

**Leidos**  
**2022 Plan Year Benefit Summary**

PLAN NAME	<b>HMSA/HI</b>
PRODUCT NAME	<b>Preferred Provider Plan</b>
Leidos SYSTEMS CODE	HMSA
GROUP NUMBER	17640-1-8
PLAN STATES	HI
CUSTOMER SERVICE PHONE	1-808-948-6111
WEB ADDRESS	<a href="http://www.hmsa.com">www.hmsa.com</a>

Benefit	2022 Plan Year - In Network - Employee Pays	2022 Plan Year - Out of Network* - Employee Pays
<b>ANNUAL DEDUCTIBLE</b>	None	\$100 Individual \$300 Family
<b>ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDING DEDUCTIBLE)</b>	\$2,500 Individual \$7,500 Family Combined with Out-of-Network	\$2,500 Individual \$7,500 Family Combined with In-Network
<b>LIFETIME MAXIMUM BENEFIT</b>	Unlimited	
<b>OFFICE VISITS</b>	\$12 copay	30% after deductible
<b>LAB X-RAY DIAGNOSTICS</b>	Inpatient: 10% Outpatient: 20%	30% after deductible
<b>PREVENTIVE CARE</b>	Preventive screenings are covered at 100% based on USPSTF Recommendations Grade A and B	30% (deductible may apply; contact Plan for specifics)
<b>HOSPITAL CARE</b>		
<b>Inpatient</b>	10%	30% after deductible
<b>Outpatient</b>	Cutting and/or Anesthesia: 10% Non-cutting: 20%	30% after deductible
<b>EMERGENCY CARE</b>		
<b>In-area</b>	20% coinsurance	
<b>Out-of-area</b>	20% coinsurance	
<b>Physician Visit</b>	\$12 copay	
<b>PRESCRIPTIONS</b>		
<b>Out-of-Pocket Limit (annual)</b>	\$3,600 Individual \$4,200 Family	\$3,600 Individual \$4,200 Family
<b>Retail</b>	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
<b>Mail-Order</b>	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
<b>MENTAL HEALTH</b>		
<b>Inpatient</b>	Hospital and Facility Services: 10% Physician Services: 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
<b>Outpatient</b>	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
<b>SUBSTANCE ABUSE</b>		
<b>Inpatient Detox and Rehab</b>	Hospital and Facility Services: 10% Physician Services: 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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<b>Outpatient</b>	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
<b>CHIROPRACTIC</b>	Regular plan benefits apply	
<b>DURABLE MEDICAL EQUIPMENT</b>	20%	30% after deductible
<b>VISION EXAMS</b>	Not Covered	Not covered
<b>EYEWEAR</b>	Not Covered	Not covered

This plan is only available in selected service areas. Contact the Leidos Employee Services at 855-5-LEIDOS Option 3, to determine if you reside in the plan  
 \*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.*