DYNETICS, A LEIDOS COMPANY
2025 Plan Year Benefit Summary

PLAN NAME	**Healthy Focus Classic Network Plan**
PRODUCT NAME	**Healthy Focus Classic Network Plan**
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*	Not eligible	
HEALTHCARE FSA	Eligible for limited purpose FSA or regular FSA	
ANNUAL DEDUCTIBLE **(Integrated Deductible & OPM)**	$1,500 Individual $3,000 Family $1,500 Individual w/in Family deductible Not combined with Out of Network	Not covered
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) **(Integrated Deductible & OPM)**	$3,000 Individual $6,000 Family Plan pays 100% of eligible expenses after this amount has been satisfied. $3,000 Individual w/in Family	Not covered
LIFETIME MAXIMUM BENEFIT	Unlimited	Not covered
OFFICE VISITS	$30 copay PCP no deductible; $50 copay SPC no deductible	Not covered
LAB X-RAY DIAGNOSTICS	20% after deductible	Not covered
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.	Not covered
HOSPITAL CARE		
Inpatient	20% after deductible	Not covered
Outpatient	20% after deductible	Not covered
EMERGENCY CARE		
In-area	$250 copay, no deductible For non-emergent use of the emergency room, employee pays 50% after deductible	$250 copay, no deductible For non-emergent use of the emergency room, not covered.
Out-of-area	$250 copay, no deductible For non-emergent use of the emergency room, employee pays 50% after deductible	$250 copay, no deductible For non-emergent use of the emergency room, not covered.
PRESCRIPTIONS		
Retail		
Generic	$10 copay	Not covered
Preferred	$50 copay	
Non-Preferred	$100 copay	
Specialty	$250 copay	
Mail-Order		
Generic	$20 copay	Not covered
Preferred	$100 copay	
Non-Preferred	$200 copay	
Specialty	$500 copay	
MENTAL HEALTH		
Inpatient	20% after deductible	Not covered
Outpatient	Office visit - $30 copay, no deductible	Not covered
SUBSTANCE ABUSE		
Inpatient Detox and Rehab	20% after deductible	Not covered
Outpatient	Office visit - $30 copay, no deductible	Not covered
CHIROPRACTIC	$50 copay no deductible Covered if medically necessary	Not covered
DURABLE MEDICAL EQUIPMENT	50% after deductible	Not covered
HEARING AIDS	20% after deductible $2,500 per pair every three years	Not covered
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.

*** 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.