Leidos
2020 Plan Year Benefit Summary

PLAN NAME	**HMSA/HI**
PRODUCT NAME	**Preferred Provider Plan**
Leidos SYSTEMS CODE	HMSA
GROUP NUMBER	17640-1-8
PLAN STATES	HI
CUSTOMER SERVICE PHONE	1-808-948-6111
WEB ADDRESS	www.hmsa.com

Benefit	2020 Plan Year - In Network - Employee Pays	2020 Plan Year - Out of Network*** - Employee Pays
ANNUAL DEDUCTIBLE**	None	$100 Individual $300 Family
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)	$2,500 Individual $7,500 Family Combined with Out-of-Network	$2,500 Individual $7,500 Family Combined with In-Network
LIFETIME MAXIMUM BENEFIT	Unlimited	
OFFICE VISITS	$12 copay	30% after deductible
LAB X-RAY DIAGNOSTICS	Inpatient: 10% Outpatient: 20%	30% after deductible
PREVENTIVE CARE	Routine / annual physical exams not covered. Preventive screenings are covered at 100% based on USPSTF Recommendations Grade A and B	30% (deductible may apply; contact Plan for specifics)
HOSPITAL CARE		
Inpatient	10%	30% after deductible
Outpatient	Cutting and/or Anesthesia: 10% Non-cutting: 20%	30% after deductible
EMERGENCY CARE		
In-area	20% coinsurance	
Out-of-area	20% coinsurance	
PRESCRIPTIONS		
Out-of-Pocket Limit (annual)	$3,600 Individual $4,200 Family	$3,600 Individual $4,200 Family
Retail	Generic: $7 copay Preferred Brand: $30 copay Other Brand: $30 copay plus $45 other brand name cost share Mostly Specialty Drugs: $100 copay/prescription up to 30 day supply Other Specialty Drugs: $200 copay/prescription up to 30 day supply	Generic: $7 copay + 20% Preferred Brand: $30 copay + 20% Other Brand: $30 copay plus $45 other brand name cost share + 20% Mostly Specialty Drugs: Not covered Other Specialty Drugs: Not covered
Mail-Order	Generic: $11 copay Preferred Brand: $65 copay Other Brand: $65 copay plus $135 other brand name cost share Up to 90 day supply Mostly Specialty Drugs: Not covered Other Specialty Drugs: Not covered	Not covered
MENTAL HEALTH		
Inpatient	Hospital and Facility Services: 10% Physician Services: No copay to 10% Psychological Testing: 10% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics
Outpatient	Hospital and Facility Services: 10% Physician Services: $12 copay Psychological Testing: 20% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics
SUBSTANCE ABUSE		
Inpatient Detox and Rehab	Hospital and Facility Services: 10% Physician Services: No copay to 10% Psychological Testing: 10% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics

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Outpatient	Hospital and Facility Services: 10% Physician Services: $12 copay Psychological Testing: 20% Contact plan for specifics	Hospital and Facility Services: 30% after deductible Physician Services: 30% after deductible Psychological Testing: 30% after deductible Contact plan for specifics
CHIROPRACTIC	$12 copay	30% after deductible
DURABLE MEDICAL EQUIPMENT	20%	30% after deductible
VISION EXAMS	Not Covered	Not covered
EYEWEAR	Not Covered	Not covered

***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.**

****Out-of-Network benefits based on Usual, Reasonable, and Customary (URC) charges for the specific service in that geographic region.**

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 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.