

PLAN DESIGN AND BENEFITS - MI Indemnity Plan 1.2

PLAN FEATURES	COST SHARE
Deductible (per calendar year)	\$500 Individual \$1,000 Family
Unless otherwise indicated, the Deductible must be met prior to benefits being payable. 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 *	80%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year, excludes deductible)	\$1,000 Individual \$2,000 Family
All covered expenses accumulate toward the Payment Limit, however, 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 pre-certification penalty amounts. Once the 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.
Provider Payment	Recognized Charge **
Primary Care Physician Selection	Not Applicable
Certification Requirements- Certification for certain types of 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
PHYSICIAN SERVICES	COST-SHARE
Office Visits to Non-Specialist	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 and in-office surgery.	
Specialist Office Visits	80% after deductible
Primary Care & Specialist Physician E-Visits	80% after deductible
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	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	80% after deductible
Allergy Testing / Treatment	80% after deductible
Allergy Injections	80% after deductible

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PREVENTIVE CARE	COST-SHARE
Routine Adult Physical Exams/ Immunizations (Limited to 1 exam every 12 months for members age 18 and older.)	80% after deductible
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.)	80% after deductible
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.)	80% after deductible
PREVENTIVE CARE (CONTINUED)	COST-SHARE
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.)	80% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test (For covered males age 40 and over. Frequency schedule applies.)	80% after deductible
Colorectal Cancer Screening (For all members age 50 and over. Frequency schedule applies.)	80% after deductible
Routine Eye Exams at Specialist	Not Covered
Routine Hearing Exams at Specialist	Not Covered
DIAGNOSTIC PROCEDURES	COST-SHARE
Outpatient Diagnostic Laboratory and X-ray (except for Complex Imaging Services)	80% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (Includes MRA/MRS, MRI, PET and CAT Scans)	80% after deductible

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EMERGENCY MEDICAL CARE	COST-SHARE
Urgent Care Provider	80% after deductible
Non-Urgent use of Urgent Care Provider	Not Covered
Emergency Room	80% after deductible
Non-Emergency care in an Emergency Room	Not Covered
Emergency Ambulance	80% after deductible
Non-Emergency Ambulance	80% after deductible
HOSPITAL CARE	COST-SHARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum)	80% after deductible
Transplants (Limited to \$1,000,000 maximum benefit per transplant per lifetime.)	80% after deductible
Outpatient Surgery (Provided in an outpatient hospital department or a freestanding surgical facility)	80% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy	80% after deductible
MENTAL HEALTH SERVICES	COST-SHARE
Inpatient Mental Illness (Limited to 30 days per member per calendar year for Inpatient Mental Illness, Inpatient Detoxification and Inpatient Rehabilitation combined.)	50% after deductible
Outpatient Mental Illness (Limited to 20 visits per member per calendar year.)	50% after deductible

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ALCOHOL/DRUG ABUSE SERVICES	COST-SHARE
Inpatient Detoxification (Limited to 30 days per member per calendar year for Inpatient Mental Illness, Inpatient Detoxification and Inpatient Rehabilitation combined.)	50% after deductible
Outpatient Detoxification (Limited to \$4,500 maximum benefit per member per calendar year.)	50% after deductible
Inpatient Rehabilitation (Limited to 30 days per member per calendar year for Inpatient Mental Illness, Inpatient Detoxification and Inpatient Rehabilitation combined.)	50% after deductible
Outpatient Rehabilitation (Limited to \$4,500 maximum benefit per member per calendar year.)	50% after deductible
OTHER SERVICES	COST-SHARE
Convalescent Facility (Skilled Nursing Facility) (Limited to 30 days per member per calendar year.)	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.)	80% after deductible
Infusion Therapy (Provided in the home, physician's office, an outpatient hospital department or freestanding facility)	80% after deductible
Inpatient Hospice Care (Limited to \$10,000 maximum benefit per member per lifetime for Inpatient and Outpatient Hospice Care combined.)	80% after deductible
Outpatient Hospice Care (Limited to \$10,000 maximum benefit per member per lifetime for Inpatient and Outpatient Hospice Care combined.)	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.)	80% after deductible
Spinal Manipulation Therapy (Chiropractic) (Limited to 20 visits per member per calendar year.)	80% after deductible
Durable Medical Equipment	80% after deductible
FAMILY PLANNING	COST-SHARE
Infertility Treatment (Covered only for the diagnosis and treatment of the underlying medical condition.)	80% after deductible
Voluntary Sterilization (Including tubal ligation and vasectomy.)	80% after deductible

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PHARMACY - PRESCRIPTION DRUG BENEFITS	COST-SHARE
Retail Up to a 30-day supply	Participating Pharmacies: \$15 Copay for generic drugs, \$35 Copay for brand-name formulary drugs, and \$50 Copay for brand-name non-formulary drugs Non-Participating Pharmacies: 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	Participating Pharmacies: \$30 Copay for generic drugs, \$70 Copay for brand-name formulary drugs, and \$100 Copay for brand-name non-formulary drugs Non-Participating Pharmacies: 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: contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies 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 care is determined based upon the lowest of: the provider's usual charge for furnishing it; or the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made. These charges are referred to in your plan as "reasonable" or "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.**

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- (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;
- (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). Member is responsible for obtaining precertification for certain services. 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 precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Aetna receives rebates from drug

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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.