

LEIDOS
2018 Plan Year Benefit Summary

PLAN NAME	Healthy Focus Essential Plan
PRODUCT NAME	BlueCard PPO Network
Leidos SYSTEMS CODE	MDBCE
PLAN STATES	AK, AL, AZ, CO, CT, FL, GA, IN, KY, LA, MA, MS, NC, NM, OH, PR, RI, SC, TN, TX, UT, WA, APO/FPO*
CUSTOMER SERVICE PHONE	1-866-403-6183
WEB ADDRESS	www.anthem.com/Leidos/ ; https://www.leidos.com/benefitspd

Benefit	In Network - Employee Pays	Out of Network*** - Employee Pays
HSA	Employee only: \$500 if salary is \$85,000 or less; \$250 if salary is between \$85,001 and \$150,000 Family: \$875 if salary is \$85,000 or less; \$500 if salary is between \$85,001 and \$150,000 \$0 if salary greater than \$150,000	
HEALTHCARE FSA	If elect HSA, only eligible for limited purpose FSA	
ANNUAL DEDUCTIBLE**	\$2,000 Individual \$4,000 Family**	\$2,000 Individual \$4,000 Family**
(Integrated Deductible w/ Embedded OPM)	\$4,000 Individual w/in Family deductible Not combined with Out of Network	\$4,000 Individual w/in Family deductible Not combined with In Network
ANNUAL OUT-OF-POCKET MAXIMUM	\$5,000 Individual \$10,000 Family	\$5,000 Individual \$10,000 Family
(Integrated Deductible w/ Embedded OPM)	\$7,150 Individual w/in Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with Out of Network	\$7,150 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	35% after deductible	50% after deductible
LAB X-RAY DIAGNOSTICS	35% 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	35% after deductible	50% after deductible
Outpatient	35% after deductible	50% after deductible
EMERGENCY CARE		
In-area	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
Out-of-area	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
PRESCRIPTIONS		
Retail	After deductible, \$5 generics, 30% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
Mail-Order	After deductible, \$5 generics, 30% brand and 50% non-formulary brand. Certain preventive drugs not subject to deductible.****	Not covered
MENTAL HEALTH		
Inpatient	35% after deductible	50% after deductible
Outpatient	35% after deductible	50% after deductible
SUBSTANCE ABUSE		
Inpatient Detox and Rehab	35% after deductible	50% after deductible
Outpatient	35% after deductible	50% after deductible
CHIROPRACTIC	35% after deductible if medically necessary	50% after deductible if medically necessary
DURABLE MEDICAL EQUIPMENT	35% after deductible	50% after deductible
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, formerly Medco)

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.