

Your Plan at a Glance

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
Annual Out-of-Pocket Maximum (includes deductible, coinsurance and 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) <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> obesity counseling <ul style="list-style-type: none"> 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

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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
<p>Preventive Screening and Counseling (cont'd)</p> <ul style="list-style-type: none"> • tobacco use preventive counseling <ul style="list-style-type: none"> - up to 8 counseling sessions per calendar year • alcohol/drug abuse counseling: <ul style="list-style-type: none"> - up to 5 visits per calendar year (Also see the Behavioral Health Care section for additional benefits) 	<p>Covered in full</p> <p>Covered in full</p>	<p>40% coinsurance after you meet the deductible</p> <p>40% coinsurance after you meet the deductible</p>
<p>Female Contraceptive Counseling</p> <p>Contraceptive Counseling Services – Maximum Visits either in a group or individual setting</p> <p>*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i>.</p>	<p>Covered in full</p> <p>2* visits per 12 months</p>	<p>40% coinsurance after you meet the deductible</p> <p>2* visits per 12 months</p>
<p>Contraceptive Devices and Injectables (provided and billed by your physician include insertion/administration)</p> <ul style="list-style-type: none"> • generic devices/injectables and devices with no generic equivalent • brand-name 	<p>Covered in full</p> <p>\$20 copay after you meet the deductible</p>	<p>40% coinsurance after you meet the deductible</p> <p>40% coinsurance after you meet the deductible</p>

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Routine Prostate Screening	Covered in full	40% coinsurance after you meet the deductible
<p>Routine Colorectal Cancer Screening (average-risk members aged 45 years and older when these tests are recommended by their physician)</p> <ul style="list-style-type: none"> • Colonoscopy: 1 every 10 years or • CT Colonography (virtual colonoscopy): 1 every 5 years or • Double contrast barium enema (DCBE): 1 every 5 years or • Sigmoidoscopy: 1 every 5 years or • Immunohistochemical or guaiac-based fecal occult blood testing (FOBT): every year or • Stool DNA (FIT-DNA, Cologuard): 1 every 3 years <p>*Important Note: Please refer to Clinical Policy Bulletin 0516 for additional information.</p>	Covered in full	40% coinsurance after you meet the deductible
<p>Routine Annual Ob/Gyn Exam (includes one Pap smear and related lab fees)</p> <ul style="list-style-type: none"> • 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
<p>Routine Lung Cancer Screening</p> <ul style="list-style-type: none"> • 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 Services	Covered by the Aetna Vision Preferred Plan. Refer to the Summary of Aetna Vision 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 <ul style="list-style-type: none"> • hearing aid evaluation • hearing aids (adults and children) 	\$20 copay per visit after you meet the deductible 10% coinsurance after you meet the deductible 1 per ear every 36 months; \$1,500 max	40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible 1 per ear every 36 months; \$1,500 max
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 CVS Caremark Specialty Pharmacy Administration: 40% coinsurance after you meet the deductible for injection in your physician's office.

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Family Planning and Maternity		
Maternity Care <ul style="list-style-type: none"> • routine prenatal and postnatal office visits • delivery (hospital charges) 	Covered in full After you meet the deductible, you pay \$150 per confinement copay, then 10% coinsurance	40% coinsurance after you meet the deductible After you meet the deductible, you pay \$150 per confinement copay, then 40% coinsurance
Lactation Support Services <i>(services available during pregnancy or post-partum)</i> <ul style="list-style-type: none"> • up to 6* visits for lactation counseling services per 12 months <p>*Important Note: Additional visits are covered as physician's office visits, subject to the applicable deductible, coinsurance and/or copay</p>	Covered in full	40% coinsurance after you meet the deductible
Voluntary Sterilization <ul style="list-style-type: none"> • physician's office • outpatient facility 	\$20 copay per visit after you meet the deductible (member deductible and copay waived for tubal ligation) 10% coinsurance after you meet the deductible (member deductible and coinsurance waived for tubal ligation)	40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible
Infertility Services <ul style="list-style-type: none"> • physician's office • outpatient facility 	If eligible, covered services include: <ul style="list-style-type: none"> • diagnosis and treatment of the underlying cause of infertility • advanced reproductive technologies Infertility services are subject to a \$100,000 lifetime maximum across all FCPS self-insured plans. Refer to the Clinical Policy Bulletins for more information on covered services.	40% 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
Hospital Care		
Inpatient Facility Copay	\$150 per confinement	\$150 per confinement
Inpatient Care <i>(room and board are covered up to the hospital's semi-private room rate; also includes physician services and anesthesiologist)</i>	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 <ul style="list-style-type: none"> physician's office outpatient facility or freestanding surgical center 	<p>\$20 copay per visit after you meet the deductible</p> <p>10% coinsurance after you meet the deductible</p>	<p>40% coinsurance after you meet the deductible</p> <p>40% coinsurance after you meet the deductible</p>
Alternatives to Inpatient Hospital Care		
Skilled Nursing Facility Care <ul style="list-style-type: none"> 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 per confinement copay, then 40% coinsurance. Copay waived if you transfer directly from covered inpatient care in another facility.
Home Health Care <ul style="list-style-type: none"> up to 90 visits per calendar year 	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible
Private Duty Nursing <ul style="list-style-type: none"> 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	<p>Inpatient: After you meet the deductible, you pay \$150 per confinement copay, then 10% coinsurance</p> <p>Alternative settings: 10% coinsurance after you meet the deductible</p>	<p>Inpatient: After you meet the deductible, you pay \$150 per confinement copay, then 40% coinsurance</p> <p>Alternative settings: 40% coinsurance after you meet the deductible</p>

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Emergency and Urgent Care		
Emergency Room <ul style="list-style-type: none"> • emergency care • non-emergency care 	\$250 copay per visit, then 10% coinsurance for all services after you meet the deductible Copay waived if admitted Not covered	\$250 copay per visit, then 10% coinsurance for all services after you meet the deductible Copay waived if admitted Not covered
Urgent Care <ul style="list-style-type: none"> • urgent care center 	10% coinsurance; no deductible	10% coinsurance; no deductible
Telemedicine (Teladoc)	\$20 copay per session; no deductible	Covered through Teladoc only.
Telemedicine (other providers)	\$20 copay per session after you meet the deductible	40% coinsurance after you meet the deductible
Walk-In Clinic	\$20 copay per visit; no deductible	40% coinsurance no deductible
Ambulance <ul style="list-style-type: none"> • emergency use/medically necessary transport • non-clinical/not medically necessary use 	10% coinsurance after you meet the deductible Not covered	40% coinsurance after you meet the deductible Not covered
Other Covered Expenses		
Chiropractic Care (Coverage dependent on periodic review for medical necessity.)	\$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Complex Imaging (includes MRI, PET scan, and CT scan)	\$75 copay after you meet the deductible	40% coinsurance after you meet the deductible
Diagnostic X-Ray and Lab Tests <ul style="list-style-type: none"> • billed with physician's office visit • outpatient hospital or freestanding facility 	Included with office visit copayment (deductible applies) Covered in full after you meet the deductible	40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible
Durable Medical Equipment	10% coinsurance after you meet the deductible	40% coinsurance after you meet the deductible

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<p>Habilitation Therapy Services – Autism Spectrum Disorder (physical, occupational, speech)</p> <ul style="list-style-type: none"> office visit <p>No visit limitations</p> <p>Habilitation Therapy Services – Diagnosis other than Autism Spectrum Disorder (physical, occupational, speech)</p> <p>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.</p> <ul style="list-style-type: none"> office visit 	<p>\$20 copay per visit after you meet the deductible</p> <p>\$20 copay per visit after you meet the deductible</p>	<p>40% coinsurance after you meet the deductible</p> <p>40% coinsurance after you meet the deductible</p>
<p>Short-Term Rehabilitation (physical, occupational, speech)</p> <p>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.)</p> <ul style="list-style-type: none"> Office visit Outpatient hospital or facility 	<p>\$20 copay per visit after you meet the deductible</p> <p>10% coinsurance after you meet the deductible</p>	<p>40% coinsurance after you meet the deductible</p> <p>40% coinsurance after you meet the deductible</p>

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Behavioral Health Care (precertification may be required – please refer to the Precertification section)		
Mental Health Treatment <ul style="list-style-type: none"> • inpatient • outpatient office visit • outpatient facility 	After you meet the deductible, you pay \$150 per confinement copay, then 10% coinsurance \$20 copay per visit after you meet the deductible 10% coinsurance after you meet the deductible	After you meet the deductible, you pay \$150 per confinement copay, then 40% coinsurance 40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible
Substance Abuse Treatment <ul style="list-style-type: none"> • inpatient • outpatient office visit • outpatient facility 	After you meet the deductible, you pay \$150 per confinement copay, then 10% coinsurance \$20 copay per visit after you meet the deductible 10% coinsurance after you meet the deductible	After you meet the deductible, you pay \$150 per confinement copay, then 40% coinsurance 40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible

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