LEIDOS
2026 Plan Year Benefit Summary

PLAN NAME	**SmarterCare PPO**
PLAN STATES	All 50 States
CUSTOMER SERVICE PHONE	1-833-549-1179
WEB ADDRESS	www.anthem.com

Benefit	In Network - Employee Pays	Out of Network[1] - Employee Pays
ANNUAL DEDUCTIBLE[2] **(Integrated Deductible & OOPM)**	$750 Individual $1,500 Family Not combined with Out-of-Network	$4,000 Individual $8,000 Family Not combined with In-Network
ANNUAL OUT-OF-POCKET MAXIMUM[3] **(INCLUDING DEDUCTIBLE)** **(Integrated Deductible & OOPM)**	$2,000 Individual $4,000 Family Plan pays 100% of eligible expenses after this amount has been satisfied. Not combined with Out of Network	$8,000 Individual $16,000 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	PCP: $30 copay; SCP: $60 copay (no deductible)	50% after deductible
LAB / X-RAY DIAGNOSTICS	20% 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	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
EMERGENCY CARE		
In-area	$300 copay + 20% For non-emergent use of the emergency room, employee pays $300 copay + 50%	$300 copay + 20% For non-emergent use of the emergency room, employee pays $300 copay + 50%
Out-of-area	$300 copay + 20% For non-emergent use of the emergency room, employee pays $300 copay + 50%	$300 copay + 20% For non-emergent use of the emergency room, employee pays $300 copay + 50%
PRESCRIPTIONS[4]	No deductible	
Retail	$10 generics, 20% brand and 50% non-formulary brand	Not covered
Mail-Order	$20 generics, 20% brand and 50% non-formulary brand	Not covered
MENTAL HEALTH		
Inpatient	20% after deductible	50% after deductible
Office Visits	$30 copay (no deductible)	50% after deductible
SUBSTANCE ABUSE		
Inpatient Detox and Rehab	20% after deductible	50% after deductible
Office Visits	$30 copay (no deductible)	50% after deductible
CHIROPRACTIC	PCP: $30 copay; SCP: $60 copay (no deductible)	50% after deductible
DURABLE MEDICAL EQUIPMENT	20% after deductible	50% after deductible
HEARING AIDS **Combined in-network and out-of-network limit**	20% after deductible $2,500 per pair every three years	20% after deductible $2,500 per pair every three years

[1] For physician charges, out-of-network benefits are based on 150% of the Medicare reimbursement amount. Does not apply to Mental Health and Substance Use Disorder claims. If a Medicare reimbursement is not available, Anthem will calculate the claim payment based on rates paid in that specific region. For facility charges, benefits are based on Anthem's maximum

[2]The family deductible can be satisfied by any combination of family members but an individual would never satisfy more than their own individual amount.

[3]The family out-of-pocket maximum can be satisfied by any combination of family members but an individual would never satisfy more than their own individual amount.

[4] Prescription Drugs are administered by Capital Rx

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.