**Benefit** | **2021 Plan Year - In Network - Employee Pays**
---|---
**ANNUAL DEDUCTIBLE** | $500 Individual  
$1,000 Family

**ANNUAL OUT-OF-POCKET MAXIMUM** | $3,000 Individual  
$6,000 Family

(INCLUDING DEDUCTIBLE)

**LIFETIME MAXIMUM BENEFIT** | None

**OFFICE VISITS** | $10 copay

**LAB X-RAY DIAGNOSTICS** | Deductible, then $10 copay

**PREVENTIVE CARE** | $0 copay

**HOSPITAL CARE** | Deductible, then 10%

Inpatient

Outpatient

**EMERGENCY CARE** | Deductible, then 10%

In-area

Out-of-area

**PRESCRIPTIONS** | $10 Generic and $30 Brand  
30 day supply  

Mail-Order | $20 Generic and $60 Brand  
100 day supply

**MENTAL HEALTH** | Deductible, then 10%

Inpatient

Outpatient | $10 copay for individual visit  
$5 copay for group visit

**SUBSTANCE ABUSE** | Deductible, then 10%

Inpatient Detox and Rehab

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

**EYEWEAR** | Not Covered

*Available in selected service areas. Contact the Employee Service Center at 855-5-LEIDOS, Option 3 to determine if you reside in the plan service area.

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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.