LEIDOS
2027 Plan Year Benefit Summary

PLAN NAME	**TSSS**
PRODUCT NAME	**Preferred Provider Plan**
LEIDOS SYSTEMS CODE	TSSS
GROUP NUMBER	SP0007021
PLAN TERRITORY	PR
CUSTOMER SERVICE PHONE	787-774-6060
WEB ADDRESS	www.ssspr.com

Benefit	Employee Pays
ANNUAL DEDUCTIBLE	N/A
ANNUAL OUT-OF-POCKET MAXIMUM	$6,350 Individual $12,700 Family
LIFETIME MAXIMUM BENEFIT	Unlimited
OFFICE VISITS	$10 General Practitioner $20 Specialist/Sub-specialist $0 copay in Salus Clinics
LAB X-RAY DIAGNOSTICS	25% In-network / 40% Out of Network 0% coinsurance in Salus Clinics
PREVENTIVE CARE	Covered 100%
HOSPITAL CARE	
Inpatient	$75 Preferred Hospital / $125 Non-Preferred Hospital
Partial Hospitalization	$35 Preferred Hospital / $60 Non-Preferred Hospital
Ambulatory Surgery	$75 copay
EMERGENCY CARE	
Accident	$0 copay
Illness	$100 copay
Recommended by Teleconsulta	$25 copay
Urgent Care	$15 copay illness and accident $10 copay in Salus Clinics
TELECONSULTA MD	$10 copay per virtual visit
MICONSULTA MD	$0 copay
PRESCRIPTIONS	
Retail	Preferred Generic: $10 copay Non-Preferred Generic: $10 copay Preferred Brand: 25% minimum $25 Non-Preferred Brand: 35% minimum $35 Preferred Specialty Medication: 30% Non-Preferred Specialty Medication: 30% Oral Chemotherapy: 10% $0 copay Over the Counter (OTC List)
Mail-Order/90 days Retail	Preferred Generic: $20 copay Non-Preferred Generic: $20 copay Preferred Brand: 19% minimum $50 Non-Preferred Brand: 27% minimum $70
MENTAL HEALTH	
Inpatient	Hospital and Facility Services: $75 Preferred Hospital / $125 copay Non-Preferred Hospital / $35 Preferred Hospital / $60 Non-Preferred Hospital
Outpatient	Hospital and Facility Services: $75 Preferred Hospital / $125 copay Non-Preferred Hospital / $35 Preferred Hospital / $60 Non-Preferred Hospital Physician Services: $20 copay Contact plan for specifics
Group Therapy Visits	$20 copay

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Benefit	Employee Pays
SUBSTANCE ABUSE	
Inpatient Detox and Rehab	Hospital and Facility Services: $75 Preferred Hospital / $125 copay Non-Preferred Hospital / $35 Preferred Hospital / $60 Non-Preferred Hospital
Outpatient	Hospital and Facility Services: $75 Preferred Hospital / $125 copay Non-Preferred Hospital / $35 Preferred Hospital / $60 Non-Preferred Hospital Physician Services: $20 copay Contact plan for specifics
CHIROPRACTIC	$7 copay manipulations
DURABLE MEDICAL EQUIPMENT	25% coinsurance
ORGAN TRANSPLANT	100% Covered up to $2,000,000 per lifetime
VISION	Eyeglasses or contact lenses up to $100 per policy year
TRIPLE S NATURAL	$15 copay up to six (6) visits per policy year
LIFE INSURANCE	$10,000 Basic Life and $10,000 AD&D

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.

For services rendered by non-participating providers in Puerto Rico, the member will pay the difference between the billed amount and Triple S established fees for participating providers. Services outside of Puerto Rico are covered through the Blue Cross & Blue Shield (BCBS) network and require preauthorization. Non-participating providers are covered only in case of emergency. Triple S will pay these services per the fees established by the local BCBS plan for non-participating providers.

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.