LEIDOS
2024 Plan Year Benefit Summary

PLAN NAME	**Healthy Focus Premier Plan**
PRODUCT NAME	**Aetna Choice POS II Network**
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
HSA*	Employer contribution for employee only: $500 if salary is $85,000 or less; $250 if salary is between $85,001 and $150,000 Employer contribution for family: $1,000 if salary is $85,000 or less; $500 if salary is between $85,001 and $150,000 $0 employer contribution if salary greater than $150,000 Employees may elect to contribute additional funds up to annual maximum	
HEALTHCARE FSA	Only eligible for limited purpose FSA	
ANNUAL DEDUCTIBLE** **(Integrated Deductible & OPM)**	$1,600 Individual $3,200 Family** $3,200 Individual w/in Family deductible Not combined with Out of Network	$3,200 Individual $6,400 Family** $6,400 Individual w/in Family deductible Not combined with In Network
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) (Integrated Deductible & OPM)	$1,600 Individual $3,200 Family $3,200 Individual w/in Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with Out of Network	$3,200 Individual $6,400 Family $6,400 Individual w/in Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with In Network
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited
OFFICE VISITS	0% after deductible	0% after deductible
LAB X-RAY DIAGNOSTICS	0% after deductible	0% after deductible
PREVENTIVE CARE	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 100% after deductible; limit 1 per calendar year. Contact plan for specifics.
HOSPITAL CARE		
Inpatient	0% after deductible	0% after deductible
Outpatient	0% after deductible	0% after deductible
EMERGENCY CARE		
In-area	0% after deductible	0% after deductible.
Out-of-area	0% after deductible.	0% after deductible.
PRESCRIPTIONS		
Retail	After deductible, 0% generics, 0% brand and 0% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
Mail-Order	After deductible, 0% generics, 0% brand and 0% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
MENTAL HEALTH		
Inpatient	0% after deductible	0% after deductible
Outpatient	0% after deductible	0% after deductible
SUBSTANCE ABUSE		
Inpatient Detox and Rehab	0% after deductible	0% after deductible
Outpatient	0% after deductible	0% after deductible
CHIROPRACTIC	0% after deductible Covered if medically necessary	0% after deductible if medically necessary
DURABLE MEDICAL EQUIPMENT	0% after deductible	0% after deductible
HEARING AIDS	0% after deductible $2,500 per pair every three years	0% after deductible $2,500 per pair every three years
VISION EXAMS	Not covered	Not covered
EYEWEAR	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.