LEIDOS
2027 Plan Year Benefit Summary

PLAN NAME	**KAISER/Wash. D.C. Area**
PRODUCT NAME	**Signature HMO***
LEIDOS SYSTEMS CODE	KSDC
GROUP NUMBER	3120
PLAN STATES	DC/MD/VA
CUSTOMER SERVICE PHONE	1-800-777-7902 or 301-468-6000
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	Unlimited
OFFICE VISITS	$10 copay (waived for children under 5)
LAB X-RAY DIAGNOSTICS	$10 copay $50 specialty imaging CT Scan / MRI
PREVENTIVE CARE	$0 copay
HOSPITAL CARE	
Inpatient	10% after deductible
Outpatient	10% after deductible
EMERGENCY CARE	
In-area	10% after deductible
Out-of-area	
PRESCRIPTIONS	
Retail (Generic / Brand Form. / Brand Non-Form.)	Kaiser Pharmacy: $10 / $30 / $50 Community Pharmacy: $30 / $50 / $75
Mail-Order	$20 / $60 / $100
MENTAL HEALTH	
Inpatient	No charge
Outpatient	No charge
SUBSTANCE ABUSE	
Inpatient Detox and Rehab	No charge
Outpatient	No charge
CHIROPRACTIC	$10 copay per visit; 20 visits per contract year
DURABLE MEDICAL EQUIPMENT	10% after deductible
VISION EXAMS	$10 copay per visit
EYEWEAR	Adult: Eyeglass lenses and frames: $75 discount off retail price for eyeglass lenses and for eyeglass frames, combined, in lieu of the discount on contact lenses once per calendar year Contact lenses: $25 discount off retail price on initial pair of contact lenses, in lieu of the discount on glasses, once per calendar year. Pediatric: Eyeglass lenses and frames: No charge for one pair per calendar year Contact lenses: No charge for initial fit and first purchase per calendar year

***Available in selected service areas. Contact Employee Services 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 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.