

**Leidos**  
**2020 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	<a href="http://kp.org">kp.org</a>

Benefit	2019 Plan Year - In Network - Employee Pays
<b>ANNUAL DEDUCTIBLE**</b>	\$500 Individual \$1,000 Family
<b>ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)</b>	\$3,000 Individual \$6,000 Family
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited
<b>OFFICE VISITS</b>	\$10 copay (waived for children under 5)
<b>LAB X-RAY DIAGNOSTICS</b>	\$10 copay \$50 specialty imaging CT Scan / MRI
<b>PREVENTIVE CARE</b>	\$0 copay with HCR preventive services included
<b>HOSPITAL CARE</b>	
Inpatient	10%
Outpatient	10%
<b>EMERGENCY ROOM</b>	
In-area	
Out-of-area	10%
<b>PRESCRIPTIONS</b>	
Retail (Generic / Brand Form. / Brand Non-Form.)	Kaiser Pharmacy: \$10 / \$30 / \$50 Community Pharmacy: \$30 / \$50 / \$75
Mail-Order	\$20 / \$60 / \$100
<b>MENTAL HEALTH</b>	
Inpatient	10%
Outpatient	\$5 copay for group therapy \$10 copay for individual therapy
<b>SUBSTANCE ABUSE</b>	
Inpatient Detox and Rehab	10%
Outpatient	\$5 copay for group therapy \$10 copay for individual therapy
<b>CHIROPRACTIC</b>	\$10 copay/visit 20 visits/cont yr
<b>DURABLE MEDICAL EQUIPMENT</b>	10%
<b>VISION EXAMS</b>	\$10 copay per visit
<b>EYEWEAR</b>	25% discount

\*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

*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.*