LEIDOS
2027 Plan Year Benefit Summary

PLAN NAME	**HMSA/HI**
PRODUCT NAME	**Preferred Provider Plan**
LEIDOS SYSTEMS CODE	HMSA
GROUP NUMBER	17640-1-8
PLAN STATES	HI
CUSTOMER SERVICE PHONE	1-808-948-6111
WEB ADDRESS	www.hmsa.com

Benefit	In Network – Employee Pays	Out of Network – Employee Pays*
ANNUAL DEDUCTIBLE	None	$100 Individual $300 Family
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)	Medical: $2,500 Individual / $7,500 Family Rx: $5,000 Individual / $7,500 Family Combined with Out-of-Network	Medical: $2,500 Individual / $7,500 Family Rx: $5,000 Individual / $7,500 Family Combined with In-Network
LIFETIME MAXIMUM BENEFIT	Unlimited	
OFFICE VISITS	$12 copay	30% after deductible
LAB X-RAY DIAGNOSTICS	Inpatient: 10% Outpatient: 20%	30% after deductible
PREVENTIVE CARE	Preventive screenings are covered at 100% based on USPSTF Recommendations Grade A and B	30% (deductible may apply; contact Plan for specifics)
HOSPITAL CARE		
Inpatient	10%	30% after deductible
Outpatient	10% coinsurance	30% after deductible
EMERGENCY CARE		
In-area	20% coinsurance	
Out-of-area	20% coinsurance	
Physician Visit	$12 copay	$12 copay (deductible does not apply)
Urgent Care	$17 copay	30% after deductible
PRESCRIPTIONS		
Out-of-Pocket Limit (annual)	$5,000 Individual $7,500 Family	$5,000 Individual $7,500 Family
Retail	Generic: $7 copay Preferred Brand: $30 copay Other Brand: $30 copay plus $45 other brand name cost share Mostly Specialty Drugs: 20% up to 30 day supply Other Specialty Drugs: 25% up to 30 day supply	Generic: $7 copay + 20% Preferred Brand: $30 copay + 20% Other Brand: $30 copay plus $45 other brand name cost share + 20% Mostly Specialty Drugs: Not covered Other Specialty Drugs: Not covered
Mail-Order	Generic: $11 copay Preferred Brand: $65 copay Other Brand: $65 copay plus $135 other brand name cost share Up to 90 day supply Mostly Specialty Drugs: Not covered Other Specialty Drugs: Not covered	Not covered
MENTAL HEALTH		
Inpatient	Hospital and Facility Services: 10% Physician Services: 10% Psychological Testing: 10% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics
Outpatient	Hospital and Facility Services: 10% Physician Services: $12 copay Psychological Testing: 20% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics

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SUBSTANCE ABUSE		
Inpatient Detox and Rehab	Hospital and Facility Services: 10% Physician Services: 10% Psychological Testing: 10% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics
Outpatient	Hospital and Facility Services: 10% Physician Services: $12 copay Psychological Testing: 20% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics
CHIROPRACTIC	Regular plan benefits apply	
DURABLE MEDICAL EQUIPMENT	20%	30% after deductible
VISION EXAMS	Not covered	Not covered
EYEWEAR	Not covered	Not covered

This plan is only available in selected service areas. Contact the Leidos Employee Services at 855-5-LEIDOS Option 3, to determine if you reside in the plan service area.

***Out-of-Network benefits based on Usual, Reasonable, and Customary (URC) charges for the specific service in that geographic region.**

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.