LEIDOS
2027 Plan Year Benefit Summary

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://choose.kp.org/leidos

Benefit	In Network – Employee Pays
ANNUAL DEDUCTIBLE	$500 Individual $1,000 Family
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)	$3,000 Individual $6,000 Family
LIFETIME MAXIMUM BENEFIT	None
OFFICE VISITS	$10 copay
LAB X-RAY DIAGNOSTICS	$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	
Emergency Transportation	10% coinsurance, up to a $150 copay maximum
PRESCRIPTIONS	
Retail	$10 Generic and $30 Brand 30 day supply
Mail-Order	$20 Generic and $60 Brand 100 day supply
MENTAL HEALTH	
Inpatient	No charge
Outpatient	No charge
SUBSTANCE ABUSE	
Inpatient Detox and Rehab	No charge
Outpatient	No charge
CHIROPRACTIC	Not covered
DURABLE MEDICAL EQUIPMENT	20%, deductible does not apply
VISION EXAMS	No charge
EYEWEAR	Not covered

***Available in selected service areas. Contact the Employee Service Center at 855-5-LEIDOS, Option 3 to determine if you reside in the plan service area.**

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.