THE MITRE CORPORATION AETNA HMO

Effective Date: 01-01-2017
Aetna Select[SM] - ASC
(Note on the Aetna website, choose Select Open Access under the Aetna Open Access plans)

Administered by Aetna (Medical) and CVS Caremark (Prescription Drugs)

PLAN FEATURES	MEMBER COST	
Annual Medical Deductible	None	
Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	
Annual Medical Out-of-Pocket Limit	$1,500	Employee
	$3,000	Employee + 1 Dependent
	$3,000	Family
Annual Prescription Drug Out-of-Pocket Limit	$1,500	Employee
	$2,000	Employee +1 Dependent
	$3,000	Family

All covered expenses may be used to satisfy the Out-of-Pocket Limits. ***Note the out-of-pocket limits are not integrated*.** Once the Family Out-of-Pocket limit is met, all family members will be considered as having met their Out-of-Pocket limit for the remainder of the calendar year.

Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**MEMBER COST**
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year for members age 18 and older	Covered 100%, no copay
Routine Well Child Exams/Immunizations	Covered 100%, no copay
7 exams in first 12 months of life, 3 exams in 13th-24th months; 3 exams in 25th to 36th months; 1 exam per 12 months thereafter to age 18	
Routine Gynecological Care Exams 1 exam per calendar year. Includes routine tests and related lab fees	Covered 100%, no copay
Routine Mammograms One baseline covered from age 35 to 40, then annual exam covered females age 40 and over.	Covered 100%, no copay
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over. 1 per calendar year	Covered 100%, no copay
Colorectal Cancer Screening For all members age 50 and over. 1 exam every 10 years.	Covered 100%, no copay
Routine Eye Exams 1 routine exam per 24 months	Covered 100%, no copay
Routine Hearing Exams 1 routine exam per 24 months	Covered 100%, no copay
Hearing Aids	Covered 100%, no copay
PHYSICIAN SERVICES	**MEMBER COST**
Office Visits to Primary Physician Includes services of an internist, general physician, family practitioner or pediatrician.	$20 copay per visit
Minute Clinic services	$10 copay per visit
Specialist Office Visits	$30 copay per visit
Allergy Testing	$30 copay per visit
Allergy Injections	Covered 100%

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DIAGNOSTIC PROCEDURES	MEMBER COST
Diagnostic Laboratory and X-ray	Covered 100%
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	
Complex Imaging Tests (outpatient)	$100 copay per procedure
EMERGENCY MEDICAL CARE	**MEMBER COST**
Urgent Care Provider (benefit availability may vary by location)	$20 copay per visit
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$150 copay per visit
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%
HOSPITAL CARE	**MEMBER COST**
Inpatient Coverage	$200 copay per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Inpatient Maternity Coverage	$200 copay per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient Surgery (hospital setting)	$100 copay per procedure
Outpatient Hospital Expenses (excluding surgery)	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
MENTAL HEALTH SERVICES	**MEMBER COST**
Inpatient	$200 copay per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	$20 copay per visit
ALCOHOL/DRUG ABUSE SERVICES	**MEMBER COST**
Inpatient	$200 copay per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	$20 copay per visit
OTHER SERVICES	**MEMBER COST**
Skilled Nursing Facility	$200 copay per confinement
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	Covered 100%
Limited to 40 visits per calendar year. 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	$200 copay per confinement
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	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
Outpatient Short-Term Rehabilitation	$30 copay per visit
Occupational and Physical Therapy limited to 40 visits combined per calendar year. Speech Therapy limited to 30 visits per calendar year.	
Durable Medical Equipment	Covered 100%
Diabetic Supplies	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100% (payable as any other covered expense)
Transplants Coverage is provided at an IOE contracted facility only.	$200 copay per confinement

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Bariatric	$200 copay per confinement
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Acupuncture Limited to 30 visits per year.	$30 copay per visit
Spinal Manipulation Therapy Limited to 30 visits per year	$30 copay per visit
FAMILY PLANNING - Limited to $40,000 per lifetime ($25,000 medical/$15,000 prescription drugs)	**MEMBER COST**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Covered 100%
Coverage includes Artificial Insemination and Ovulation Induction.	
Advanced Reproductive Technology (ART)	Covered 100%
ART coverage includes: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	
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
Prescription Drugs (administered by CVS Caremark)	**MEMBER COST**
Retail - up to a 30 day supply	Generic - $5 copay Formulary brand - $30 copay Non-Formulary brand - $50 copay
Maintenance Choice/Mail Order - up to a 90 day supply	Generic - $10 copay Formulary brand - $60 copay Non-Formulary brand - $100 copay
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26.
Fitness Reimbursement	$200

GENERAL EXCLUSIONS

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.

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; Nonmedically necessary services or supplies; Over-the-counter medications and supplies; Reversal of sterilization; 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 MITRE Health Plan documents to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

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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.

While this information is believed to be accurate as of the print date, it is subject to change.