

**LEIDOS**  
**2024 Plan Year Benefit Summary**

PLAN NAME	<b>Healthy Focus Basic Plan</b>
PRODUCT NAME	<b>Aetna Choice POS II Network</b>
PLAN STATES	All 50 States
CUSTOMER SERVICE PHONE	1-800-843-9126
WEB ADDRESS	www.aetna.com

Benefit	In Network - Employee Pays	Out of Network*** - Employee Pays
<b>HSA*</b>	Employees may elect to contribute funds up to annual maximum. No employer contribution provided.	
<b>HEALTHCARE FSA</b>	Only eligible for limited purpose FSA	
<b>ANNUAL DEDUCTIBLE**</b>	\$4,000 Individual \$8,000 Family**	\$8,000 Individual \$16,000 Family**
<b>(Integrated Deductible &amp; OPM)</b>	\$8,000 Individual w/in Family deductible Not combined with Out of Network	\$16,000 Individual w/in Family deductible Not combined with In Network
<b>ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) (Integrated Deductible &amp; OPM)</b>	\$6,750 Individual \$13,500 Family \$8,550 Individual w/in Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with Out of Network	\$13,000 Individual \$27,000 Family \$27,000 Individual w/in Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with In Network
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	Unlimited
<b>OFFICE VISITS</b>	50% after deductible	50% after deductible
<b>LAB X-RAY DIAGNOSTICS</b>	50% after deductible	50% after deductible
<b>PREVENTIVE CARE</b>	Adult routine care: covered at 100% (not subject to deductible); limit 1 per calendar year. Coverage for enhanced women's health benefits at 100%. Contact plan for specifics.	Adult routine care: covered at 50% after deductible; limit 1 per calendar year. Contact plan for specifics.
<b>HOSPITAL CARE</b>		
<b>Inpatient</b>	50% after deductible	50% after deductible
<b>Outpatient</b>	50% after deductible	50% after deductible
<b>EMERGENCY CARE</b>		
<b>In-area</b>	In 50% after deductible	50% after deductible.
<b>Out-of-area</b>	50% after deductible	50% after deductible.
<b>PRESCRIPTIONS</b>		
<b>Retail</b>	After deductible, 50% generics, 50% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
<b>Mail-Order</b>	After deductible, 50% generics, 50% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
<b>MENTAL HEALTH</b>		
<b>Inpatient</b>	50% after deductible	50% after deductible
<b>Outpatient</b>	50% after deductible	50% after deductible
<b>SUBSTANCE ABUSE</b>		
<b>Inpatient Detox and Rehab</b>	50% after deductible	50% after deductible
<b>Outpatient</b>	50% after deductible	50% after deductible
<b>CHIROPRACTIC</b>	50% after deductible Covered if medically necessary	50% after deductible if medically necessary
<b>DURABLE MEDICAL EQUIPMENT</b>	50% after deductible	50% after deductible
<b>HEARING AIDS</b>	50% after deductible \$2,500 per pair every three years	50% after deductible \$2,500 per pair every three years
<b>VISION EXAMS</b>	Not covered	Not covered
<b>EYEWEAR</b>	Not covered	Not covered

\*APO/FPO addresses are not eligible for HSA plan set-up. A physical U.S. address must be provided.

\*\* The family deductible is an aggregate deductible where you must satisfy entire deductible before the plan pays benefits for any member

\*\*\* Out-of-Network benefits based on Usual, Reasonable, and Customary (URC) charges for the specific service in that geographic region.

\*\*\*\* Prescription Drugs are administered by Express Scripts (ESI)

Information contained in the summary is designed for general reference only. If there is any conflict between this benefit summary and the plan document/certificate, the plan document/certificate governs.