LEIDOS
2027 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 Islands)
WEB ADDRESS	https://choose.kp.org/leidos

Benefit	In Network – Employee Pays
ANNUAL DEDUCTIBLE**	None
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)	$2,000 Individual $6,000 Family
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	$15 copay per visit
LAB X-RAY DIAGNOSTICS	10% after deductible
PREVENTIVE CARE	Covered at 100%
HOSPITAL CARE	
Inpatient	$50 per day
Outpatient	$15 copay
EMERGENCY CARE	
In-area	$50 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 100 day supply
MENTAL HEALTH	
Inpatient	$50 per day
Outpatient	$15 copay
SUBSTANCE ABUSE	
Inpatient Detox and Rehab	$50 per day
Outpatient	$15 copay
CHIROPRACTIC	Not covered
DURABLE MEDICAL EQUIPMENT	20% after deductible
VISION EXAMS	$15 copay
EYEWEAR	$150 allowance per calendar year

***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.**

****The family deductible is an aggregate deductible where you must satisfy entire deductible before the plan pays benefits for any member.**

Please refer to the Plan Document/Certificate 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 Plan Document/Certificate 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.