Leidos
2021 Plan Year Benefit Summary

PLAN NAME	**CIGNA INTERNATIONAL HIGH**
PRODUCT NAME	**High Option Comprehensive Medical Plan**
Leidos SYSTEMS CODE	CGHI
GROUP NUMBER	00666A
PLAN STATES	For Expatriate Employees
CUSTOMER SERVICE PHONE	1-800-441-2668 or 001-302-797-3100 outside the US (collect calls accepted)
WEB ADDRESS	www.CIGNAenvoy.com

Benefit	2021 Plan Year - Outside U.S. Employee Pays	2021 Plan Year - In Network U.S. Employee Pays	2021 Plan Year - Out of Network U.S. Employee Pays
ANNUAL DEDUCTIBLE**	$200 Individual $400 Family	$1,000 Individual $2,000 Family	$2,000 Individual $4,000 Family
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)	$1,250 Individual $2,500 Family	$2,000 Individual $4,000 Family	$4,000 Individual $8,000 Family
LIFETIME MAXIMUM BENEFIT		Unlimited	
OFFICE VISITS	15% after plan deductible	20% after plan deductible	40% after plan deductible
LAB X-RAY DIAGNOSTICS	15% after plan deductible	20% after plan deductible	40% after plan deductible
PREVENTIVE CARE		Covered 100%	
HOSPITAL CARE			
Inpatient	15% after deductible and separate $200 copay	20% after deductible and separate $250 copay	40% after deductible and separate $250 copay
Outpatient	15% after plan deductible	20% after plan deductible	40% after plan deductible
EMERGENCY CARE			
In-area	15% after plan deductible	20% after plan deductible	20% after plan deductible (except if not a true emergency, then 40% after plan deductible)
Out-of-area	15% after plan deductible	20% after plan deductible	20% after plan deductible (except if not a true emergency, then 40% after plan deductible)
PRESCRIPTIONS			
Retail	15%. Prescriptions are covered under the major medical coverage subject to coinsurance and annual deductible	20%. Prescriptions are covered under the major medical coverage subject to coinsurance	40%. Prescriptions are covered under the major medical coverage subject to coinsurance and annual deductible
Mail-Order	Not covered	20%. If a prescription is filled via mail order, the benefit is payable under the plan coinsurance.	Not covered
MENTAL HEALTH			
Inpatient	15% after deductible and separate $200 copay	20% after deductible and separate $250 copay	40% after deductible and separate $250 copay
Outpatient	15% after plan deductible	20% after plan deductible	40% after plan deductible
SUBSTANCE ABUSE			
Inpatient Detox and Rehab	15% after deductible and separate $200 copay	20% after deductible and separate $250 copay	40% after deductible and separate $250 copay
Outpatient	15% after plan deductible	20% after plan deductible	40% after plan deductible
CHIROPRACTIC	15% after plan deductible	20% after plan deductible	40% after plan deductible
DURABLE MEDICAL EQUIPMENT	15% after plan deductible. Requires plan preauthorization	20% after plan deductible. Requires plan preauthorization	40% after plan deductible. Requires plan preauthorization
VISION EXAMS	Covered 100% One Per Calendar Year	Covered 100% One Per Calendar Year	Covered 100% One Per Calendar Year
EYEWEAR	$200 Annual Maximum (Frames and Lenses Combined)	$200 Annual Maximum (Frames and Lenses Combined)	$200 Annual Maximum (Frames and Lenses Combined)

******Benefit changes other than those indicated in these summaries may apply due to ongoing evaluation, interpretation, and guidance related to the Patient Protection and Affordable Health Care Act. Please contact plan for complete coverage provisions and limitations.**

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.