# Aetna/Innovation Health - Your Plan at a Glance 2019

## Summary of Medical Benefits

This chart summarizes the benefits available under the Aetna/ Innovation Health Preferred Provider Plan, Open POS II medical plan:

| **Plan Feature** | **In-Network**<br>You Pay | **Out-of-Network**<br>You Pay |
|---|---|---|
| **Annual Deductible** | | |
| Individual | $250 per calendar year | $500 per calendar year |
| Family | $500 per calendar year | $1,000 per calendar year |
| **Out-of-Pocket Maximum** (includes deductible, coinsurance copays) | | |
| Individual | $2,000 per calendar year | $4,000 per calendar year |
| Family | $4,000 per calendar year | $8,000 per calendar year |

| **Covered Services** | **In-Network*** <br>You Pay | **Out-of-Network**** <br>You Pay |
|---|---|---|
| **Preventive Care *** ** | | |
| Routine Physical Exam (office visit)<br>• 1 exam per calendar year for adults and children age 18 and over | Covered in full | 40% coinsurance after you meet the deductible |
| Well Child Visits<br>• 1st 12 months: 7 exams<br>• 13-24 months: 3 exams<br>• 25-36 months: 3 exams<br>• 3-18 years: 1 exam per calendar year | Covered in full | 40% coinsurance after you meet the deductible |
| Preventive Screening and Counseling<br>• Obesity Counseling<br>— up to age 22: unlimited visits<br>— age 22 and over: up to 26 visits per calendar year (healthy diet counseling limited to 10 visits per year) | Covered in full | 40% coinsurance after you meet the deductible |
| • Tobacco Use Preventive Counseling: up to 8 counseling sessions per calendar year | Covered in full | 40% coinsurance after you meet the deductible |

*****For in-network services, Plan payment will not exceed the negotiated charge.
******For out-of-network charges, Plan payment is generally 60% of the recognized charge.
*** Please refer to **https://www.hhs.gov/healthcare/about-the-law/index.html#CoveredPreventiveServicesforAdults** for a full list of preventive services.

| **Covered Services** | **In-Network*** You Pay | **Out-of-Network**** You Pay |
|---|---|---|
| Alcohol/Drug Abuse Counseling: up to 5 visits per calendar year *(Also see the Behavioral Health Care section for additional benefits)* | Covered in full | 40% coinsurance after you meet the deductible |
| Female Contraceptive Counseling<br><br>Contraceptive Counseling Services - Maximum Visits either in a group or individual setting<br><br>*Important Note: **Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the** *Physician Services* **office visit section of the** *Schedule of Benefits.* | Covered in full.<br><br>2* visits per 12 months | 40% coinsurance after you meet the deductible<br>2* visits per 12 months |
| Contraceptive devices and injectables provided and billed by your physician *(includes insertion/administration)*<br>• Generic devices/injectables and devices with no generic equivalent<br>• Brand-name | Covered in full<br><br>$20 copay after you meet the deductible | 40% coinsurance after you meet the deductible<br><br>40% coinsurance after you meet the deductible |
| Routine Prostate Screening | Covered in full | 40% coinsurance after you meet the deductible |
| Routine Colorectal Cancer Screening *(for those age 50 and over)*<br>• sigmoidoscopy: 1 every 5 years<br>• colonoscopy: 1 every 10 years | Covered in full | 40% coinsurance after you meet the deductible |
| Routine Annual Ob/Gyn Exam *(includes one Pap smear and related lab fees)*<br>• 1 exam per calendar year | Covered in full | 40% coinsurance after you meet the deductible |
| Routine Mammogram | Covered in full | 40% coinsurance after you meet the deductible |
| Routine Lung Cancer Screening<br>• 1 screening per calendar year, beginning at age 55 | Covered in full | 40% coinsurance after you meet the deductible |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| Covered Services | In-Network*<br>You Pay | Out-of-Network**<br>You Pay |
|---|---|---|
| **Vision and Hearing** | | |
| Routine Vision Exams | Covered by the Aetna Vision Preferred Plan. Refer to the Summary of Aetna Vison Preferred℠ Benefits for more information | |
| Routine Hearing Exams | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| Hearing Aids<br>• Hearing aid evaluation<br>• Hearing aids *(covered only when needed as a result of accidental injury)* | $20 copay per visit after you meet the deductible<br>If covered, 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible<br>If covered, 40% coinsurance after you meet the deductible |
| **Outpatient Care** | | |
| Office Visit: Primary Care Physician | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| Office Visit: Specialist | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| Allergy Testing | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| Allergy Injections/Treatment *(including serum)* | $20 copay per visit after you meet the deductible Covered in full after deductible for injections if no office visit is billed. | 40% coinsurance after you meet the deductible |
| Outpatient Prescription Drugs (*non-self-injectable medications only)* | Drug: 10% coinsurance after you meet the deductible if shipped to home address. Covered in full after the deductible when medication is shipped for administration at your physician's office.<br>.<br>Administration: $20 copay per visit after you meet the deductible for injection in your physician's office. | Drug: These injectable drugs must be purchased through Aetna Specialty Pharmacy<br>Administration: 40% coinsurance after you meet the deductible for injection in your physician's office. |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| Covered Services | In-Network*<br>You Pay | Out-of-Network**<br>You Pay |
|---|---|---|
| **Family Planning and Maternity** | | |
| Maternity Care | | |
| Routine prenatal and postnatal office visits, | Covered in full | 40% coinsurance after you meet the deductible |
| Delivery | After you meet the deductible, $150 per confinement copay, then 10% coinsurance | After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance |
| Lactation Support Services<br>*(services available during pregnancy or post-partum)*<br>• Up to 6* visits for lactation counseling services per 12 months<br>* **Important Note**: Additional visits are covered as physician's office visits, subject to the applicable deductible, coinsurance and/or copay | Covered in full | 40% coinsurance after you meet the deductible |
| Voluntary Sterilization | | |
| • physician's office | $20 copay per visit after you meet the deductible (member deductible and copay waived for tubal ligation) | 40% coinsurance after you meet the deductible |
| • outpatient facility | 10% coinsurance after you meet the deductible (member deductible and coinsurance waived for tubal ligation) | 40% coinsurance after you meet the deductible |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| **Covered Services** | **In-Network*** You Pay | **Out-of-Network**** You Pay |
|---|---|---|
| Infertility Services<br>If eligible, covered services include:<br>• diagnosis and treatment of the underlying cause of infertility<br>• advanced reproductive technologies | | |
| • physician's office | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| • outpatient facility | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| Note: Infertility services are subject to a $100,000 lifetime maximum across all FCPS self-insured plans. Refer to Aetna's Clinical Policy Bulletin for more information on covered services. | | |
| **Hospital Care** | | |
| Inpatient Facility Copay | $150 per confinement | $150 per confinement |
| Inpatient Care<br>*(room and board are covered up to the hospital's semi-private room rate; also includes physician services and anesthesiologist)* | After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance | After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance |
| Outpatient Care | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| **Outpatient Surgery** | | |
| Outpatient Surgery | | |
| • physician's office | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| • outpatient facility or freestanding surgical center | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| Covered Services | In-Network*<br>You Pay | Out-of-Network**<br>You Pay |
|---|---|---|
| **Alternatives to Inpatient Hospital Care** | | |
| Skilled Nursing Facility Care<br>• up to a maximum of 120 days per confinement<br>• Inpatient rehabilitation up to a maximum of 90 days per confinement. Requires Utilization Management approval. | After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance. Copay waived if you transfer directly from covered inpatient care in another facility. | After you meet the deductible, you pay $150 copay per confinement copay, then 40% coinsurance. Copay waived if you transfer directly from covered inpatient care in another facility. |
| Home Health Care<br>• up to 90 visits per calendar year | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| Private Duty Nursing<br>• up to 360 8-hour shifts per calendar year | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| Hospice Care | Inpatient: After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance.<br><br>Alternative settings: 10% coinsurance after you meet the deductible. | Inpatient: After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance<br><br>Alternative settings: 40% coinsurance after you meet the deductible |
| **Emergency Care** | | |
| Emergency Room<br>• emergency care | $150 copay per visit, then 10% coinsurance for all services after you meet the deductible. Copay waived if admitted | $150 copay per visit, then 10% coinsurance for all services after you meet the deductible. Copay waived if admitted |
| • non-emergency care | Not covered | Not covered |
| Urgent Care<br>• Urgent Care Center | 10% coinsurance after you meet the deductible | 10% coinsurance after you meet the deductible |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| **Covered Services** | **In-Network*** You Pay | **Out-of-Network**** You Pay |
|---|---|---|
| Telemedicine (Teladoc) | $20 copay per session after you meet the deductible | Covered through Teladoc only. |
| Walk-In Clinic | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| Ambulance | | |
| • emergency use/medically necessary transport | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| • non-clinical/not medically necessary use | Not covered | Not covered |
| **Other Covered Expenses** | | |
| Complex Imaging *(includes MRI, PET scan, and CT scan)* | $75 copay after you meet the deductible | 40% after you meet the deductible |
| Diagnostic X-Ray and Lab Tests | | |
| • billed with physician's office visit | Included with office visit copayment (deductible applies) | 40% coinsurance after you meet the deductible |
| • outpatient hospital or freestanding facility | Covered in full after you meet the deductible | 40% after you meet the deductible |
| Durable Medical Equipment | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| Short-Term Rehabilitation *(physical, occupational, speech)* Up to 90 visits per calendar year for physical therapy; up to 90 visits per year for occupational therapy; up to 90 visits per year for speech therapy. (Aetna will review periodically to determine appropriateness.) | | |
| • office visit | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| • Outpatient hospital or outpatient facility | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| Chiropractic Care (Aetna will review periodically to determine appropriateness.) | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| **Covered Services** | **In-Network*** You Pay | **Out-of-Network**** You Pay |
|---|---|---|
| **Behavioral Health Care** (precertification may be required – please refer to the Precertification section) | | |
| Mental Health Treatment | | |
| • Inpatient | After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance. | After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance. |
| • outpatient visit | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| • outpatient facility | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |
| Substance Abuse Treatment | | |
| • inpatient | After you meet the deductible, you pay $150 per confinement copay, then 10% coinsurance. | After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance. |
| • outpatient visit | $20 copay per visit after you meet the deductible | 40% coinsurance after you meet the deductible |
| • outpatient facility | 10% coinsurance after you meet the deductible | 40% coinsurance after you meet the deductible |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

# Summary of Aetna Vision Preferred℠ Benefits

This chart summarizes the optional vision benefits available through Aetna Vision Preferred:

| **Covered Services** | **In-Network*** You Pay | **Out-of-Network**** You Pay |
|---|---|---|
| **Exams** | | |
| Routine Eye Exam<br>• one per calendar year | $20 copay<br>Not subject to deductible | Up to $40 reimbursement |
| Standard Contact Lens Fit/Follow-up | Discounted Fee | Not covered |
| Premium Contact Lens Fit/Follow-up | Discounted Fee | Not covered |
| **Frames and Lenses**<br>Lenses *or* contacts every calendar year<br>Frames every two years | | |
| Frames | $130 allowance. You receive a 20% discount on the balance | Up to $45 reimbursement |
| Standard Plastic Lenses | | |
| • Single vision | $0 copay; Plan pays 100% | Up to $40 reimbursement |
| • Bifocal | $0 copay; Plan pays 100% | Up to $60 reimbursement |
| • Trifocal | $0 copay; Plan pays 100% | Up to $80 reimbursement |
| • Lenticular | $0 copay; Plan pays 100% | Up to $80 reimbursement |
| • Standard progressive | $65 copay; then the Plan pays 100% | Up to $60 reimbursement |
| • Premium progressive[1] | $65 copay plus a 80% of the retail cost, minus $120 allowance | Up to $60 reimbursement |
| Lens options | | |
| • UV treatment | $15 copay | Not covered |
| • Tint (solid and gradient) | $15 copay | Not covered |
| • Standard plastic scratch coating | $0 copay; Plan pays 100% | Not covered |
| • Standard polycarbonate | $0 copay; Plan pays 100% | Not covered |
| • Standard anti-reflective coating | $45 copay; Plan pays 100% | Not covered |
| • Polarized | 20% discount applies to retail cost | Not covered |
| • Other add-ons | 20% discount applies to retail cost | Not covered |

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.

| **Covered Services** | **In-Network*** You Pay | **Out-of-Network**** You Pay |
|---|---|---|
| Contact Lenses [3] | | |
| • Conventional | $125 allowance. 15% discount on remaining balance | Up to $125 reimbursement |
| • Disposable | $125 allowance. You pay 100% of balance over the allowance | Up to $125 reimbursement |
| • Medically Necessary | $0 copay; Plan pays 100% | $200 reimbursement |
| Laser Vision Correction<br>Lasik or PRK from U.S. Laser Network[2] | 15% discount off retail cost or 5% off promotional price | Not covered |

[1] Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions.

[2] Lasik or PRK from the U.S. Laser network, owned and operated by LCA Vision.

[3] Out of network reimbursement is for materials only.

If there are discrepancies between this summary document and the Summary Plan Description, the Summary Plan Description document governs.

*For in-network services, Plan payment will not exceed the negotiated charge.
**For out-of-network charges, Plan payment is generally 60% of the recognized charge.