## Leidos 2018 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://my.kp.org/leidos/

ANNUAL DEDUCTIBLE \$\$0 Individual \$1,000 Family ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) \$\$0,000 Family LIFETIME MAXIMUM BENEFIT None OFFICE VISITS \$\$10 copay LAB X-RAY DIAGNOSTICS Deductible, then \$10 copay PREVENTIVE CARE HOSPITAL CARE Inpatient Outpatient Deductible, then 10% Outpatient Deductible, then 10% Out-of-area PRESCRIPTIONS Retail \$\$10 Generic and \$30 Brand 30 day supply  MENTAL HEALTH Inpatient Outpatient Deductible, then 10%  Outpatient S\$0 Generic and \$40 Brand 100 day supply  MENTAL HEALTH Inpatient Outpatient S\$0 copay for group visit \$\$5 copay for group visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for individual visit \$\$5 copay for group visit \$\$5 copay for group visit \$\$5 copay for group visit \$\$5 copay for dother outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT VISION EXAMS \$\$10 copay for visit or \$\$0 if coded as preventive care  EYEWEAR	Benefit	2018 Plan Year - In Network - Employee Pays
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE) S8,000 Family LIFETIME MAXIMUM BENEFIT None OFFICE VISITS S10 copay  LAB X-RAY DIAGNOSTICS Deductible, then \$10 copay PREVENTIVE CARE HOSPITAL CARE Inpatient Outpatient Deductible, then 10% Outpotient S10 Generic and \$30 Brand 30 day supply Mail-Order S20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10% Outpatient S10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10% Outpatient S10 copay for individual visit \$5 copay for group visit \$5 copay for group visit \$5 copay for group visit \$5 copay for individual visit \$5 copay for individual visit \$5 copay for group visit \$5 copay for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	ANNUAL DEDUCTIBLE	
CINCLUDING DEDUCTIBLE)   \$6,000 Family     LIFETIME MAXIMUM BENEFIT		\$1,000 Family
LIFETIME MAXIMUM BENEFIT OFFICE VISITS S10 copay  LAB X-RAY DIAGNOSTICS Deductible, then \$10 copay  PREVENTIVE CARE HOSPITAL CARE Inpatient Deductible, then 10% Outpatient EMERGENCY CARE In-area Out-of-area PRESCRIPTIONS Retail \$10 Generic and \$30 Brand 30 day supply  MAII-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient Deductible, then 10%  S20 Generic and \$30 Brand 30 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient S10 copay for individual visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	ANNUAL OUT-OF-POCKET MAXIMUM	
DEFICE VISITS  LAB X-RAY DIAGNOSTICS  PREVENTIVE CARE  HOSPITAL CARE Inpatient  Outpatient  EMERGENCY CARE In-area  Out-of-area  PRESCRIPTIONS  Retail  Mail-Order  MENTAL HEALTH Inpatient  Deductible, then 10%  Outpatient  Deductible, then 10%  So Generic and \$30 Brand 30 day supply  MENTAL HEALTH Inpatient  Outpatient  Deductible, then 10%  Deductible, then 10%  So Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient  Deductible, then 10%  Outpatient  So Copay for group visit \$5 copay for group visit \$5 copay for group visit \$5 copay for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab  Deductible, then 10%  Outpatient  So Copay for group visit \$5 copay for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab  Deductible, then 10%  Outpatient  So Copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC  Not Covered  DURABLE MEDICAL EQUIPMENT  20%	(INCLUDING DEDUCTIBLE)	\$6,000 Family
LAB X-RAY DIAGNOSTICS   Deductible, then \$10 copay	LIFETIME MAXIMUM BENEFIT	None
PREVENTIVE CARE  HOSPITAL CARE Inpatient  Outpatient  Deductible, then 10%  Deductible, then 10%  EMERGENCY CARE In-area  Out-of-area  PRESCRIPTIONS  Retail  \$10 Generic and \$30 Brand 30 day supply  Mail-Order  \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient  Deductible, then 10%  Outpatient  \$5 copay for individual visit \$5 copay for group visit \$5 copay for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab  Outpatient  \$10 copay for individual visit \$5 copay for group visit \$5 copay for group visit \$5 copay for other outpatient services  CHIROPRACTIC  Not Covered  DURABLE MEDICAL EQUIPMENT  20%  VISION EXAMS  \$10 copay per visit or \$0 if coded as preventive care	OFFICE VISITS	\$10 copay
HOSPITAL CARE Inpatient Deductible, then 10% Outpatient Deductible, then 10%  EMERGENCY CARE In-area Deductible, then 10%  Out-of-area PRESCRIPTIONS Retail \$10 Generic and \$30 Brand 30 day supply  Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	LAB X-RAY DIAGNOSTICS	Deductible, then \$10 copay
Inpatient Deductible, then 10% Outpatient Deductible, then 10%  EMERGENCY CARE In-area Deductible, then 10%  Out-of-area PRESCRIPTIONS Retail \$10 Generic and \$30 Brand 30 day supply Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay for group visit \$5 copay for group visit \$5 copay for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	PREVENTIVE CARE	\$0 copay
Outpatient     Deductible, then 10%       EMERGENCY CARE       In-area     Deductible, then 10%       Out-of-area     Deductible, then 10%       PRESCRIPTIONS       Retail     \$10 Generic and \$30 Brand       30 day supply       Mail-Order     \$20 Generic and \$60 Brand       100 day supply       MENTAL HEALTH     Inpatient       Inpatient     Deductible, then 10%       Outpatient     \$10 copay for individual visit       \$5 copay per day for other outpatient services       SUBSTANCE ABUSE     Inpatient Detox and Rehab     Deductible, then 10%       Outpatient     \$10 copay for individual visit       \$5 copay for group visit     \$5 copay for group visit       \$5 copay per day for other outpatient services       CHIROPRACTIC     Not Covered       DURABLE MEDICAL EQUIPMENT     20%       VISION EXAMS     \$10 copay per visit or \$0 if coded as preventive care	HOSPITAL CARE	
EMERGENCY CARE In-area  Out-of-area  PRESCRIPTIONS Retail \$10 Generic and \$30 Brand 30 day supply  Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	Inpatient	Deductible, then 10%
In-area   Deductible, then 10%	Outpatient	Deductible, then 10%
Out-of-area  PRESCRIPTIONS  Retail \$10 Generic and \$30 Brand 30 day supply  Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	EMERGENCY CARE	
PRESCRIPTIONS  Retail \$10 Generic and \$30 Brand 30 day supply  Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Substance Abuse Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	In-area	Deductible thee 100/
Retail \$10 Generic and \$30 Brand 30 day supply  Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	Out-of-area	Deductible, then 10%
Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	PRESCRIPTIONS	
Mail-Order \$20 Generic and \$60 Brand 100 day supply  MENTAL HEALTH Inpatient Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay for group visit \$5 copay for group visit \$5 copay for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	Retail	\$10 Generic and \$30 Brand
MENTAL HEALTH Inpatient Deductible, then 10% Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10% Outpatient \$10 copay for individual visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20% VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care		, ,,,
MENTAL HEALTH Inpatient  Outpatient  S10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab  Outpatient  S10 copay for individual visit \$5 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC  Not Covered  DURABLE MEDICAL EQUIPMENT  20%  VISION EXAMS  \$10 copay per visit or \$0 if coded as preventive care	Mail-Order	
Inpatient Outpatient S10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10% Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay for group visit \$5 copay for group visit \$5 copay for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20% VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care		100 day supply
Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10% Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	MENTAL HEALTH	
\$5 copay for group visit \$5 copay per day for other outpatient services  SUBSTANCE ABUSE Inpatient Detox and Rehab Deductible, then 10%  Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	Inpatient	· · · · · · · · · · · · · · · · · · ·
SUBSTANCE ABUSE Inpatient Detox and Rehab Outpatient Stopay per day for other outpatient services  Deductible, then 10% Stopay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT Stopay per visit or \$0 if coded as preventive care	Outpatient	
SUBSTANCE ABUSE Inpatient Detox and Rehab  Outpatient S10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care		
Inpatient Detox and Rehab  Outpatient  S10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC  Not Covered  DURABLE MEDICAL EQUIPMENT  VISION EXAMS  Deductible, then 10%  \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  Not Covered  20%		\$5 copay per day for other outpatient services
Outpatient \$10 copay for individual visit \$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care		
\$5 copay for group visit \$5 copay per day for other outpatient services  CHIROPRACTIC  Not Covered  DURABLE MEDICAL EQUIPMENT  VISION EXAMS  \$10 copay per visit or \$0 if coded as preventive care	•	· · · · · · · · · · · · · · · · · · ·
\$5 copay per day for other outpatient services  CHIROPRACTIC Not Covered  DURABLE MEDICAL EQUIPMENT 20%  VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care	Outpatient	
CHIROPRACTIC     Not Covered       DURABLE MEDICAL EQUIPMENT     20%       VISION EXAMS     \$10 copay per visit or \$0 if coded as preventive care		
DURABLE MEDICAL EQUIPMENT     20%       VISION EXAMS     \$10 copay per visit or \$0 if coded as preventive care	OUUD O DD A OTIO	<u> </u>
VISION EXAMS \$10 copay per visit or \$0 if coded as preventive care		
<u></u>		
EYEWEAR Not Covered		
	EYEWEAR	Not Covered

<sup>\*</sup>Available in selected service areas. Contact the Employee Service Center to determine if you reside in the plan service area.

This benefit summary has been prepared by Mercer based on documents provided by the applicable licensed insurance carrier. Please refer to the Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require precertification 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.