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) • 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

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** 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
Preventive Screening and Counseling (cont'd) • tobacco use preventive counseling - up to 8 counseling sessions per calendar year • alcohol/drug abuse counseling: - up to 5 visits per calendar year (Also see the Behavioral Health Care section for additional benefits)	Covered in full Covered in full	40% coinsurance after you meet the deductible 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

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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
Routine Colorectal Cancer Screening (average-risk members aged 45 years and older when these tests are recommended by their physician) • 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 *__Important Note: Please refer to Clinical Policy Bulletin 0516 for additional information.__	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 Services	Covered by the Aetna Vision Preferred Plan. Refer to the Summary of Aetna Vision 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		
• hearing aid evaluation	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
• hearing aids (adults and children)	10% coinsurance after you meet the deductible 1 per ear every 36 months; $1,500 max	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 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 (hospital charges)	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
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
Infertility Services	If eligible, covered services include: • 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.	
• 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

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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 *(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 • outpatient facility or freestanding surgical center	 $20 copay per visit after you meet the deductible 10% coinsurance after you meet the deductible	 40% coinsurance after you meet the deductible 40% coinsurance after you meet the deductible
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 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

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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Emergency and Urgent 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
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		
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		
• 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% 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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Covered Services	In-Network* You Pay	Out-of-Network** You Pay
Habilitation Therapy Services – Autism Spectrum Disorder (physical, occupational, speech) • office visit No visit limitations	$20 copay per visit after you meet the deductible	40% coinsurance after you meet the deductible
Habilitation Therapy Services – Diagnosis other than Autism Spectrum Disorder (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. • office visit	$20 copay per visit 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 facility	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
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 office 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 office 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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