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
Out-of-Pocket Maximum (includes deductible, coinsurance copays)		
Individual	$1,000	$2,000
Family	$2,000	$4,000

Covered Services	**In-Network***	**Out-of-Network****
Preventive Care * **		
Routine Physical Exam (office visit) • 1 exam per calendar year	Covered in full	40% after 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% after 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)	Covered in full	40% after the deductible
• Tobacco Use Preventive Counseling: up to 8 counseling sessions per calendar year	Covered in full	40% after 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 HHS.gov/healthcare/prevention 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% after 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% after the deductible 2* visits per 12 months
Contraceptive devices and injectables provided and billed by your physician *(includes insertion/administration)*	Covered in full	40% after the deductible
Routine Prostate Screening	Covered in full	40% after 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% after the deductible
Routine Annual Ob/Gyn Exam *(includes one Pap smear and related lab fees)* • 1 exam per calendar year	Covered in full	40% after the deductible
Routine Mammogram	Covered in full	40% after the deductible
Vision and Hearing		
Routine Vision Exams (by Aetna Vision Preferred/EyeMed provider) • 1 exam every calendar year (not subject to deductible)	$20 copay	Maximum reimbursement of $40 per calendar year
Routine Hearing Exams	$20 copay, after deductible	40% after the deductible
Hearing Aids • Hearing aid evaluation	$20 copay, after deductible	40% after the deductible

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*** Please refer to HHS.gov/healthcare/prevention for a full list of preventive services.

Covered Services	In-Network* You Pay	Out-of-Network** You Pay
• Hearing aids *(covered only when needed as a result of accidental injury)*	If covered, 10% coinsurance after deductible	If covered, 40% after the deductible
Outpatient Care		
Primary Care Physician	$20 copay, after deductible	40% after the deductible
Specialist	$20 copay, after deductible	40% after the deductible
Allergy Testing	$20 copay, after deductible	40% after the deductible
Allergy Injections/Treatment *(including serum)*	$20 copay, after deductible Covered in full after deductible for injections if no office visit is billed.	40% after the deductible
Outpatient Prescription Drugs (*non-self-injectable medications only)*	10% coinsurance after deductible if shipped to home address. Covered in full after deductible when medication is shipped for administration at your physician's office. Please note that an office visit copay will apply for administration of medications.	40% after the deductible
Family Planning and Maternity		
Maternity Care		
Routine prenatal and postnatal office visits,	Covered in full	40% after the deductible
Delivery	$150 per admission copay, then 10%, after deductible	40% after the deductible
Lactation Support Services	Covered in full for first 6 visits in a 12 month period. Services available during pregnancy or post-partum	40% after the deductible for first 6 visits in a 12 month period. Services available during pregnancy or post-partum
Voluntary Sterilization • physician's office • outpatient facility	 $20 copay per visit after deductible 10% coinsurance after deductible (member coinsurance waived for tubal ligation)	 40% after the deductible 40% after the deductible

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******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 If eligible, covered services include: • diagnosis and treatment of the underlying cause of infertility • advanced reproductive technologies • physician's office • outpatient facility 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.	$20 copay per visit after deductible 10% coinsurance after deductible	40% after the deductible 40% after the deductible
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)*	10% after $150 per confinement copay Deductible applies	40% after $150 per confinement copay Deductible applies
Outpatient Care	10% after deductible	40% after the deductible
Outpatient Surgery		
Outpatient Surgery • physician's office • outpatient facility or freestanding surgical center	$20 copay after deductible 10% after deductible	40% after the deductible 40% after the deductible
Alternatives to Inpatient Hospital Care		
Skilled Nursing Facility Care • up to a maximum of 120 days per confinement • Inpatient Rehabilitative up to a maximum of 90 days per confinement. Requires Utilization Management approval.	$150 copay per admission, then 10% after deductible. Per admission copay waived if transfer directly from inpatient care.	$150 copay per admission, then 40% after the deductible. Per admission copay waived if transfer directly from inpatient care.

*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
Home Health Care • up to 90 visits per calendar year	10% after deductible	40% after the deductible
Private Duty Nursing • up to 360 8-hour shifts per calendar year	10% after deductible	40% after the deductible
Hospice Care	$150 per admission copay (facility charge), then 10% coinsurance. Deductible applies. 10% coinsurance for alternative settings. Deductible applies	$150 per admission copay (facility charge), then 40% after the deductible 40% coinsurance for alternative settings. Deductible applies
Emergency Care		
Emergency Room • emergency care • non-emergency care	$150 copay, then 10% coinsurance for all services. Deductible applies. Copay waived if admitted Not covered	$150 copay, then 10% coinsurance for all services. Deductible applies Copay waived if admitted Not covered
Urgent Care • Urgent Care Center	10% after deductible	10% after deductible
Telemedicine (Teladoc)	$20 copay per session after deductible	Covered through Teladoc only.
Walk-In Clinic	$20 copay after deductible	40% after the deductible
Ambulance • emergency use/medically necessary transport • non-clinical/not medically necessary use	10% after deductible Not covered	40% after the deductible Not covered
Other Covered Expenses		
Complex Imaging *(includes MRI, PET scan, and CT scan)*	Covered in full after deductible **Your physician must obtain authorization before services are performed**	40% after the deductible **Your physician must obtain authorization before services are performed**

*****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*	Out-of-Network**
Diagnostic X-Ray and Lab Tests		
• billed with physician's office visit	Included with office visit copayment (deductible applies)	You pay 40% after the deductible
• outpatient hospital or freestanding facility	Covered in full after deductible	You pay 40% after the deductible
Durable Medical Equipment	10% after deductible	You pay 40% after 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 deductible	40% after the deductible
• outpatient hospital or outpatient facility	10% coinsurance after deductible	40% after the deductible
Chiropractic Care	$20 copay per visit after deductible	40% after the deductible
Behavioral Health Care (precertification may be required – please refer to the Precertification section)		
Mental Health Treatment		
• inpatient	$150 per confinement copay, then 10% coinsurance. Deductible applies	$150 per confinement copay, then 40%. Deductible applies.
• outpatient visit	$20 copay after deductible	40% after the deductible
• outpatient facility	10% coinsurance after deductible	40% after the deductible
Substance Abuse Treatment		
• inpatient	$150 per confinement copay, then 10% coinsurance. Deductible applies.	$150 per confinement copay, then 40%. Deductible applies.
• outpatient visit	$20 copay after deductible	40% after the deductible
• outpatient facility	10% coinsurance after deductible	40% after the deductible

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******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*	Out-of-Network**
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 20% discount of the charge 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
Contact Lenses [3]		
• Conventional	$125 allowance. 15% discount on remaining balance	Up to $125 reimbursement

Covered Services	In-Network*	Out-of-Network**
• 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.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
○ Qualified sign language interpreters
○ Written information in other formats (large print, audio, accessible electronic formats, other formats)
• Provides free language services to people whose primary language is not English, such as:
○ Qualified interpreters
○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. California HMO/HNO Members: Civil Rights Coordinator, PO Box 24030 Fresno CA, 93779, 1-800-648-7817, TTY 711, Fax 860-262-7705, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Language Assistance

TTY: 711

For language assistance in English call 1-888-982-3862 at no cost. (English)

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Para obtener asistencia lingüística en español, llame sin cargo al 1-888-982-3862 . (Spanish)

欲取得繁體中文語言協助，請撥打1-888-982-3862 ， 無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le 1-888-982-3862 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-888-982-3862 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí koji' t'áá jíik'e hólne' 1-888-982-3862 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-888-982-3862 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 1-888-982-3862 . (Albanian)

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للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 1-888-982-3862. (Arabic)

Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-888-982-3862 առանց գնով: (Armenian)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-888-982-3862 ku busa. (Bantu-Kirundi)

Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-888-982-3862 nga walay bayad. (Bisayan-Visayan)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 1-888-982-3862 -তে কল করুন। (Bengali- Bangala)

ဒွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-888-982-3862 ကို ခေါ်ဆိုပါ။ (Burmese)

Per rebre assistència en (català), truqui al número gratuït 1-888-982-3862 . (Catalan)

Para ayuda gi fino' (Chamoru), ågang 1-888-982-3862 sin gåstu. (Chamorro)

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(Chahta) anumpa ya apela a chi l paya hinla **1**-888-982-3862 . (Choctaw)

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-888-982-3862 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-888-982-3862 . (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-888-982-3862 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-888-982-3862 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-888-982-3862 પર કૉલ કરો.

No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-888-982-3862 . Kāki ʻole ʻia kēia kōkua nei. (Hawaiian)

(Hindi) हिन्दी में भाषा सहायता के लिए, 1-888-982-3862 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-888-982-3862 . (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 1-888-982-3862 na akwụghị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-888-982-3862 nga awan ti bayadanyo. (Ilocano)

Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya. (Bahasa Indonesia)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-888-982-3862 . (Italian)

日本語で援助をご希望の方は、1-888-982-3862 まで無料でお電話ください。(Japanese)

လာတ်မၤစၢၤတ်ကတိၤကျိဉ်အဂီၢ် ကျိဉ် ကိး 1-888-982-3862 လၢတအိဉ်ဒီးတ်လၢာ်ဘျဉ်လၢာ်စုဟဉ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-888-982-3862 번으로 전화해 주십시오. (Korean)

Bé m̀ ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wùɖùǔn wɛ̃ɛ, ɖá 1-888-982-3862 (Kru-Bassa)

(Kurdish) .بۆ وەرگرتنی ڕێنوێنی پێوەندیدار بە زمان بە زمان بە ژمارەی 1-888-982-3862 بە خۆڕایی پەیوەندی بکەن

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 1-888-982-3862 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

तील भाषा (मराठी) सहाय्यासाठी 1-888-982-3862 क्रमांकावर कोणत्याही खर्चाशिवाय कॉल करा. (Marathi)

Ñan bōk jipañ ilo Kajin Majol, kallok 1-888-982-3862 ilo ejjelok wōnān. (Marshallese)

Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-888-982-3862 ni sohte isais. (Micronesian-Pohnpeian).

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-888-982-3862 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-888-982-3862 मा फोन गर्नुहोस्। (Nepali)

Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-888-982-3862 kecïn aɣöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 1-888-982-3862 kostnadsfritt. (Norwegian)

Fer Helfe in Deitsch, ruf: 1-888-982-3862 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 1-888-982-3862 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-888-982-3862 . (Polish)

Para obter assistência linguística em português ligue para o 1-888-982-3862 gratuitamente.
(Portuguese)

(Punjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-888-982-3862 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।

Pentru asistenţă lingvistică în româneşte telefonaţi la numărul gratuit 1-888-982-3862 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-888-982-3862 . (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-888-982-3862 e aunoa ma se totogi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-888-982-3862 . (Serbo-Croatian)

Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-888-982-3862 . Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-888-982-3862 bila malipo. (Swahili)

ܐܢ ܟܐܢܐ ܐܝܬ ܡܣܢܩܢܘܬܐ ܠܡܗܝܪܢܘܬܐ ܒܠܫܢܐ ܣܘܪܝܝܐ

ܩܪܝ ܠܗ ܡܢܝܢܐ ܕܡܓܢܐܝܬ 1-888-982-3862 ܡܟܠܢ. (Assyrian-Syriac)

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-888-982-3862 కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 1-888-982-3862 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-888-982-3862 'o 'ikai hā tōtōngi. (Tongan)

Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-888-982-3862 nge esapw kamé ngonuk. (Turkese-Chuukese)

(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-888-982-3862 . (Turkish)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-888-982-3862. (Ukrainian)

اُردو میں لسانی معاونت کے لیے 1-888-982-3862 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-888-982-3862. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 1-888-982-3862 פריי פון אפצאל. (Yiddish)

Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-888-982-3862 lái san owó kankan rárá. (Yoruba)