Leidos Benefits Summary Plan Description

Medical Plans

Leidos offers eligible employees four (4) comprehensive Consumer Directed Health Plans (CDHP) featuring a Health Savings Account (HSA):

- **Healthy Focus Basic Plan**
- **Healthy Focus Essential Plan**
- **Healthy Focus Advantage Plan**
- **Healthy Focus Premier Plan**

The plans listed above are self-insured by Leidos, which means that Leidos fully funds the plans.

The CDHP plans feature a Health Savings Account (HSA) to help you save and budget for eligible healthcare expenses, with tax-free advantages. The company may contribute to the Health Savings Account (HSA) if you enroll in a Healthy Focus plan. The biweekly company contribution will be based on an employee's annual salary* and the coverage level elected for medical coverage.

***Note:** Company's HSA contribution will be based on an employee's base salary as of their benefit eligibility/new hire date, whichever occurs later. The Company's contribution will not change in the event that salary and/or coverage level (e.g. Employee Only to Employee+ Spouse) later change.

In addition, employees living in certain areas may also be eligible to elect medical coverage through **Health Maintenance Organizations (HMOs)** or **CIGNA International Plans**.

Eligibility

A Leidos employee is eligible to enroll in Leidos benefit programs under the following conditions:
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Type of Coverage	Eligibility Requirements
Medical Program	• Must be an active, regular full-time employee working at least 30 hours per week or a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and • Must live in the geographic area served by a particular plan.

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Dependents

Participants may also enroll their eligible dependents in some Leidos benefit programs. Dependents that are eligible to be enrolled in these programs are:

- The participant's legal spouse or registered domestic partner (See "Registered Domestic Partners")
- Each child of the participant or registered domestic partner younger than age 26, including:
    - A natural child or stepchild;
    - An adopted child (coverage begins as of the earlier of the date the child was placed in the participant's home or the date of final adoption); and
    - Any other child who depends on the participant for support and lives with the participant in a parent-child relationship, if the participant provides proof of legal guardianship.
- Unmarried children, age 26 and older who are incapable of self-sustaining employment because they are mentally or physically disabled, as long as:
    - The mental or physical disability existed while the child was covered under the plan and began before age 26;
    - The child is primarily dependent on the participant for support; and
    - The participant provides periodic evidence of incapacity.

Participants must notify HR Employee Services, in writing, within 31 days of any change in dependent eligibility.

Important: Double coverage is not allowed under Leidos' benefit programs. Therefore, participants may not cover a spouse, registered domestic partner or dependent child who is also a Leidos employee and has elected his or her own coverage.

If a participant and his or her spouse or registered domestic partner are both Leidos employees, each can choose individual coverage or one can cover the other as a dependent — but not both.

If the participant has children, only the participant or spouse or registered domestic partner can choose coverage for dependent children.

Registered Domestic Partners

The participant may enroll his or her registered domestic partner and the registered domestic partner's eligible dependent children in participating medical, dental and vision plans in which the participant is enrolled.

For purposes of Leidos coverage, a registered domestic partnership is a committed same-sex or opposite-sex relationship, in which registered domestic partners:

- Live together at the same address and have lived together continuously for at least one year;
- Are not legally married to one another or anyone else;
- Do not have another registered domestic partner and have not signed a registered domestic partner declaration with another within the past year;
- Are mentally competent to consent to a contract or affidavit;
- Are not related by blood in such a way as would prohibit legal marriage; and
- Are jointly responsible for each other's common welfare and are financially interdependent.

A *Declaration of Domestic Partnership* must be completed, notarized and submitted with any other required documents in order to enroll a registered domestic partner. The Declaration must be presented to insurers upon request. Contact HR Employee Services for additional information on enrolling in registered domestic partner coverage. The *Declaration of Domestic Partnership* form can be found on the Benefits: Health & Welfare page on Prism.

Registered domestic partner coverage is different from spouse coverage. For instance:

- Participant contributions for registered domestic partner coverage and their eligible children must be paid on an after-tax basis;
- The value of benefits provided to a registered domestic partner and/or his or her eligible children is considered taxable income. As a result, the Leidos employee must pay any state, federal, FICA and other applicable tax withholding in the form of imputed income. This amount is based on the value of the coverage Leidos provides to the partner.

Dependent Eligibility Verification (DEV) Process

As a government contractor, Leidos is required by the Defense Contract Audit Agency (DCAA) to demonstrate that our claims for benefit costs are legitimate and ensure that we provide health and welfare benefit coverage only to eligible dependents of our employees. This ongoing verification also assures that the company does not bill the customer for medical costs associated with ineligible dependents.

To support this ongoing effort, the company maintains a Dependent Eligibility Verification (DEV) program which is administered by a third-party administrator, Budco. Throughout the year, Budco verifies that any dependent added to our plans is, in fact, eligible for coverage. This includes dependents who are enrolled as a result of new employees joining the company, a qualifying life event (i.e., marriage, birth), as well as new dependents added to our plans during the annual Open Enrollment (OE) period in the fall.

In addition to the ongoing verification process, the company is also required to perform random dependent verifications - even if an employee's dependents were previously verified. This is necessary in order to ensure that a dependent's eligibility remains unchanged.

If an employee receives a request from Budco to verify current dependents, even if the dependent has been verified before, it is critical that the request is not ignored. Failure to provide the requested documentation within the specified timeframe will result in the dependent(s) being deemed ineligible and removed from our plans.

Covering ineligible dependents is a violation of the company's Code of Conduct and could expose the company to sanctions from the government. The company's eligibility verification process helps ensure that we are compliant with our requirements as a government contractor.

Questions about the dependent eligibility verification program may be directed to Budco at 866-488-2001, or HR Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

Healthy Focus Basic Plan

The Healthy Focus Basic plan is a Consumer Driven Healthcare Plan (CDHP) that gives participants a choice when it comes to getting medical care. Participants may go to any provider they wish; however, when they use a provider participating in the CDHP network, they receive a higher level of benefits.

Most network and out-of-network services are covered at 50% after the deductible. Regardless of whether a participant uses a network or out-of- network provider, the Healthy Focus Basic plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers prescription drugs purchase data retail pharmacy or through the mail-order program.

Healthy Focus Basic Plan: Cost of Coverage

This section will help participants understand how they pay for medical coverage under the Healthy Focus Basic plan.

Employee Contributions

Leidos and participants share in the cost of coverage. Each pay period, employee contributions are deducted from the participant's paycheck on a biweekly basis. The employee contribution amount will vary based on the coverage level elected:

- Employee only;
- Employee plus spouse or domestic partner;
- Employee plus one or more children; or
- Family coverage

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The individual (employee only coverage) deductible is $4,000; the family deductible is $8,000.

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE. Services must be provided in physician’s office as part of the preventive care office visit. Services provided by third parties are subject to annual deductible and coinsurance.

Coinsurance

"Coinsurance" is the percentage of eligible expenses participant pays for medical services once the participant meets the annual deductible.

Annual Out-Of-Pocket Maximum

The "out-of-pocket maximum" is the amount of coinsurance payments a participant must pay each calendar year before the Healthy Focus Basic plan begins paying 100% of eligible expenses up to the negotiated rate (for in-network providers) or reasonable and customary (R&C) limit (for out-of- network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "Network Benefits" in the Healthy Focus Basic plan section for more information about negotiated rates and "Out-of-Network Benefits" for more information about R&C limits.

The following expenses do not count toward a participant's annual out-of-pocket maximum:

- Payments for eligible expenses incurred in a different calendar year;
- Charges that are not covered under the plan;
- Charges that exceed R&C limits; and
- Charges that exceed the maximum benefits for that year

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum must be met before the plan begins paying 100 percent for any individual. The individual (employee only coverage) annual out-of-pocket maximum is $6,750; the family annual out-of- pocket maximum is $13,000 (with an embedded individual max of $8,150).

Healthy Focus Basic Plan: Plan Design

This section will help participants understand how benefits are payable under the Healthy Focus Basic plan.

Network Benefits

If a participant receives services from a network provider, he or she generally saves money because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, whenever the participant receives medical services, he or she pays a percentage of the provider's negotiated rate (coinsurance). The plan pays the remaining amount.

There are no claim forms to file because the CDHP network provider submits claims for the participant.

Out-of-Network Benefits

When a participant uses a provider who does not participate in the CDHP network, that provider is considered to be out-of-network.

The participant must meet the annual deductible. Then, whenever the participant receives medical services, the plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage (coinsurance) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own claims for reimbursement. Participants should check with their provider for information on their payment and claim filing policies.

Reasonable and Customary (R&C) Limit

The R&C limit is the maximum amount the plan will pay for a covered service received from an out-of-network provider, based on what providers in the participant's geographic area charge for similar services.

Participants are responsible for paying any difference between the R&C limit and the amount billed. The determination of what the reasonable and customary limit is for a specific medical service is within the sole discretion of the Claims Administrator and is not subject to challenge or review.

Multiple and Bilateral Surgical Procedures

Multiple surgical procedures consist of more than one surgical procedure performed on the same date of service during the same surgical session. Bilateral surgeries consist of surgery performed during the same surgical session through separate incisions to matching parts of the body (e.g., both shoulders). When multiple or bilateral surgical procedures are performed during the sameoperative setting, the allowed amount of secondary and subsequent procedures is reduced.

- Major(first)procedure–Covered at100%of R&C
- Second procedure–You pay 50% of R&C
- Subsequent procedure–You pay 75% of R&C

If multiple or bilateral surgicalproceduresareperformedby network providers, participants will not have to pay any more as a result of the reduced amount. Participants who choose out-of- network providers could incur additional costs if the provider chooses to bill the member for the remaining balance.

Multiple Scan / Images Procedure

When multiple images of adjacent bodyparts are taken during a single session, a reduction willbe applied to the technical component of the services performed. Professional fees billed separately are not affected.

- Initial scan/imaging– Covered at 100% of R&C
- Subsequent scan/imaging –You pay 50% of R&C

Healthy Focus Essential Plan

The Healthy Focus Essential plan is a Consumer Driven Healthcare Plan (CDHP) that gives participants a choice when it comes to getting medical care. Participants may go to any provider they wish; however, when they use a provider participating in the CDHP network, they receive a higher level of benefits.

Most network services are covered at65% after the deductible, while most out-of-network services are covered at 50% after the deductible Regardless of whether a participant uses a network or out-of-network provider, the Healthy Focus Essential plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers prescription drugs purchase data retail pharmacy or through the mail-order program.

Healthy Focus Essential Plan: Cost of Coverage

This section will help participants understand how they pay for medical coverage under the Healthy Focus Essential plan.

Employee Contributions

Leidos and participants share in the cost of coverage. Each pay period, employee contributions are deducted from the participant's paycheck on a biweekly basis. The employee contribution amount will vary based on the coverage level elected:

- Employee only;
- Employee plus spouse or domestic partner;
- Employee plus one or more children; or
- Family coverage

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The individual (employee only coverage) deductible is $2,000; the family deductible is $4,000.

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE. Services must be provided in physician's office as part of the preventive care office visit. Services provided by third parties are subject to annual deductible and coinsurance.

Coinsurance

"Coinsurance" is the percentage of eligible expenses participant pays for medical services once the participant meets the annual deductible.

Annual Out-Of-Pocket Maximum

The "out-of-pocket maximum" is the amount of coinsurance payments a participant must pay each calendar year before the Healthy Focus Essential plan begins paying 100% of eligible expenses up to the negotiated rate (for in-network providers) or reasonable and customary (R&C) limit (for out-of-network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "Network Benefits" in the Healthy Focus Essential plan section for more information about negotiated rates and "Out-of-Network Benefits" for more information about R&C limits.

The following expenses do not count toward a participant's annual out-of-pocket maximum:

- Payments for eligible expenses incurred in a different calendar year;
- Charges that are not covered under the plan;
- Charges that exceed R&C limits; and
- Charges that exceed the maximum benefits for that year

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum must be met before the plan begins paying 100 percent for any individual. The individual (employee only coverage) annual out-of-pocket maximum is $5,000; the family annual out-of- pocket maximum is $10,000 (with an embedded individual max of $8,150).

Healthy Focus Essential Plan: Plan Design

This section will help participants understand how benefits are payable under the Healthy Focus Essential plan.

Network Benefits

If a participant receives services from a network provider, he or she generally saves money because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, whenever the participant receives medical services, he or she pays a percentage of the provider's negotiated rate (coinsurance). The plan pays the remaining amount.

There are no claim forms to file because the CDHP network provider submits claims for the participant.

Out-of-Network Benefits

When a participant uses a provider who does not participate in the CDHP network, that provider is considered to be out of network.

The participant must meet the annual deductible. Then, whenever the participant receives medical services, the plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage (coinsurance) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own claims for reimbursement. Participants should check with their provider for information on their payment and claim filing policies.

Reasonable and Customary (R&C) Limit

The R&C limit is the maximum amount the plan will pay for a covered service received from an out-of-network provider, based on what providers in the participant's geographic area charge for similar services. Participants are responsible for paying any difference between the R&C limit and the amount billed. The determination of what the reasonable and customary limit is for a specific medical service is within the sole discretion of the Claims Administrator and is not subject to challenge or review.

Multiple and Bilateral Surgical Procedures

Multiple surgical procedures consist of more than one surgical procedure performed on the same date of service during the same surgical session. Bilateral surgeries consist of surgery performed during the same surgical session through separate incisions to matching parts of the body (e.g., both shoulders). When multiple or bilateral surgical procedures are performed during the same operative setting, the allowed amount of secondary and subsequent procedures is reduced.

- Major (first) procedure – Covered at 100% of R&C
- Second procedure – You pay 50% of R&C
- Subsequent procedure – You pay 75% of R&C

If multiple or bilateral surgical procedures are performed by network providers, participants will not have to pay any more as a result of the reduced amount. Participants who choose out-of- network providers could incur additional costs if the provider chooses to bill the member for the remaining balance.

Multiple Scan / Images Procedure

When multiple images of adjacent body parts are taken during a single session, a reduction will be applied to the technical component of the services performed. Professional fees billed separately are not affected.

- Initial scan/imaging– Covered at 100% of R&C
- Subsequent scan/imaging –You pay 50% of R&C

Healthy Focus Advantage Plan

The Healthy Focus Advantage plan is a Consumer Driven Healthcare plan that gives participants a choice when it comes to getting medical care. Participants may go to any provider they wish; however, when they use a provider participating in the CDHP network, they receive a higher level of benefits.

Most network services are covered at 80% after the deductible, while most out-of-network services are covered at 50% after the deductible. Regardless of whether a participant uses a network or out-of-network provider, the Healthy Focus Advantage plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers prescription drugs purchased at a retail pharmacy or through the mail order program.

Healthy Focus Advantage Plan: Cost of Coverage

This section will help participants understand how they pay for medical coverage under the Healthy Focus Advantage plan.

Employee Contributions

Leidos and participants share in the cost of coverage. Each pay period, employee contributions are deducted from the participant's paycheck on a biweekly basis. The employee contribution amount will vary based on the coverage level elected:

- Employee only;
- Employee plus spouse or domestic partner;
- Employee plus one or more children; or
- Family coverage

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The individual (employee only coverage) deductible is $1,400; the family deductible is $2,800.

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE. Services must be provided in physician's office as part of the preventive care office visit. Services provided by third parties are subject to annual deductible and coinsurance.

Coinsurance

"Coinsurance" is the percentage of eligible expenses participant pays for medical services once the participant meets the annual deductible.

Annual Out-Of-Pocket Maximum

The "out-of-pocket maximum" is the amount of coinsurance payments a participant must pay each calendar year before the Healthy Focus Advantage plan begins paying 100% of eligible expenses up to the negotiated rate (for in-network providers) or reasonable and customary (R&C) limit (for out-of-network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "Network Benefits" in the Healthy Focus Advantage plan section for more information about negotiated rates and "Out-of-Network Benefits "for more information about R&C limits.

The following expenses do not count toward a participant's annual out-of-pocket maximum:

- Payments for eligible expenses incurred in a different calendar year;
- Charges that are not covered under the plan;
- Charges that exceed R&C limits; and
- Charges that exceed the maximum benefits for that year

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum must be met before the plan begins paying 100 percent for any individual. The individual (employee only coverage) annual out-of-pocket maximum is $3,000; the family annual out-of- pocket maximum is $6,000.

Healthy Focus Advantage Plan: Plan Design

This section will help participants understand how benefits are payable under the Healthy Focus Advantage plan.

Network Benefits

If a participant receives services from a network provider, he or she generally saves money because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, whenever the participant receives medical services, he or she pays a percentage of the provider's negotiated rate (coinsurance). The plan pays the remaining amount.

There are no claim forms to file because the CDHP network provider submits claims for the participant.

Out-of-Network Benefits

When a participant uses a provider who does not participate in the CDHP network, that provider is considered to be out of network.

The participant must meet the annual deductible. Then, whenever the participant receives medical services, the plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage (coinsurance) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own claims for reimbursement. Participants should check with their provider for information on their payment and claim filing policies.

Reasonable and Customary (R&C) Limit

The R&C limit is the maximum amount the plan will pay for a covered service received from an out-of-network provider, based on what providers in the participant's geographic area charge for similar services. Participants are responsible for paying any difference between the R&C limit and the amount billed. The determination of what the reasonable and customary limit is for a specific medical service is within the sole discretion of the Claims Administrator and is not subject to challenge or review.

Multiple and Bilateral Surgical Procedures

Multiple surgical procedures consist of more than one surgical procedure performed on the same date of service during the same surgical session. Bilateral surgeries consist of surgery performed during the same surgical session through separate incisions to matching parts of the body (e.g., both shoulders). When multiple or bilateral surgical procedures are performed during the same operative setting, the allowed amount of secondary and subsequent procedures is reduced.

- Major (first) procedure – Covered at 100% of R&C
- Second procedure – You pay 50% of R&C
- Subsequent procedure – You pay 25% of R&C

If multiple or bilateral surgical procedures are performed by network providers, participants will not have to pay any more as a result of the reduced amount. Participants who choose out-of- network providers could incur additional costs if the provider chooses to bill the member for the remaining balance.

Multiple Scan / Images Procedure

When multiple images of adjacent body parts are taken during a single session, a reduction will be applied to the technical component of the services performed. Professional fees billed separately are not affected.

- Initial scan/imaging– Covered at 100% of R&C
- Subsequent scan/imaging –You pay 50% of R&C

Healthy Focus Premier Plan

The Healthy Focus Premier plan is a Consumer Driven Healthcare plan that gives participants a choice when it comes to getting medical care. Participants may go to any provider they wish; however, when they use a provider participating in the CDHP network, they receive a higher level of benefits.

Most network and out-of-network services are covered at 100% after the deductible. Regardless of whether a participant uses a network or out-of-network provider, the Healthy Focus Premier plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers prescription drugs purchased at a retail pharmacy or through the mail order program.

Healthy Focus Premier Plan: Cost of Coverage

This section will help participants understand how they pay for medical coverage under the Healthy Focus Premier plan.

Employee Contributions

Leidos and participants share in the cost of coverage. Each pay period, employee contributions are deducted from the participant's paycheck on a biweekly basis. The employee contribution amount will vary based on the coverage level elected:

- Employee only;
- Employee plus spouse or domestic partner;
- Employee plus one or more children; or
- Family coverage

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The individual (employee only coverage) deductible is $1,400; the family deductible is $2,800.

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray,

routine mammograms, routine pap smears, and PSA/DRE. Services must be provided in physician's office as part of the preventive care office visit. Services provided by third parties are subject to annual deductible and coinsurance.

Coinsurance

"Coinsurance" is the percentage of eligible expenses participant pays for medical services once the participant meets the annual deductible.

Annual Out-Of-Pocket Maximum

The "out-of-pocket maximum" is the amount of coinsurance payments a participant must pay each calendar year before the Healthy Focus Premier plan begins paying 100% of eligible expenses up to the negotiated rate (for in-network providers) or reasonable and customary (R&C) limit (for out-of-network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "Network Benefits" in the Healthy Focus Premier plan section for more information about negotiated rates and "Out-of-Network Benefits" for more information about R&C limits.

The following expenses do not count toward a participant's annual out-of-pocket maximum:

- Payments for eligible expenses incurred in a different calendar year;
- Charges that are not covered undertheplan;
- Charges that exceed R&C limits; and
- Charges that exceed the maximum benefits for that year

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum must be met before the plan begins paying 100 percent for any individual. The individual (employee only coverage) annual out-of-pocket maximum is $1,400; the family annual out-of- pocket maximum is $2,800.

Healthy Focus Premier Plan: Plan Design

This section will help participants understand how benefits are payable under the Healthy Focus Premier plan.

Network Benefits

If a participant receives services from a network provider, he or she generally saves money because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, whenever the participant receives medical services, he or she pays a percentage of the provider's negotiated rate (coinsurance). The plan pays the remaining amount.

There are no claim forms to file because the CDHP network provider submits claims for the participant.

Out-of-Network Benefits

When a participant uses a provider who does not participate in the CDHP network, that provider is considered to be out of network.

The participant must meet the annual deductible. Then, whenever the participant receives medical services, the plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage (coinsurance) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own claims for reimbursement. Participants should check with their provider for information on their payment and claim filing policies.

Reasonable and Customary (R&C) Limit

The R&C limit is the maximum amount the plan will pay for a covered service received from an out-of-network provider, based on what providers in the participant's geographic area charge for similar services. Participants are responsible for paying any difference between the R&C limit and the amount billed. The determination of what the reasonable and customary limit is for a specific medical service is within the sole discretion of the Claims Administrator and is not subject to challenge or review.

Multiple and Bilateral Surgical Procedures

Multiple surgical procedures consist of more than one surgical procedure performed on the same date of service during the same surgical session. Bilateral surgeries consist of surgery performed during the same surgical session through separate incisions to matching parts of the body (e.g., both shoulders).

When multiple or bilateral surgical procedures are performed during the same operative setting, the allowed amount of secondary and subsequent procedures is reduced.

- Major (first) procedure – Covered at 100% of R&C
- Second procedure – You pay 50% of R&C
- Subsequent procedure – You pay 25% of R&C

If multiple or bilateral surgical procedures are performed by network providers, participants will not have to pay any more as a result of the reduced amount. Participants who choose out-of- network providers could incur additional costs if the provider chooses to bill the member for the remaining balance.

Multiple Scan / Images Procedure

When multiple images of adjacent body parts are taken during a single session, a reduction will be applied to the technical component of the services performed. Professional fees billed separately are not affected.

- Initial scan/imaging – Covered at 100% of R&C
- Subsequent scan/imaging – You pay 50% of R&C

Comparing the Healthy Focus Medical Plans

The chart below provides some basic plan information about the Leidos self-insured plans.

Self-Insured Medical Plans (Healthy Focus)								
	Healthy Focus Basic Plan		**Healthy Focus Essential Plan**		**Healthy Focus Advantage Plan**		**Healthy Focus Premier Plan**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****
Annual Deductible								
• **Employee Only**	$4,000	$8,000	$2,000	$4,000	$1,400	$2,800	$1,400	$2,800
• **Family**	$8,000	$16,000	$4,000	$8,000	$2,800	$5.600	$2,800	$5,600
Annual Out-of-Pocket (OOP) Maximum (includes deductible)								
• **Employee Only**	$6,750	$13,000	$5,000	$10,000	$3,000	$6,000	$1,400	$2,800
• **Family**	$13,500	$27,000	$10,000	$20,000	$6,000	$12,000	$2,800	$5,600
• **Embedded OOP**	$8,550 individual within family	N/A	$8,550 individual within family	N/A	N/A	N/A	N/A	N/A
Office Visits – Preventive Care	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	Covered at 100% after deductible
Office Visits – Non-Preventive Care	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Office Visits – Well-Child Preventive Care	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	Covered at 100% after deductible

Self-Insured Medical Plans (Healthy Focus)								
	Healthy Focus Basic Plan		**Healthy Focus Essential Plan**		**Healthy Focus Advantage Plan**		**Healthy Focus Premier Plan**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****
Emergency Room	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible ***	You pay 50% after deductible	You pay 20% after deductible ***	You pay 50% after deductible	You pay 0% after deductible ***	You pay 0% after deductible
Hospital Admission	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Lab and X-ray	You pay 50% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 35% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 20% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 0% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 0% after deductible
Outpatient Surgery	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Routine Mammograms (Over age 40)	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%: maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	Covered at 100% after deductible
Prostate Screening (Over age 40)	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%: maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	Covered at 100% after deductible
Skilled Nursing Facility (maximum visits combined with Home Health Care and Private Duty Nursing)	You pay 50% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 35% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 20% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 0% after deductible for up to 60 days per confinement	You pay 0% after deductible for up to 60 days per confinement

Self-Insured Medical Plans (Healthy Focus)								
	Healthy Focus Basic Plan		**Healthy Focus Essential Plan**		**Healthy Focus Advantage Plan**		**Healthy Focus Premier Plan**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****
Home Health Care (maximum visits combined with Skilled Nursing Facility and Private Duty Nursing)	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 35% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 20% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 0% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 0% after deductible for up to 100 visits per year, up to 4 hours = 1 visit
Private Duty Nursing (maximum visits combined with Skilled Nursing Facility and Home Health Care)	You pay 50% after deductible for up to 100 visits per year, up to 8 hours = 1 visit	Not covered	You pay 35% after deductible for up to 100 visits per year, up to 8 hours = 1 visit	Not Covered	You pay 20% after deductible for up to 100 visits per year, up to 8 hours = 1 visit	Not covered	You pay 0% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	Not Covered
Hospice Care (up to 30 days per lifetime for inpatient and $10,000 per lifetime)	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Outpatient Rehabilitation – Physical and Speech Therapy (as medically necessary)	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Durable Medical Equipment	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Mental Health & Substance Abuse – Outpatient	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible

Self-Insured Medical Plans (Healthy Focus)								
	Healthy Focus Basic Plan		Healthy Focus Essential Plan		Healthy Focus Advantage Plan		Healthy Focus Premier Plan	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**
Mental Health and Substance Abuse – Inpatient	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible

Covered services received from a network provider will be paid based on the negotiated rate.

** Covered services received from an out-of-network provider will be paid based on the reasonable and customary (R&C) limit.

*** For non-emergent use of the emergency room, employee pays 50% after deductible.

How the Medical Plans Work

The Healthy Focus Medical Plans are Consumer Directed Health Plans (CDHP).For all non-preventive care,theplans paythemajority ofthecost forin-networkcoverageafteryou meetthe annual deductible. Your share is a percentage called coinsurance. In-network preventive care iscovered100 percent, no deductible. Once you meet the out-of-pocket maximum, the plan pays 100percentof covered costs.BothCDHP plans featureaHealth Savings Account (HSA)tohelp save and budget for eligible healthcare expenses, with tax-free advantages.

Pre-existing condition clauses do not apply to theLeidos medical plans. For more information about the medical plan options that Leidos offers, participants should read the information in this summary.

Inpatient and Emergency Pre-Admission Certification

When inpatient care is necessary, the participant must notify Aetna or Anthem and obtain authorization in advance, whether he or she is using Aetna or Anthem or an out-of-network provider.

If an emergency occurs, and it is not possible to get advance authorization, the participant must notify Aetna or Anthem of all inpatient treatment within 48 hours of the admission (or the next business day if the patient receives treatment on a weekend or holiday). The participant must contact Aetna or Anthem regarding an emergency admission, regardless of whether he or she is in an Aetna or Anthem or non- contracting facility.

Precertification

If a participant is enrolled in the Healthy Focus Plan and needs hospitalization, skilled nursing care, home healthcare, hospice care or convalescent facility care, the participant is responsible for following the requirements for Preadmission Certification and Continued Stay Review (also known as “precertification"). Preadmission Certification and Continued Stay Review are procedures used to certify the medical necessity and length of any hospital confinement for inpatient care.

If a participant or a dependent is scheduled for a hospital admission, the participant should call the number on his or her Medical ID card before admission and request precertification. Obtaining precertification is the participant’s responsibility. Even if the doctor agrees to initiate admission, the participant must follow-up to ensure that it has been accomplished.

A CDHP network customer service representative will work with a participant’s doctor to ensure that the hospitalization is appropriate, medically necessary, and timely, and then let the participant know the number of days for which admission has been certified.

What the Healthy Focus Medical Plans Cover

Services or supplies must be considered medically necessary by the Claims, be delivered for the treatment of illness or injury, and be performed or prescribed by a licensed physician to be covered by the Leidos self-insured medical plans. The services listed below are subject to any applicable annual deductibles, coinsurance, co-payments, and plan maximums. See Comparing the Leidos Medical Plans for more detail.

The Leidos self-insured medical plan covers:

- Physician's office visits;
- Other physician's services;
- Emergency or urgent care;
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given;
- Hospital expenses including:
    - *Inpatient hospital expenses:* Charges for room and board, and other hospital services and supplies for a person confined as a full-time inpatient;
    - *Outpatient hospital expenses:* Charges for hospital services and supplies for a person who is not confined as a full-time inpatient; and

- *Convalescent facility expenses*: Charges for a person who is confined to convalesce from a disease or injury for room and board and general expenses made in connection with room occupancy, use of special treatment rooms, X-ray and lab work; physical, occupational or speech therapy; oxygen and other gas therapy; and medical supplies. Benefits will be paid for up to the maximum number of days during any one convalescent period for the same or related cause beginning on the day the person is confined in a convalescent facility if he or she:
  - Was confined in a hospital while covered under the plan for treatment of a disease or injury;
  - Is confined in the facility within 15 days after discharge from the hospital; and
  - Is confined in the facility for services needed to convalesce from the condition that caused the hospital stay;

- Benefits end when the person has been confined in a hospital, convalescent facility or other place giving nursing care for 90 days in a row;
- Periodic health assessments(preventive care) includes one exam every calendar year;
- Immunizations;
- Home healthcare expenses when the charge is made by a home health care agency, the care is given under a home health care plan, and the care is given to a person in his or her home for part- time or intermittent care by an R.N. (or L.P.N. when an R.N. is not available); part-time or intermittent home health aide patient care services; and physical, occupational and speech therapy. There is a maximum of 100 visits covered in a plan year and a visit equates to up to four hours by a home health aide;
- Hospice care expenses for part-time or intermittent care by an R.N. (or L.P.N. when an R.N. isn't available) up to eight hours a day, medical social services under the direction of a physician, psychological and dietary counseling, consultation or case management services by a physician, and physical and occupational therapy. This includes charges for bereavement counseling if it is given to the person's immediate family, is given during three months following the person's death, and is directly related to the person's death;
- Drugs and medicines which by law need a physician's prescription, including medically necessary weight control drugs;
- Acupuncture- when performed by a physician or certified acupuncturist for treatment of a disease or injury, to alleviate chronic pain given, or as a form of anesthesia in connection with a surgery;
- Diagnostic lab work and X-rays- routine and non-routine- up to plan maximum;
- X-ray, radium and radioactive isotope therapy;

- Anesthetics and oxygen;
- Rental of durable medical or surgical equipment, including repair of such equipment or replacement when it is proved that it is needed due to a change in the person's physical condition;
- Maternity;
- Mammograms;
- Routine pap smears-one diagnostic test per calendar year;
- Chiropractic care, if medically necessary;
- Prostate specific antigen (PSA) age 40+;
- Infertility treatment for a female employee, the wife or registered domestic partner of an Leidos employee, including invitro fertilization, uterine embryo lavage, embryo transfer, gamete intra fallopian tube transfer(GIFT),zygote intra fallopian tube transfer(ZIFT),low tubal ovum transfer and prescription drug therapy used specifically for infertility, will be covered up to $5,000 per lifetime. The following conditions must be met:
    - The female participant must have been unable to conceive after having unprotected intercourse for one year or more;
    - The female participant must have been unable to attain a successful pregnancy through less costly treatment covered under the plan;
    - The female participant must have FSH levels which are less than or equal to 19 miU on day 3 of her menstrual cycle;
    - The procedure cannot involve surrogates; and
    - The procedure must be perform data medical facility that conforms to generally accepted medical standards.
- Artificial insemination;
- Voluntary sterilization;
- Skilled nursing care expenses made by an R.N. or L.P.N. or a nursing agency for skilled nursing care, which includes visiting nursing care from an R.N. or L.P.N. for up to four hours for the purpose of performing skilled nursing tasks, and private duty nursing from an R.N. or L.P.N. for up to eight hours if the person's condition requires skilled nursing services and visiting nursing care is not adequate. Private duty nursing benefit is combined with home healthcare benefits with a maximum of 100 visits per year;
- Spinal disorders;
- Treatment of the mouth, jaws and teeth due to a medical condition affecting the teeth, mouth, jaws, jaw joints or supporting tissue (including bones, muscles and nerves) based on medical, not dental, necessity;
- TMJ or malocclusion involving the joints or muscles(includes medically necessary, non-dental, bite blocks, splints, arch bars, and occlusal guards);

- Physical therapy, if medically necessary, and maintenance therapy (both limited to 52 visits, with pre-certification being required after the 24th visit) for certain chronic medical conditions seriously limiting a member's activities of daily living;
- Occupational therapy, if medically necessary;
- Speech therapy for loss of speech, or speech impaired or developmentally delayed due to a diagnosed disease, injury or congenital defect;
- Artificial limbs and eyes;
- Sex-change surgery or any treatment of gender identity disorders;
- Wigs for hair loss due to injury, disease or treatment of disease, including costs for repair or replacement
- Listed transplants are covered only if performed by the Administrator's contracted Institutes (or Centers) of Excellence (IOE) facilities. List of IOE Procedure and Treatment types - heart transplant, lung transplant, liver transplant, bone marrow transplant, heart/lung transplant, kidney transplant, pancreas transplant, kidney/pancreas transplant.
- For IOE procedure and treatments-The Plan will pay for transportation and lodging between participant's home and the IOE to receive services in connection with IOE procedure or treatment. Travel and lodging expenses for IOE patient and one companion/parent/guardian traveling with the IOE patient must be approved in advance by Administrator. The Plan will reimburse a maximum of $50 per person per night for lodging expenses.

The Plan will reimburse travel and lodging expenses incurred up to maximum of $10,000 per episode of care. The Plan will pay expenses incurred during a period which begins on the day a participant becomes an IOE patient and ends on the earlier of one year after the day the procedure is performed or the date the IOE patient ceases to receive any service from the IOE in connection with the procedure.

What the Healthy Focus Medical Plans Do Not Cover

The following services and supplies are not covered by the Leidos self-insured medical plans:

- Treatment for the mouth, jaws and teeth when an injury or illness is dental in nature, including restorative dental and/or surgical treatment of the mouth or jaw, including but not limited to:
  - Non-accident related diagnosis and treatment of teeth and their supporting structures;
  - Treatment relating to or secondary to treatment of dental caries (cavities);
  - Extraction of a diseased or decayed tooth or for surgical removal or impacted teeth; and
  - Root canal therapy, periodontal surgery or X-rays and other diagnostic tests;
- Cosmetic surgery, unless required because of an accidental injury that takes place while the participant is covered by the plan, or the congenital malformation of a child born to the participant or his or her spouse or registered domestic partner while the participant has dependent coverage under the plan;

- Charges above the reasonable and customary limits as determined by the applicable Claims Administrator;
- Custodial care;
- Eye care exams and eyeglasses;
- Hearing aids;
- Orthopedic shoes or other devices to support the feet;
- Experimental, investigational or educational treatment or services as determined by the Claims Administrator
- Treatment for accidents related to employment or an illness covered under Workers' Compensation or similar laws;
- Assistant surgeon services when the services of an assistant surgeon are not medically necessary for the surgical procedure;
- Treatment in a convalescent facility for drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation and any other mental disorder;
- Skilled nursing care that does not require the education, training and technical skills of an R.N. or L.P.N. (such as transportation, meal preparation, charting of vital signs), any private duty nursing care given while the person is an inpatient in a hospital or other health care facility, care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting or care provided solely for skilled observation. Any service provided solely to administer oral medicines except where applicable law requires that such medicines be administered by a R.N. or LPN
- Examinations to determine the need for, or adjustment of, hearing aids;
- Foot treatment for:
    - Weak, strained, flat, unstable or unbalanced feet; metatarsalgia; or bunions, except open cutting operations; and
    - Corns, calluses or toenails, except the removal of nail roots and medically necessary services prescribed by a doctor (M.D or D.O.) in the treatment of metabolic or peripheral-vascular disease;
- Treatment resulting from an intentionally self-inflicted injury;
- Illness or injury due to an act of war (whether declared or undeclared) or an injury sustained while the participant is in military service for any country at war;
- Services, treatment, education testing or training related to learning disabilities or developmental delays;
- Care furnished mainly to provide a surrounding free from exposure that can worsen the participant's illness or injury;
- Treatments involving:
    - Bioenergetic therapy;
    - Carbon dioxide therapy;
    - Megavitamin therapy;
    - Primal therapy;

    - Psychodrama;
    - Rolfing; or
    - Vision perception training;
- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as part of their training in that field;
- Services of a resident doctor or intern rendered in that capacity;
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment;
- Therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Career, social adjustment, pastoral or financial counseling;
- Speech therapy except for loss of speech, or speech impairment or developmentally delayed speech due to a diagnosed disease, injury or congenital defect;
- Reversal of a sterilization procedure;
- Medical services performed or provided by a close relative;
- Services of "standby" surgeons;
- Services received before coverage begins or after coverage ends;
- Charges that participants are not legally required to pay or charges that would not have been made if the plans were not available;
- Charges above any maximum amounts shown;
- Convenience or personal care services, such as use of a telephone or television; and
- Medical expense not specifically described in the plans

Mental Health and Drug or Alcohol Treatment

The Healthy Focus Plans include mental health and substance abuse benefits. These benefits are administered by Aetna or Anthem.

How Mental Health and Substance Abuse Benefits Work

The mental health and substance abuse benefits are network-based and give participants a choice when it comes to receiving mental health and substance abuse treatment:

- For outpatient care, under the Healthy Focus Plans, a participant must meet the deductible and pay the applicable coinsurance.
- For inpatient care, under the Healthy Focus Plans, a participant must meet the deductible and pay the applicable coinsurance.

Participants must call Aetna or Anthem (depending on their state of residence) to receive

information and guidance on how to locate a network provider or participants can search for a provider on the Aetna or Anthem website. If a participant elects to use an out-of-network provider, the participant will be responsible for additional out-of-pocket costs.

Mental Health Network Benefits

Participants receive the highest plan benefits for mental health and substance abuse treatment by using network providers:

For outpatient care, you pay as follows:

- Healthy Focus Basic Plan: 50% after deductible
- Healthy Focus Essential Plan: 35% after deductible
- Healthy Focus Advantage Plan: 20% after deductible
- Healthy Focus Premier Plan: 0% after deductible

For inpatient care, you pay as follows:

- Healthy Focus Basic Plan: 50% after deductible
- Healthy Focus Essential Plan: 35% after deductible
- Healthy Focus Advantage Plan: 20% after deductible
- Healthy Focus Premier Plan: 0% after deductible

Note: Coinsurance for mental health and substance abuse services received through Aetna or Anthem count toward the annual out-of-pocket maximums for the Healthy Focus plans.

Mental Health Out-of-Network Benefits

If a participant chooses to use an out-of-network provider to obtain mental health and substance abuse treatment outpatient services, you pay a percentage of the cost as follows:

- Healthy Focus Basic Plan: 50% of Reasonable &Customary charges after deductible
- Healthy Focus Essential Plan: 50% of Reasonable & Customary charges after deductible
- Healthy Focus Advantage Plan: 50% of Reasonable & Customary charges after deductible
- Healthy Focus Premier Plan: 0% Reasonable & Customary charges after deductible

The participant pays the remaining amount (the coinsurance).

Note: Deductibles and coinsurance for mental health and substance abuse services received through Aetna or Anthem count toward the deductible or the annual out-of-pocket maximums.

Mental Health and Substance Abuse Coverage

Services or supplies must be considered medically necessary by the Administrator, be delivered for the treatment of illness or injury, and be performed or prescribed by a licensed physician to be covered by the Leidos self-insured medical plans. The services are subject to any applicable annual deductibles, coinsurance, and co-payments. See Comparing the Leidos Plans for more detail.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider;
- This Plan includes follow-up treatment; and
- This Plan is for a condition that can favorably be changed.

What is Not Covered - Mental Health and Substance Abuse Benefits

No payment will be made by Aetna or Anthem for the following care, services or supplies:

- Educational rehabilitation or treatment of learning disabilities, regardless of the setting in which such services are provided;
- Educational/academic testing and services;
- Residential Coverage for Wilderness Programs or Military Schools;
- Residential treatment facilities that do not meet Aetna or Anthem medical necessity requirements; Custodial care;
- Treatment for personal or professional growth development, or training or professional certification;
- Evaluations, consultations or therapy for educational or professional training or for investigational purposes relating to employment;
- Therapies which do not meet national standards for mental health professional practice;
- Experimental or investigational therapies;
- Court-ordered psychiatric or substance abuse treatment, except when certified by Aetna or Anthem as medically necessary;
- Psychological testing, except when considered medically necessary by Aetna or Anthem;
- Services, supplies or treatment that are covered for benefits under the medical portion of this plan;
- Prescription drugs;

- Private duty nursing, except when pre-certified by Aetna or Anthem as medically necessary;
- Treatment of congenital and/or organic disorders; Non-abstinence-based or nutritionally-based treatment for substance abuse;
- Treatment or consultations provided via telephone;
- Services, treatment or supplies:
  - Provided as a result of Worker's Compensation laws or similar legislation;
  - Obtained through, or required by, any governmental agency or program whether federal, state or any subdivision thereof (exclusive of Medicaid/Medi-Cal); or
  - Caused by the conduct or omission of a third-party for which the Member has a claim for damages or relief, unless the participant provides Aetna or Anthem with alien against such claim for damages or relief in a form and manner satisfactory to Aetna or Anthem;
- Treatment or consultations provided by the member's parents, siblings, children or current or former spouse or domiciliary partner;
- Sexual therapy programs;
- Remedial education beyond evaluation and diagnosis of learning disabilities, education rehabilitation, academic education, and educational therapy for learning disabilities;
- Marital therapy;
- Treatment for caffeine or nicotine intoxication, withdrawal or dependence;
- Treatment in a convalescent facility for drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation and any other mental disorder.

Coordination of Benefits

If a participant or a participant's dependents are covered under more than one medical plan, all of the medical plans that provide coverage can work together to coordinate benefits. The participant is responsible for filing or submitting any necessary paperwork to the appropriate plans.

Under Leidos' coordination of benefits provisions, the plans will pay benefits up to the level which would have been paid if the Leidos plan had been the primary plan. This coordination of benefits provision applies to:

- The Healthy Focus Basic Plan:
- The Healthy Focus Essential Plan;
- The Healthy Focus Advantage Plan;
- The Healthy Focus Premier Plan

When the Leidos medical plan is the primary plan, benefits are paid first without regard to any other plans. The participant is responsible for coordinating any benefits by submitting the Explanation of Benefits and itemized bill to the secondary plan.

See information on additional coordination of benefits, such as third party recovery (subrogation), overpayments, etc.

Determining Which Plan Pays First

Leidos uses the following insurance industry guidelines for determining the primary and secondary payers for employees and dependents.

Employees

The plan that covers the participant as an employee is the primary payer. The plan that covers the participant as a dependent is the secondary payer.

Dependents

For an employee's spouse or registered domestic partner, a plan that covers him or her as an employee is the primary payer for his or her claims. If an employee has elected coverage for his or her spouse or registered domestic partner as a dependent and he or she has coverage through another employer, the Leidos medical plan is the secondary payer.

For an employee's dependent children, the plan of the parent whose birthday occurs first in the calendar year is usually the primary payer. If the plan of an employee's spouse or registered domestic partner plan does not follow this "birthday rule, "then the "gender rule" applies. That is, the plan covering the child's father as an employee pays first.

In the case of divorced or separated parents, benefits are determined in the following order:

- The plan of the parent who has financial responsibility by court decree;
- The plan of the stepparent who is the spouse of the parent who has custody of the child; and
- The plan of the parent who does not have custody of the child.

When none of these rules establishes order, benefits are paid first by the plan that has covered the person for the longer period of time. An exception is a plan that covers a laid-off or retired employee. That plan is secondary to a plan that covers a person as an active employee.

Leidos Healthy Focus Medical Plan Administrators

Aetna Inc. and Anthem administer the Leidos Consumer Directed Healthcare Plans (CDHP) – Healthy Focus Advantage Plan and Healthy Focus Essential Plan:

- **Aetna Open Access Plans**—Aetna Choice POSII network, administered by Aetna Inc.
- **BlueCard PPO network**—administered by Anthem

Aetna Open Access Plans

Employees who live in these states/district are eligible for the Aetna Open Access Plans– Aetna Choice POS II network, administered by Aetna Inc.:

- Arkansas
- California
- Delaware
- District of Columbia
- Iowa
- Idaho
- Illinois
- Kansas
- Maine
- Maryland
- Michigan
- Minnesota
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New York
- North Dakota
- Oklahoma
- Oregon

- Pennsylvania
- South Dakota
- Vermont
- Virginia
- West Virginia
- Wisconsin
- Wyoming

Product Name: Aetna Open Access Plans– Aetna Choice POSII network
Leidos Group Number: 698685
Aetna Customer Service Phone: 800-843-9126
Web site: **Aetna**(www.aetna.com)

Blue Card PPO Network

Employees who live in these states/commonwealth are eligible for the Blue Card PPO network, administered by Anthem:

- Alabama
- Alaska
- Arizona
- Colorado
- Connecticut
- Florida
- Georgia
- Indiana
- Kentucky
- Louisiana
- Massachusetts
- Mississippi
- New Mexico
- North Carolina
- Ohio
- Puerto Rico
- Rhode Island

- South Carolina
- Tennessee
- Texas
- Utah
- Washington state

Produce Name: Blue Card PPO Network
Leidos Group Number: 170105
Anthem Customer Service Phone Number: 866-403-6183
Website: https://www.anthem.com

Filing Claims

If a participant receives medical care, mental health or substance abuse treatment from an out-of- network provider, he or she must pay the full cost of care, then file a claim for reimbursement. Most medical claim forms should be submitted to the Claims Administrator.

Aetna out-of-network claims should be submitted on the Aetna Medical claim form and mailed to:

Aetna Inc.
P.O. Box 14089
Lexington, KY 40512-4089

Anthem out-of-network claims should be submitted on the Anthem Medical Claim form and mailed to:

Anthem.
P.O. Box 60007
Los Angeles, CA 90060

If a participant has concerns about how a claim has been administered or wishes to appeal a claims decision, he or she may refer to information on relevant procedures available in the Claims Appeal and in the Plan Information section.

Healthy Focus Prescription Drug Program

Prescription drug coverage under the Healthy Focus medical plans is provided through Express Scripts. Prescription drugs are covered when they are purchased from a retail pharmacy or through the Express Scripts pharmacy mail order program.

Retail Pharmacies

A participant who needs to take medication for a short period of time (up to 30 days) should have their prescription filled at retail pharmacy.

To find an Express Scripts participating pharmacy, participants can log onto Express Scripts (www.express-scripts.com/leidos) website or call Express Scripts at 877-223-4721.

Mail Order

A participant who needs to use a long-term, maintenance medication (usually a prescription for more than 30 days) can fill his or her prescription through the Express Scripts pharmacy mail order program. Through the Express Scripts pharmacy mail order program, participants can receive up to a 90-day supply of medication and prescriptions are mailed directly to the participant's home.

Mail Order Address:
Express Scripts
P.O. Box 650322
Dallas, TX 75265-0322

For refills, participants can submit requests directly to Express Scripts:

- Through the Express Scripts website (www.express-scripts.com)
- By phone 877-223-4721

Types of Prescriptions Available

The amount a participant pays for a prescription depends on the type of drug he or she purchases:

Prescription Drug Patient Cost	
Type of Prescription	**In-Network Retail Pharmacy (up to a 30-day supply) or through Mail Order (up to a 90-day supply)**
Generic	$5 after deductible
Brand Formulary	30% after deductible
Brand Non-Formulary	50% after deductible

- **Generic drugs** have the same chemical composition and potency as brand-name equivalents, but are less costly.
- **Brand formulary drugs** are on a preferred list of prescriptions (called a formulary) due to significant discounts negotiated with the drug manufacturer and/or proven effectiveness.
- **Brand non-formulary drugs** are brand-name drugs that do not have a generic equivalent and are not included on the list of preferred drugs. Brand-name drugs that are not on the formulary require the highest copayment, since these drugs are the most costly to the plan.

Prescription drug formularies are subject to change. For up-to-date formulary information, participants should visit Express Scripts (www.expressscripts.com/leidos) website or call Express Scripts at 877-223-4721.

Note: You must meet the annual medical plan deductible before the plan begins sharing the cost for non-preventive prescription drugs. The deductible does not apply to certain preventive drugs, such as medications to treat and prevent hypertension, high cholesterol, asthma and diabetes. Click here to view the **Preventive Drug List**.

Prescription Drug Clinical Management Programs

Prior Authorization

Prior Authorization is a feature of your prescription benefits that helps ensure the appropriate use of selected prescription drugs. Certain prescription drugs require your doctor to get approval before they're covered. This process helps make sure you receive the right medicine in the correct dose, which is very important if you're taking a specialty drug.

Step Therapy

Step Therapy is an approach intended to control the costs and risks posed by certain prescription drugs. It begins by trying the safest and most cost-effective drug therapy for a medical condition and progresses to other more costly or risky drug therapies only if necessary.

Smart90

The Smart90 program is a feature of the Express Scripts prescription benefit. With this program, you have two ways to get a 90-day supply of your long-term maintenance medication — drugs you take regularly for ongoing conditions. You can conveniently fill these prescriptions through the Express Scripts mail service or any Walgreens network pharmacy. Your copay/coinsurance for your 90-day supply of medication will be the same whether you fill your prescriptions through Express Scripts home delivery or at a Walgreens network pharmacy.

Note: If you continue to fill 30-day supplies of your long-term medication after the first two fills, you will pay a penalty (100% of the prescription drug cost). Penalties paid for not filing prescriptions through Express Scripts (ESI) mail order or Walgreens will not count towards the deductible or out-of-pocket maximum. Additionally, participants will still pay penalties after they meet their out-of-pocket maximum.

Health Savings Account (HSA) Eligible

The Healthy Focus plans qualify as High Deductible Health Plans (HDHP) which, if elected, allows employees to qualify for a Health Savings Account (HSA) which is different from a healthcare flexible spending account. **A standard healthcare flexible spending account (the plan offered by Leidos) cannot be used in conjunction with an HSA.**

What Is A Health Savings Account (HSA)?

A Health Savings Account (HSA) is an alternative to traditional health insurance; it is a savings product that offers a different way for consumers to pay for their healthcare. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. You must be covered by a High Deductible Health Plan (HDHP) to take advantage of HSAs.

You own and you control the money in your HSA. Decisions on how to spend the money are made by you without relying on a third party or a health insurer. You will also decide what types of investments to make with the money in the account in order to make it grow.

Getting Money Into Your HSA?

There are two ways money goes into your account:

From Leidos:	From You:
Leidos may contribute to your HSA when you enroll in a Healthy Focus medical plan on a per-pay basis. **The Leidos contribution is based on your medical plan, coverage level, annual salary and your eligibility date.**	You can make pre-tax contributions from your pay, up to: • $3,550 for individuals coverage • $7,100 for family coverage • An extra $1,000 if you are age 55 or older Any money you have in your account at the end of the plan year rolls over into the next year. *Note: This is the 2020 IRS HSA Account maximum, and it subject to change annually. Maximums include both Leidos and employee contributions.* *If you do not meet HSA eligibility requirements for the full tax year, you may not be able to contribute the maximum amount.*

Making Changes To Your HSA Contributions

You can increase or decrease your HSA contribution at any time. Note that changes to your contribution do not go into effect until the first pay of the following month.

Health Maintenance Organizations (HMOs)

HMOs offer healthcareforparticipants andtheirfamilies througha limited networkof healthcare providers.

How the Plans Work

HMOs require that participants receive all medical care exclusively from theHMO's network of providers in orderforthemtoreceive benefits.When aparticipantenrollsin anHMO,heorshe,as well as hisorher covereddependents should see their primary care physician (PCP) for all routinemedical care and will need a referral toa networkspecialist whenever he or she needs specialty care.

If aparticipant receives medical care *without*goingthrough hisorherPCPfirst,orifthe participant’s careisnot authorized bytheplan,theHMOmaynotpay anybenefits,andtheparticipant willpaythe full cost of any out-of-network or unauthorized care. For most plans, emergency care received out-of-networkor unauthorized by the plan will generally be covered.

In general, when the participant visits a provider, he or she pays the required copayment for covered services. No further payment is required. The participant does not have to file a claim form after receiving care.

HMOs generally include a prescription drug benefit.

For more information about how a specific HMO works and what payments are required, participants should refer to their evidence of coverage booklet.

ID Cards

When a participant enrolls in an HMO, he or she, and each of his or her covered dependents, will receive an ID card in the mail. Participants should be sure to keep their ID cards with them at all times.

A participant must present his or her ID card when he or she:

- Visits a doctor's office;
- Is admitted to a hospital; and
- Fills a prescription at a retail pharmacy

The participant's ID card contains important information about the participant and the HMO plan. By presenting the card to their healthcare provider, participants ensure that they receive the right level of coverage.

If a participant does not receive an ID card, he or she should contact the HMO's Member Services.

What the Kaiser Plans Cover and Do Not Cover

Generally, HMOs cover preventive, wellness, emergency, surgical, and hospital services. For a complete list of what is covered by an HMO, participants should refer to the HMO's **Evidence of Coverage.**

Cigna International Medical Plan

If a participant is an expatriate and scheduled to be overseas for a minimum of six months, he or she may be eligible to elect coverage through a CIGNA International medical plan.

How the Plan Works

Participants in the Cigna International High Plan can receive medical care from any provider. Before the plan begins paying benefits, participants must pay an annual deductible.

For more information about how a CIGNA International plan works,participants should refer to the individual plan's **Evidence of Coverage**.

Medical Plan Benefit Charts

For more information about each insured medical plan, participants can download the following PDFs:

Self-Insured Medical Plans		
Plan Name	**Aetna**	**Anthem**
Healthy Focus Basic Plan	2020 Benefit Summary 2020 Evidence of Coverage	2020 Benefit Summary 2020 Evidence of Coverage
Healthy Focus Essential Plan	2020 Benefit Summary 2020 Evidence of Coverage	2020 Benefit Summary 2020 Evidence of Coverage
Healthy Focus Advantage Plan	2020 Benefit Summary 2020 Evidence of Coverage	2020 Benefit Summary 2020 Evidence of Coverage
Healthy Focus Premier Plan	2020 Benefit Summary 2020 Evidence of Coverage	2020 Benefit Summary 2020 Evidence of Coverage
Fully-Insured Medical Plans		
Plan Name	**Benefit Summary**	**Detailed Plan Information**
Cigna International High Plan	2020 Plan Year	2020 Evidence of Coverage
HMSA Hawaii Plan	2020 Plan Year	2020 Evidence of Coverage
Kaiser Hawaii Plan	2020 Plan Year	2020 Evidence of Coverage
Kaiser California Plan	2020 Plan Year	2020 Evidence of Coverage
Kaiser Mid-Atlantic Plan	2020 Plan Year	2020 Evidence of Coverage
Tricare Supplement Plan	2020 Plan Year	N/A

Medicare Part D Notice of Creditable Coverage

Important Notice from Leidos About Your Prescription Drug Coverage and Medicare
The key purpose of this notice is to advise you that the prescription drug coverage you have under your Leidos medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2020. (This is known as "creditable coverage.") The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Leidos and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage becameavailablein2006toeveryone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Leidos has determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are covered under one of Leidos' prescription drug plans, your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage in 2020. Therefore, if you are or become eligible for Medicare, you can keep this coverage and not pay extra if you later decide to enroll in a Medicare prescription drugplan.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer/union coverage maybe eligible fora Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered,with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in Medicare prescription drug plan and drop your Leidos prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enrolling a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Leidos and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Leidos changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit the **Medicare website** (www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the **Social Security Administration (SSA) online** (www.socialsecurity.gov), or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Continuing Medical Coverage After Plan Coverage Ends

A federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA) enables a participant and his or her covered dependents to continue dental insurance if their coverage ends due to a reduction of work hours or termination of employment (other than for gross misconduct). Federal law also enables a participant's dependents to continue dental insurance if their coverage stops due to the participant's death or entitlement to Medicare; divorce; legal separation; or when the child no longer qualifies as an eligible dependent. The participant must elect coverage according to the rules of the Leidos health care plans. Continuation is subject to federal law, regulations, and interpretations.

In accordance with COBRA, a participant and his or her family have some important rights concerning the continuation of group healthcare benefits if that coverage ceases.

Some state laws may offer additional COBRA benefits. For more information, review the insured plan's Evidence of Coverage booklet.

For more information about participants' rights under COBRA, the participant should refer to "Continuing Health Care Coverage Through COBRA" in the Plan Information section of the Summary Plan Description (SPD).