

# Michigan 7500 Deductible Plan with Unlimited Primary Care Visits, Generic Pharmacy

Aetna Advantage Plan PPO 7500 with  
Unlimited Primary Care Visits

MEMBER BENEFITS	In-Network	Out-of-Network <sup>+</sup>
<b>Deductible</b> Individual Family	\$7,500 \$15,000	\$10,000 \$20,000
<b>Coinsurance</b> (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	\$0 once out-of-pocket max. is satisfied	
<b>Coinsurance Maximum</b> Individual Family	\$2,500 \$5,000	\$2,500 \$5,000
<b>Out-of-Pocket Maximum</b> Individual Family	\$10,000 \$20,000	\$12,500 \$25,000
	Includes deductible	
<b>Lifetime Maximum* per insured</b>	\$5,000,000	
<b>Non-Specialist Office Visit</b> Unlimited visits General Physician, Family Practitioner, Pediatrician or Internist	\$30 copay deductible waived	50% after deductible
<b>Specialist Visit</b> Unlimited visits	20% after deductible	50% after deductible
<b>Hospital Admission</b>	20% after deductible	50% after deductible
<b>Outpatient Surgery</b>	20% after deductible	50% after deductible
<b>Urgent Care Facility</b>	\$50 copay deductible waived	50% after deductible
<b>Emergency Room</b>	\$150 copay** (waived if admitted) after deductible	
<b>Annual Routine Gyn Exam</b> No waiting period, no calendar year max. Annual Pap/Mammogram	\$0 copay deductible waived	50% after deductible
<b>Maternity</b>	Not covered (except for pregnancy complications)	
<b>Preventive Health — Routine Physical</b> Aetna will pay up to \$200 per exam*	\$30 copay deductible waived	50% after deductible
	Includes lab and X-rays	
<b>Lab/X-Ray</b>	20% after deductible	50% after deductible
<b>Skilled Nursing</b> — in lieu of hospital 30 days per calendar year*	20% after deductible	50% after deductible
<b>Physical/Occupational Therapy and Chiropractic Care</b> 24 visits per calendar year*	20% after deductible	50% after deductible
	Aetna will pay up to \$25 per visit max.	
<b>Home Health Care</b> — in lieu of hospital 30 visits per calendar year*	20% after deductible	50% after deductible
<b>Durable Medical Equipment</b> Aetna will pay up to \$2,000 per calendar year*	20% after deductible	50% after deductible
<b>PHARMACY</b>		
<b>Pharmacy Deductible</b> per individual	N/A	N/A
<b>Generic</b> Oral Contraceptives Included	\$15 copay deductible waived	\$15 copay plus 50% deductible waived
<b>Preferred Brand</b> Oral Contraceptives Included	Not Covered Aetna Discount Applies	Not covered
<b>Non-Preferred Brand</b> Oral Contraceptives Included	Not Covered Aetna Discount Applies	Not covered
<b>Calendar Year Maximum</b> per individual	Unlimited	Unlimited

This material is for information only and is not an offer or invitation to contract. Health insurance plans contain exclusions and limitations. Information subject to change.

**Aetna Advantage Plans for individual, families and the self employed are underwritten by Aetna Life Insurance Company (Aetna) directly and/or through an out of state blanket trust.**

In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. These plans are medically underwritten and you may be declined coverage in accordance with your health condition.

\* Maximum applies to combined in and out-of-network benefits.

\*\* Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

+ Payment for out-of-network facility covered expenses is determined based on Aetna's Market Fee Schedule. Payment for out-of-network non-facility covered expenses is determined based on the negotiated charge that would apply if such services were received from a Network Provider.

**Access to negotiated discounts: members are eligible to receive non-covered services, including cosmetic services such as tooth whitening, at the PPO negotiated rate when visiting a participating PPO dentist at any time.**

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Above list of covered services is representative. A summary of exclusions is listed in the brochure you received in your enrollment kit. For a full list of benefit coverage and exclusions refer to the plan documents.



## MICHIGAN AETNA ADVANTAGE PLAN OPTIONS

Individual Dental PPO Max		
	Preferred	Nonpreferred
<b>Annual Deductible per Member</b> (does not apply to Diagnostic and Preventive Services)	\$25 \$75 family maximum	\$25 \$75 family maximum
Annual maximum benefit	Unlimited	Unlimited
<b>Diagnostic Services</b>		
<b>Oral Exams</b>		
Periodic oral exam	100% deductible waived	50% deductible waived
Comprehensive oral exam	100% deductible waived	50% deductible waived
Problem-focused oral exam	100% deductible waived	50% deductible waived
<b>X-rays</b>		
Bitewing - single film	100% deductible waived	50% deductible waived
Complete series	100% deductible waived	50% deductible waived
<b>Preventive Services</b>		
Adult Cleaning	100% deductible waived	50% deductible waived
Child Cleaning	100% deductible waived	50% deductible waived
Sealants - per tooth	Discount	Not covered
Flouride Application - with cleaning	100% deductible waived	50% deductible waived
Space Maintainers	Discount	Not covered
<b>Basic Services</b>		
Amalgam Filling - 2 surfaces	100% after deductible	50% after deductible
Resin filling - 2 surfaces anterior	Discount	Not covered
<b>Oral Surgery</b>		
Extraction-exposed root or erupted tooth	Discount	Not covered
Extraction of impacted tooth - soft tissue	Discount	Not covered
<b>Major Services</b>		
Complete upper denture	Discount	Not covered
Partial Upper Denture (resin base)	Discount	Not covered
Crown - porcelain with noble metal	Discount	Not covered
Pontic - porcelain with noble metal	Discount	Not covered
Inlay - metallic (3 or more surfaces)	Discount	Not covered
<b>Oral Surgery</b>		
Removal of impacted tooth-partially bony	Discount	Not covered
<b>Endodontic Services</b>		
Bicuspid root canal therapy	Discount	Not covered
Molar root canal therapy	Discount	Not covered
<b>Periodontic Services</b>		
Scaling & Root planing - per quadrant	Discount	Not covered
Osseous surgery - per quadrant	Discount	Not covered
<b>Orthodontic Services</b>		
	Discount	Not covered

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Dental insurance plans contain exclusions and limitations. Plans may be subject to restrictions.

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This list of covered services is representative. For a full list of benefit coverage and exclusions refer to the plan documents.

All products not available in all counties. Please refer to the county list located in the Aetna Advantage brochure.

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