## Leidos 2025 Plan Year Benefit Summary

PLAN NAME KAISER / Hawaii
PRODUCT NAME Traditional HMO

Leidos SYSTEMS CODE KSHI
GROUP NUMBER 1547
PLAN STATES HI

CUSTOMER SERVICE PHONE 1-808-432-5955 (Oahu) or 1-800-966-5955 (Neighbor

WEB ADDRESS <a href="https://healthy.kaiserpermanente.org/">https://healthy.kaiserpermanente.org/</a>

ANNUAL DEDUCTIBLE**  ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)  LIFETIME MAXIMUM BENEFIT  OFFICE VISITS  S15 copay per visit  LAB X-RAY DIAGNOSTICS  PREVENTIVE CARE  HOSPITAL CARE Inpatient  Out-of-area  PRESCRIPTIONS  Retail  S10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order  S20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient  S50 copay  Outpatient  \$50 copay  MENTAL HEALTH Inpatient  \$50 copay  Outpatient  \$50 copay  Dotaptient  \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  MENTAL HEALTH Inpatient  \$50 copay  Outpatient  \$50 copay	Benefit	2025 Plan Year - In Network - Employee Pays
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) LIFETIME MAXIMUM BENEFIT Unlimited  OFFICE VISITS \$15 copay per visit  LAB X-RAY DIAGNOSTICS Deductible, then 10% PREVENTIVE CARE HOSPITAL CARE Inpatient Outpatient S50 copay Outpatient S50 copay  EMERGENCY CARE In-area S50 copay per visit. Must notify plan within 48 hours Out-of-area PRESCRIPTIONS Retail \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient S50 copay Outpatient \$50 copay Outpatient S50 copay Outpatient S50 copay Outpatient S50 copay Outpatient S50 copay Outpatient DEDUCATE DURABLE MEDICAL EQUIPMENT Deductible, then 20% VISION EXAMS		
INCLUDING DEDUCTIBLE)  LIFETIME MAXIMUM BENEFIT  Unlimited  OFFICE VISITS  \$15 copay per visit  LAB X-RAY DIAGNOSTICS  Deductible, then 10%  PREVENTIVE CARE Inpatient  S50 copay  Outpatient  Inarea  Out-of-area  PRESCRIPTIONS Retail  Mail-Order  MENTAL HEALTH Inpatient  S50 copay  Outpatient  \$50 copay  Mental HEALTH Inpatient  \$50 copay  Outpatient  \$50 copay  S50 copay  S50 copay per visit. Must notify plan within 48 hours  Again and Again	ANNUAL DEDUCTIBLE**	None
LIFETIME MAXIMUM BENEFIT  OFFICE VISITS  \$15 copay per visit  LAB X-RAY DIAGNOSTICS  Deductible, then 10%  PREVENTIVE CARE  HOSPITAL CARE Inpatient  Outpatient  S50 copay  Outpatient  In-area  Out-of-area  PRESCRIPTIONS  Retail  \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order  \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient  S50 copay  Outpatient  \$50	ANNUAL OUT-OF-POCKET MAXIMUM	\$2,000 Individual
OFFICE VISITS  LAB X-RAY DIAGNOSTICS  PREVENTIVE CARE  Covered at 100%  HOSPITAL CARE Inpatient  S50 copay  Outpatient  In-area  Out-of-area  PRESCRIPTIONS Retail  Mail-Order  MENTAL HEALTH Inpatient  S50 copay  Outpatient  \$50 copay  \$50 copay per visit. Must notify plan within 48 hours  PRESCRIPTIONS  Retail  \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  MENTAL HEALTH Inpatient  \$50 copay  Outpatient  \$50 copay  Outpatie	(INCLUDING DEDUCTIBLE)	
LAB X-RAY DIAGNOSTICS  PREVENTIVE CARE  HOSPITAL CARE Inpatient  Outpatient  S50 copay  Outpatient  In-area  Out-of-area  PRESCRIPTIONS Retail  Mail-Order  MENTAL HEALTH Inpatient  S50 copay  Outpatient  \$50 copay  \$50 copay per visit. Must notify plan within 48 hours  PRESCRIPTIONS  Retail  \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  MENTAL HEALTH Inpatient  \$50 copay  Outpatient	LIFETIME MAXIMUM BENEFIT	Unlimited
PREVENTIVE CARE  HOSPITAL CARE Inpatient  Outpatient  EMERGENCY CARE In-area Out-of-area  PRESCRIPTIONS Retail  Mail-Order  MENTAL HEALTH Inpatient  Sto copay  Outpatient  \$50 copay  MENTAL HEALTH Inpatient  \$50 copay  Outpatient  \$50 copay  Outpatient  \$50 copay  MENTAL HEALTH Inpatient  \$50 copay  Outpatient  \$50 copay  Outpatient  \$50 copay  Outpatient  \$50 copay  Outpatient  \$15 copay  Outpatient  Deductible, then 20%  VISION EXAMS	OFFICE VISITS	\$15 copay per visit
HOSPITAL CARE Inpatient \$50 copay  Outpatient \$15 copay  EMERGENCY CARE In-area \$50 copay per visit. Must notify plan within 48 hours  Out-of-area \$50 copay per visit. Must notify plan within 48 hours  PRESCRIPTIONS Retail \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	LAB X-RAY DIAGNOSTICS	Deductible, then 10%
Inpatient \$50 copay  Outpatient \$15 copay  EMERGENCY CARE In-area \$50 copay per visit. Must notify plan within 48 hours  Out-of-area \$50 copay per visit. Must notify plan within 48 hours  PRESCRIPTIONS Retail \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient \$50 copay  Outpatient \$50 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	PREVENTIVE CARE	Covered at 100%
Outpatient \$15 copay  EMERGENCY CARE In-area \$50 copay per visit. Must notify plan within 48 hours  Out-of-area \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	HOSPITAL CARE	
EMERGENCY CARE In-area  Out-of-area  PRESCRIPTIONS Retail  Mail-Order  MENTAL HEALTH Inpatient Inpatient SUBSTANCE ABUSE Inpatient Detox and Rehab Outpatient  CHIROPRACTIC DURABLE MEDICAL EQUIPMENT  S50 copay  \$50 copay \$50 copay \$50 copay \$50 copay \$50 copay \$50 copay  Not Covered DURABLE MEDICAL EQUIPMENT Deductible, then 20%  \$15 copay	Inpatient	\$50 copay
In-area Out-of-area  PRESCRIPTIONS Retail  Mail-Order  Mail-Order  MENTAL HEALTH Inpatient Inpatient SUBSTANCE ABUSE Inpatient Detox and Rehab Outpatient  SUBSTANCE ABUSE Inpatient Outpatient SUBSTANCE ABUSE Inpatient Outpatient SUBSTANCE ABUSE Inpatient Detox and Rehab SSO copay  Outpatient SSO copay  Outp	Outpatient	\$15 copay
Out-of-area \$50 copay per visit. Must notify plan within 48 hours  PRESCRIPTIONS Retail \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	EMERGENCY CARE	
PRESCRIPTIONS Retail \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	In-area	CEO consumer visit. Must notify plan within 40 hours
Retail \$10 Generic / \$35 Brand / \$200 Specialty 30 day supply  Mail-Order \$20 Generic and \$70 Brand 90 day supply  MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	Out-of-area	550 Copay per visit. Iwust notify pian within 46 hours
30 day supply	PRESCRIPTIONS	
Mail-Order\$20 Generic and \$70 Brand 90 day supplyMENTAL HEALTH Inpatient\$50 copayOutpatient\$15 copaySUBSTANCE ABUSE Inpatient Detox and Rehab\$50 copayOutpatient\$15 copayCHIROPRACTICNot CoveredDURABLE MEDICAL EQUIPMENTDeductible, then 20%VISION EXAMS\$15 copay	Retail	\$10 Generic / \$35 Brand / \$200 Specialty
MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC \$15 copay  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay		
MENTAL HEALTH Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC \$15 copay  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	Mail-Order	·
Inpatient \$50 copay  Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	MENTAL HEALTH	90 day supply
Outpatient \$15 copay  SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay		¢50 conqu
SUBSTANCE ABUSE Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	<u> </u>	
Inpatient Detox and Rehab \$50 copay  Outpatient \$15 copay  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	•	\$15 copay
Outpatient \$15 copay CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20% VISION EXAMS \$15 copay	SUBSTANCE ABUSE	
CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Deductible, then 20%  VISION EXAMS \$15 copay	Inpatient Detox and Rehab	\$50 copay
DURABLE MEDICAL EQUIPMENT  VISION EXAMS  Deductible, then 20%  \$15 copay	Outpatient	\$15 copay
VISION EXAMS \$15 copay	CHIROPRACTIC	Not Covered
7	DURABLE MEDICAL EQUIPMENT	Deductible, then 20%
EVEWEAP \$150 allowance per calendar year (adult)	VISION EXAMS	\$15 copay
\$150 allowance per calendar year (addit)	EYEWEAR	\$150 allowance per calendar year (adult)

<sup>\*</sup>Available in selected service areas. Contact the Employee Service Centerat at 855-5-LEIDOS, Option 3 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.

<sup>\*\*</sup>The family deductible is an aggregate deductible where you must satisfy entire deductible before the plan pays benefits for any member