DYNETICS, A LEIDOS COMPANY
2025 Plan Year Benefit Summary

PLAN NAME	**Healthy Focus Basic Plan**
PRODUCT NAME	**HDHP Healthy Focus Basic 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*	Employees may elect to contribute funds up to annual maximum. No employer contribution provided.	
HEALTHCARE FSA	Only eligible for limited purpose FSA	
ANNUAL DEDUCTIBLE **(Integrated Deductible & OPM)**	$4,000 Individual $8,000 Family** $8,000 Individual w/in Family deductible Not combined with Out of Network	$8,000 Individual $16,000 Family** $16,000 Individual w/in Family deductible Not combined with In Network
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) **(Integrated Deductible & OPM)**	$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
LIFETIME MAXIMUM BENEFIT	Unlimited	Unlimited
OFFICE VISITS	50% after deductible	50% after deductible
LAB X-RAY DIAGNOSTICS	50% after deductible	50% 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 50% after deductible; limit 1 per calendar year. Contact plan for specifics.
HOSPITAL CARE		
Inpatient	50% after deductible	50% after deductible
Outpatient	50% after deductible	50% after deductible
EMERGENCY CARE		
In-area	50% after deductible	50% after deductible.
Out-of-area	50% after deductible	50% after deductible.
PRESCRIPTIONS		
Retail	After deductible, 50% generics, 50% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
Mail-Order	After deductible, 50% generics, 50% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
MENTAL HEALTH		
Inpatient	50% after deductible	50% after deductible
Outpatient	50% after deductible	50% after deductible
SUBSTANCE ABUSE		
Inpatient Detox and Rehab	50% after deductible	50% after deductible
Outpatient	50% after deductible	50% after deductible
CHIROPRACTIC	50% after deductible Covered if medically necessary	50% after deductible if medically necessary
DURABLE MEDICAL EQUIPMENT	50% after deductible	50% after deductible
HEARING AIDS	50% after deductible $2,500 per pair every three years	50% 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.