# Leidos
## 2018 Plan Year Benefit Summary

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|---|---|
| PLAN NAME | **KAISER/So. California & KAISER/No. California** |
| PRODUCT NAME | **HMO - Low Deductible** |
| Leidos SYSTEMS CODE | KSCA & KNCA |
| GROUP NUMBER | 104359 & 8528 |
| PLAN STATES | CA |
| CUSTOMER SERVICE PHONE | 1-800-464-4000 |
| WEB ADDRESS | https://my.kp.org/leidos/ |

| Benefit | 2018 Plan Year - In Network - Employee Pays |
|---|---|
| **ANNUAL DEDUCTIBLE** | $500 Individual<br>$1,000 Family |
| **ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)** | $3,000 Individual<br>$6,000 Family |
| **LIFETIME MAXIMUM BENEFIT** | None |
| **OFFICE VISITS** | $10 copay |
| **LAB X-RAY DIAGNOSTICS** | Deductible, then $10 copay |
| **PREVENTIVE CARE** | $0 copay |
| **HOSPITAL CARE** | |
| **Inpatient** | Deductible, then 10% |
| **Outpatient** | Deductible, then 10% |
| **EMERGENCY CARE** | |
| **In-area** | Deductible, then 10% |
| **Out-of-area** | |
| **PRESCRIPTIONS** | |
| **Retail** | $10 Generic and $30 Brand<br>30 day supply |
| **Mail-Order** | $20 Generic and $60 Brand<br>100 day supply |
| **MENTAL HEALTH** | |
| **Inpatient** | Deductible, then 10% |
| **Outpatient** | $10 copay for individual visit<br>$5 copay for group visit<br>$5 copay per day for other outpatient services |
| **SUBSTANCE ABUSE** | |
| **Inpatient Detox and Rehab** | Deductible, then 10% |
| **Outpatient** | $10 copay for individual visit<br>$5 copay for group visit<br>$5 copay per day for other outpatient services |
| **CHIROPRACTIC** | Not Covered |
| **DURABLE MEDICAL EQUIPMENT** | 20% |
| **VISION EXAMS** | $10 copay per visit or $0 if coded as preventive care |
| **EYEWEAR** | Not Covered |

***Available in selected service areas. Contact the Employee Service Center to determine if you reside in the plan service area.**

***This benefit summary has been prepared by Mercer based on documents provided by the applicable licensed insurance carrier. Please refer to the Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document/Certificate, the Plan Document/Certificate governs. Contact Plan for limitations, exclusions, and additional costs.***