Your Plan at a Glance 2018

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 You Pay	Out-of-Network 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* You Pay	Out-of-Network** You Pay
Preventive Care * **		
Routine Physical Exam (office visit) • 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 • 1st 12 months: 7 exams • 13-24 months: 3 exams • 25-36 months: 3 exams • 3-18 years: 1 exam per calendar year	Covered in full	40% coinsurance after you meet the deductible
Preventive Screening and Counseling • Obesity Counseling — up to age 22: unlimited visits — 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

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*** 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 Contraceptive Counseling Services - Maximum Visits either in a group or individual setting *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. 2* visits per 12 months	40% coinsurance after you meet the deductible 2* visits per 12 months
Contraceptive devices and injectables provided and billed by your physician *(includes insertion/administration)* • Generic devices/injectables and devices with no generic equivalent • Brand-name	 Covered in full $20 copay after you meet the deductible	 40% coinsurance after you meet the deductible 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)* • sigmoidoscopy: 1 every 5 years • 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)* • 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 • 1 screening per calendar year, beginning at age 55	Covered in full	40% coinsurance after you meet the deductible

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Vision and Hearing		
Routine Vision Exams	Covered by the Aetna Vision Preferred Plan. Refer to the Summary of Aetna Vison Preferred[SM] 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		
• Hearing aid evaluation	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• Hearing aids *(covered only when needed as a result of accidental injury)*	If covered, 10% coinsurance after you meet the deductible	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. . 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 Administration: 40% coinsurance after you meet the deductible for injection in your physician's office.

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Covered Services	In-Network* You Pay	Out-of-Network** 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 *(services available during pregnancy or post-partum)* • Up to 6* visits for lactation counseling services per 12 months * **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

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Covered Services	**In-Network*** You Pay	**Out-of-Network**** You Pay
Infertility Services If eligible, covered services include: • diagnosis and treatment of the underlying cause of infertility • 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 *(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

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Covered Services	**In-Network*** You Pay	**Out-of-Network**** You Pay
Alternatives to Inpatient Hospital Care		
Skilled Nursing Facility Care • up to a maximum of 120 days per confinement • 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 • up to 90 visits per calendar year	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
Private Duty Nursing • 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. Alternative settings: 10% coinsurance after you meet the deductible.	Inpatient: After you meet the deductible, you pay $150 per confinement copay, then 40% coinsurance Alternative settings: 40% coinsurance after you meet the deductible
Emergency Care		
Emergency Room • 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 • Urgent Care Center	10% coinsurance after you meet the deductible	10% coinsurance after you meet the deductible

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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)*	Covered in full after you meet the deductible **Your physician must obtain authorization before services are performed**	40% after you meet the deductible **Your physician must obtain authorization before services are performed**
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	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible

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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

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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 • one per calendar year	$20 copay 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 Lenses *or* contacts every calendar year 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

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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 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.

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