THE MITRE CORPORATION
Aetna PPO High Deductible Plan with a Health Saving Account (HSA)

Effective Date: 01-01-2017

(Note on the Aetna website, choose Aetna Choice POSII (Aetna Health Fund) under the Aetna Health Fund Plans)

Administered by Aetna (Medical), CVS Caremark (Prescription Drugs) and WageWorks (HSA)

PLAN FEATURES	IN-NETWORK		OUT-OF-NETWORK	
Annual Deductible	$1,500	Employee	$3,000	Employee
	$3,000	Employee + 1 Dependent	$6,000	Employee + 1 Dependent
	$3,000	Family	$6,000	Family
All covered medical and prescription drug expenses accumulate toward the In-network and Out-of-Network 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	20%		40%	
Applies to all expenses unless otherwise stated.				
Annual Out-of-Pocket Limit	$3,500	Employee	$7,000	Employee
	$7,000	Employee + 1 Dependent	$14,000	Employee + 1 Dependent
	$7,000	Family	$14,000	Family
All covered medical and prescription drug expenses including deductible, coinsurance accumulate toward the In-network and Out-of-Network Out-of-Pocket Limits. The plan has an embedded out-of-pocket maximum. Once a member covered under the family plan reaches the individual out-of-pocket limit, all covered expenses for that member must be reimbursed at 100%.				
Primary Care Physician Selection	Optional		Not applicable	
Referral Requirement	None		None	
MITRE HSA contribution	$600	Employee		
	$1,200	Employee + 1 Dependent		
	$1,200	Family		

PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK (based on usual and customary)
Routine Adult Physical Exams/ Immunizations	Covered 100%; no deductible	Not covered
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; no deductible	Not covered
7 exams in the first 12 months of life, 3 exams in the 13th-24th months of life, 3 exams in the 25th-36th months of life; 1 exam per 12 months thereafter to age 18.		
Routine Gynecological Care Exams	Covered 100%; no deductible	Not covered
1 exam per calendar year. Includes routine tests and related lab fees		
Routine Mammograms	Covered 100%; no deductible	Not covered
1 Baseline Mammogram for women 35-39, covered annually for covered females age 40 and over.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; no deductible	Not covered
For covered males age 40 and over	1 per calendar year.	
Colorectal Cancer Screening	Covered 100%; no deductible	Not covered
For all members age 50 and over.	1 exam every 10 years.	
Routine Eye Exams	Covered 100%; no deductible	Not covered
1 routine exam per 24 consecutive months		
Routine Hearing Exams	Covered 100%; no deductible	Not covered
1 routine exam per 24 months		
Hearing Aids	Covered 100%; no deductible	Covered 100%; no deductible

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PHYSICIAN SERVICES	IN-NETWORK	OUT-OF-NETWORK (based on usual and customary)
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	20% after deductible	40% after deductible
Specialist Office Visits	20% after deductible	40% after deductible
Allergy Testing	20% after deductible	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK (based on usual and customary)**
Diagnostic Laboratory and X-ray 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	20% after deductible	40% after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK (based on usual and customary)**
Urgent Care Provider (benefit availability may vary by location)	20% after deductible	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20% after deductible	Same as preferred care; after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%; after deductible	Covered 100%; after deductible
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK (based on usual and customary)**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK (based on usual and customary)**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK (based on usual and customary)**
Inpatient Limited to 30 days per calendar year.	20% after deductible	40% after deductible
Outpatient Limited to 20 visits per calendar year.	20% after deductible	40% after deductible

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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK (based on usual and customary)
Skilled Nursing Facility Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Home Health Care Limited to 40 visits per calendar year.	20% after deductible	40% after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	20% after deductible	40% after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	20% after deductible	40% after deductible
Outpatient Short-Term Rehabilitation Physical, and Occupational Therapy, limited to 40 visits per calendar year. Speech Therapy limit is 30 visits per year.	20% after deductible	40% after deductible
Spinal Manipulation Therapy Limited to 30 visits per calendar year	20% after deductible	40% after deductible
Durable Medical Equipment Includes Foot Orthotics.	20% after deductible	40% after deductible
Diabetic Supplies	20% after deductible	40% after deductible
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	100%, no deductible	40% (payable as any other covered expense) after deductible
Transplants	20% Preferred coverage is provided at an IOE contracted facility only; after deductible	No coverage for transplants at a non-IOE facility.
Bariatric Must meet clinical criteria. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after deductible	Not Covered
Mouth, Jaws and Teeth (oral surgery procedures, when medical in nature)	20% after deductible	40% after deductible
Acupuncture. Limited to 30 visits per year.	20% after deductible	40% after deductible
FAMILY PLANNING Limited to $15,000 per lifetime ($10,000 medical/$5,000 prescription drugs)	**IN-NETWORK**	**OUT-OF-NETWORK (based on usual and customary)**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	20% after deductible	40% after deductible
Comprehensive Infertility Services Coverage includes Artificial Insemination and Ovulation Induction. Lifetime maximum applies to all covered procedures except where prohibited by law.	20% after deductible	40% after deductible
Advanced Reproductive Technology (ART) 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. Lifetime maximum applies to all covered procedures except where prohibited by law.	20% after deductible	40% after deductible
Voluntary Sterilization	20% after deductible	40% after deductible

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Prescription Drugs (administered by CVS Caremark)	**IN-NETWORK**	**OUT-OF-NETWORK**
Retail - Preventive (no deductible) (up to a 30 day supply)	Generic - $5 copay Formulary Brand - 20% ($50 max) Non-Formulary Brand - 40% ($100 max)	40% of prescription cost
Retail - Non-Preventive (subject to deductible - except **generics**) (up to a 30 day supply)	Generic - $5 copay Formulary Brand - 20% ($50 max) Non-Formulary Brand - 40% ($100 max)	40% of prescription cost
Maintenance Choice/Mail Order - Preventive (no deductible) (up to a 90 day supply)	Generic - $10 copay Formulary Brand - 20% ($75 max) Non-Formulary Brand - 40% ($150 max)	Not applicable
Maintenance Choice/Mail Order - Non-Preventive (subject to deductible - except **generics**) (up to a 90 day supply)	Generic - $10 copay Formulary Brand - 20% ($75 max) Non-Formulary Brand - 40% ($150 max)	Not applicable
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

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.

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