

**LEIDOS**  
**2023 Plan Year Benefit Summary**

PLAN NAME	<b>Healthy Focus Essential 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>	Employer contribution for employee only: \$250 if salary is \$85,000 or less; \$125 if salary is between \$85,001 and \$150,000 Employer contribution for family: \$500 if salary is \$85,000 or less; \$250 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	
<b>HEALTHCARE FSA</b>	If elect HSA, only eligible for limited purpose FSA	
<b>ANNUAL DEDUCTIBLE**</b>	\$2,000 Individual \$4,000 Family**	\$4,000 Individual \$8,000 Family**
<b>(Integrated Deductible w/ Embedded OPM)</b>	\$4,000 Individual w/in Family deductible Not combined with Out of Network	\$8,000 Individual w/in Family deductible Not combined with In Network
<b>ANNUAL OUT-OF-POCKET MAXIMUM</b>	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 Family
<b>(Integrated Deductible w/ Embedded OPM)</b>	\$8,550 Individual w/in Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with Out of Network	\$20,000 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	
<b>OFFICE VISITS</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>LAB X-RAY DIAGNOSTICS</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% 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>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>Outpatient</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>EMERGENCY CARE</b>		
<b>In-area</b>	Innovation Health Facility: 35% after deductible Choice POS II facility: 35% after deductible For non-emergent use of the emergency room, employee pays 50% after deductible	35% after deductible. For non-emergent use of the emergency room, employee pays 50% after deductible
<b>Out-of-area</b>	35% after deductible. For non-emergent use of the emergency room, employee pays 50% after deductible	35% after deductible. For non-emergent use of the emergency room, employee pays 50% after deductible
<b>PRESCRIPTIONS</b>		
<b>Retail</b>	After deductible, \$5 generics, 30% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
<b>Mail-Order</b>	After deductible, \$5 generics, 30% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
<b>MENTAL HEALTH</b>		
<b>Inpatient</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>Outpatient</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>SUBSTANCE ABUSE</b>		
<b>Inpatient Detox and Rehab</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>Outpatient</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>CHIROPRACTIC</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible Covered if medically necessary	50% after deductible if medically necessary
<b>DURABLE MEDICAL EQUIPMENT</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible	50% after deductible
<b>HEARING AIDS</b>	Innovation Health Facility: 25% after deductible Choice POS II facility: 35% after deductible \$2,500 per pair every three years	35% 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.