounts) may be used to satisfy the Coinsurance Limit.

Once Family Coinsurance Limit is met, all family members will be considered as having met their Coinsurance Limit for the remainder of the plan year.

<b>Lifetime Maximum</b>	Unlimited		Unlimited	
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<b>Primary Care Physician Selection</b>	Not applicable		Not applicable	
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**Certification Requirements - NON-PREFERRED CARE**

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.

<b>Referral Requirement</b>	None		None	
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**PREVENTIVE CARE**

	In Network	Out of Network
<b>Routine Adult Physical Exams</b> 1 exam per calendar year for members age 18 and older	Covered 100%; deductible waived	Not Covered

<b>Routine Well Child Exams/Immunizations</b> 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 exam per calendar year thereafter to age 18.	Covered 100%; deductible waived	Not Covered
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<b>Routine Gynecological Care Exams</b> Includes Pap smear and related lab fees, 1 exam per calendar year	Covered 100%; deductible waived	Not Covered
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<b>Routine Mammograms</b> One per calendar year	Covered 100%; deductible waived	Not Covered
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<b>Routine Digital Rectal Exam / Prostate-specific Antigen Test</b> For covered males age 40 and over	Covered 100%; deductible waived	Not Covered
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<b>Colorectal Cancer Screening</b> For all members age 50 and over.	Covered 100%; deductible waived	Not Covered
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**PHYSICIAN SERVICES**

	In Network	Out of Network
<b>Office Visits to Non-Specialist (non-surgical)</b> Includes services of an internist, general physician, family practitioner or pediatrician.	35%, deductible waived	35%; after deductible

<b>Specialist Office Visits (non-surgical)</b>	35%, deductible waived	35%; after deductible
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<b>Maternity OB Visits</b>	35%, deductible waived	35%; after deductible
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<b>Allergy Testing</b>	35%, deductible waived	35%; after deductible
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<b>Allergy Injections</b>	35%, deductible waived	35%; after deductible
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<b>DIAGNOSTIC PROCEDURES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Diagnostic Laboratory and X-ray</b> 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	10%, deductible waived	30%; after deductible
<b>Diagnostic X-ray for Complex Imaging Services</b>	10%, deductible waived	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Urgent Care Provider</b> (benefit availability may vary by location)	\$50 copay; deductible waived	30%; after deductible
<b>Emergency Room</b>	\$75 copay; deductible waived. Copay waived if admitted	\$75 copay; deductible waived. Copay waived if admitted
<b>Ambulance</b>	10%; after deductible	10%; after deductible
<b>HOSPITAL CARE</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10%; after deductible	30%; after deductible
<b>Inpatient Maternity Coverage</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10%; after deductible	30%; after deductible
<b>Outpatient Hospital Expenses</b> (including surgery)	10%; after deductible	30%; after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
<b>MENTAL HEALTH SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10%; after deductible	30%; after deductible
<b>Outpatient</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	35%, deductible waived	35%; after deductible
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10%; after deductible	30%; after deductible
<b>Outpatient</b> The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	35%, deductible waived	35%; after deductible
<b>OTHER SERVICES</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Convalescent Facility</b> Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	10%; after deductible	30%; after deductible
<b>Home Health Care</b> 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.	100%, deductible waived	30%; after deductible
<b>Hospice Care - Inpatient</b> Limited to 30 days per lifetime. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	10%; after deductible	30%; after deductible
<b>Hospice Care - Outpatient</b> Up to a maximum benefit of \$5,000 The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	10%; after deductible	30%; after deductible
<b>Private Duty Nursing - Outpatient</b>	10%; after deductible	30%; after deductible
<b>Outpatient Short-Term Rehabilitation</b> Includes speech, physical, and occupational therapy. Including massage therapy by a licensed massage therapist, including outpatient facility services. Limited to 60 visits per year.	35%, deductible waived	40%; after deductible
<b>Massage Therapy</b> (By a licensed massage therapist) Combined 60 visit maximum with all other Outpatient Short-Term Rehab.	35%, deductible waived	35%, deductible waived
<b>Spinal Manipulation Therapy</b> Limited to 24 visits per calendar year	35%, deductible waived	40%; after deductible
<b>Acupuncture Therapy</b> Limited to 20 visits per calendar year	35%, deductible waived	35%, deductible waived



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<b>Durable Medical Equipment</b> Includes foot orthotics, orthopedic shoes and supportive devices of the feet	35%, deductible waived	35%; after deductible
<b>Diabetic Supplies</b>	35%, deductible waived	35%; after deductible
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b> (includes coverage for contraceptive visits)	35%, deductible waived	35%; after deductible

<b>Transplants</b>	10%; after deductible Preferred coverage is provided at an IOE contracted facility only	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
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<b>FAMILY PLANNING</b>	<b>In Network</b>	<b>Out of Network</b>
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<b>Infertility Treatment</b> 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
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<b>Voluntary Sterilization</b> Including tubal ligation and vasectomy	Member cost sharing is based on the type of service performed and the place	Member cost sharing is based on the type of service performed and the place
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<b>PHARMACY</b>	<b>In Network</b>	<b>Out of Network</b>
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<b>Retail</b> (34 day supply or 100 unit doses whichever is greater)	Generic - 10% copay with \$5 min/\$20 max; Brand - 25% copay with \$10 min/\$40 max	Not Covered
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<b>Mail Order</b> (90 day supply)	2X - Generic - 10% copay with \$10 min/\$40 max; Brand - 25% copay with \$20 min/\$80 max	Not Covered
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**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. Performance Enhancement Drugs

Precert for growth hormones included

**GENERAL PROVISIONS**

<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 (or an approved dependent over age 26 as determined by Michigan Tech.)
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<b>Pre-existing Conditions Exclusion</b>	On effective date: Waived After effective date: waived
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For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you.

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;



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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.