Leidos Benefits Summary Plan Description

Plan Information

Note: This document does not constitute the full Summary Plan Description (SPD) for your Leidos health and welfare employee benefit plans. Read the benefits booklets/summaries applicable to your benefit plan along with this document for plan details and the complete SPD for your Leidos health and welfare employee benefit plan. Unless otherwise noted, if there is a conflict between a specific provision under the plan document and a benefits booklet/summary (or this document), the plan document controls. If the plan document is silent on a specific issue, then the SPD controls on that issue, except where the SPD refers to a benefits booklet/summary, in which case the benefits booklet/summary controls. If both the plan document and the SPD are silent, the terms of the applicable benefits booklet/summary controls.

This section describes plan provisions and/or regulations that are applicable to most or all of the Leidos employee benefit plans. These provisions and/or regulations include:

- **Employee Retirement Income Security Act of 1974 (ERISA)**
- **Qualified Medical Child Support Orders (QMCSOs)**
- **Children's Health Insurance Program (CHIP)**
- **Claims Appeal and Review Procedures Under ERISA**
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **Health Plan Regulations**
- **Uniformed Services Employment and Reemployment Rights Act of 1994**
- **Additional Information Regarding Coordination of Benefits**

Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act (ERISA) requires plans to include in their summary plan descriptions a notice outlining participants' and beneficiaries' rights. Leidos has developed its own notice, based on the model language provided by the Department of Labor, which includes the information required under ERISA, but which is written in what we believe to be more understandable language.

ERISA Rights Statement

Participants in the plans are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description(s). The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuation of Group Health Plan Coverage

ERISA also provides that all plan participants shall be entitled to:

- Continuation of health care coverage for the participant, participant's spouse and/or participant's dependents if there is a loss of coverage under the plan as a result of a qualifying event. Participants and their dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing **COBRA continuation coverage rights**.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including the participant's employer, union, or any other person, may fire the participant or otherwise discriminate against him or her in any way to prevent his or her obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement of Participants' Rights

If a **claim** for a welfare benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps the participant can take to enforce the above rights. For instance, if the participant requests a copy of plan documents or the latest annual report from the plan and does not receive it within 30 days, the participant may file suit in a federal court. In such a case, the court

may require the plan administrator to provide the materials and pay the participant up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the administrator's control.

If the participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if the participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person the participant has sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees — for example, if it finds that the participant's claim is frivolous.

Assistance with Questions

If the participant has questions about the plan, the participant should contact the plan administrator. If the participant has any questions about this statement or about their rights under ERISA, or if the participant needs assistance in obtaining documents from the plan administrator, the participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is a judgment, decree or order issued either by a court of competent jurisdiction or through an administrative process established under state law which has the force and effect of law in that state. It directs the plan administrator to cover the participant's child for benefits under the medical, dental, and/or vision plans, if available. Federal law provides that a Medical Child Support Order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the plan pursuant to a QMCSO won't become effective until the plan administrator determines that the order is a QMCSO.

Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2023. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Claims and Appeals Review Procedure Under ERISA

This section provides general information about the claims and appeals procedures applicable to the plan under ERISA:

- Disability Plan Claims
- Non-Disability Welfare Plan Claims

Please note: Participants should also review the applicable benefit plan document. In the event of a conflict between the applicable benefit plan document and this SPD, the terms of the benefit plan document will prevail.

Disability Plan Claims

Claim Review

When a participant (or the participant's beneficiary, where applicable) files a claim with the insurance carrier, the participant's claim will be promptly evaluated. Within 45 days after the participant's claim has been received, the participant will be provided with:

- A written decision on the participant's claim; or
- A notice that the period to decide the participant's claim is being extended for 30 days. Before the end of this extension period, the participant will be sent:
    - A written decision on the participant's claim; or
    - A notice that the period to decide the participant's claim is being extended for an additional 30 days

If an extension is due to the participant's failure to provide information necessary to decide the claim, the extended time period for deciding the participant's claim will be tolled beginning with the date the plan notifies the participant of the missing information and will not begin until the participant provides the necessary information.

If the period to decide the participant's claim is extended, the participant will be notified of the following:

- The reasons for the extension;
- When it is expected that the decision on the participant's claim will be made;
- An explanation of the standards on which entitlement to benefits is based;
- Any unresolved issues preventing a decision; and
- Any additional information needed to resolve those issues

If additional information is requested, the participant will have 45 days to provide the information. If the participant does not provide the requested information within 45 days, the participant's claim may be decided based on the information that has been received.

If a Claim Is Denied

If all or part of the participant's claim is denied, the participant will receive a written notice of denial containing:

- The specific reasons for the decision and the standards applied in reaching the decision, including the basis for disagreeing with the views of medical and/or vocational professionals, or with disability benefit determinations by the Social Security Administration;
- Reference to the specific provisions of the plan documents on which the decision is based;
- A description of any additional information needed to support the participant's claim and an explanation of why it is needed;
- Information describing procedures and time limits to appeal the decision;
- Information concerning the participant's right to receive, free of charge upon request, copies of non-privileged documents and records relevant to the participant's claim, including the participant’s claims file;
- Any internal rule, guidelines, protocol or similar criterion relied on in making the decision; and
- A statement of the participant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following an appeal.

The notice of determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Claims Appeal Procedure If a Claim Is Denied

If all or part of the participant's claim is denied, the participant may request an appeal. The participant must request a review of the denied claim in writing within 180 days after receiving notice of the denial. The participant's request should be sent to the address specified in the claims denial.

The participant may also send written comments or other items to support his or her claim. The participant may review and receive copies, free of charge, of any non-privileged information that is relevant to his or her request for an appeal. The participant may also request the names of medical or vocational experts who provided advice about his or her claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person.

The appeal will include any written comments or other items the participant submits to support his or her claim.

The participant's appeal will be promptly reviewed following receipt of all necessary information. Within 45 days after receipt of the participant's request for an appeal, the participant will be sent:

- A written decision on the appeal; or
- A notice that the review period is being extended for 45 days.

If the extension is due to the participant's failure to provide information necessary to decide the appeal, the extended time period for review of the participant's claim will be tolled beginning with the date the plan notifies the participant of the missing information, and will not begin until the participant provides the necessary information. If the participant does not provide the requested information within 45 days, a decision on the review of the participant’s claim may be based on the information that has been received.

If the review period is extended, the participant will be notified of the following:

- The reasons for the extension;
- When a decision on the participant's appeal is expected; and
- Any additional information needed to decide the participant's claim

If additional information is requested, the participant will have 45 days to provide the information. If the participant does not provide the requested information within 45 days, a decision on the review of the participant's claim may be based on the information that has been received.

To the extent that new or additional evidence or rationales are considered, they may not be relied upon or used as a basis for denial of the appeal unless claimants are first given notice and a fair opportunity to respond.

Following the re-review, if all or part of the participant's claim is denied, he or she will receive a written notice of denial containing:

- The specific reasons for the decision and the standards applied in reaching the decision, including the basis for disagreeing with the views of medical and/or vocational professionals, or with disability benefit determinations by the Social Security Administration;
- Reference to the specific provisions of the plan documents on which the decision is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the decision;
- Information concerning the participant's right to receive, free of charge, copies of non-privileged documents and records relevant to the participant's claim upon request, including the participant's claims file;
- A statement of the participant's right to bring a civil action under Section 502(a) of ERISA; and
- A statement that "The participant or the plan administrator may have other voluntary alternative dispute resolution options, such as mediation. One way for the participant to find out what may be available is to contact his or her local U.S. Department of Labor Office or state insurance regulatory agency."

The notice of determination may be provided in written or electronic form. Electronic notes will be provided in a form that complies with any applicable legal requirements.

Non-Disability Welfare Plan Claims

Definitions

- **Claim:** Any request for plan benefits made in accordance with the plan's claims filing procedures, including any request for a service that must be pre-approved.
- **Urgent Care Claim:** Any claim for medical care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize the participant's life or health or the participant's ability to regain maximum function, or in the opinion of a physician with knowledge of the participant's condition, could subject the

participant to severe pain that cannot be adequately managed without the care or treatment addressed in the claim.

- **Pre-service Claim:** Any claim for a benefit — other than an urgent care claim — that must be approved in advance of receiving medical care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- **Post-service Claim:** Any other type of claim.
- **Concurrent Care Decision:** Any decision in which the plan — after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments — subsequently reduces or terminates coverage for the treatments (other than by plan amendment or termination).
- **Adverse Decision or Adverse Decision on Appeal:** A denial, reduction, or termination of, or a failure to provide or make, payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on:
    - An individual's being ineligible to participate in the plan;
    - Utilization review;
    - A service's being characterized as experimental or investigational or not medically necessary or appropriate; and
    - A concurrent care decision.
- **Authorized Representative:** An individual authorized to act on the participant's behalf in pursuing a claim or appeal in accordance with procedures established by the plan. For urgent care claims, a health care professional with knowledge of the participant's medical condition may act as an authorized representative. (A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law.) For information about appointing an authorized representative, contact Human Resources.

Filing an Initial Claim

The participant must file a claim for benefits within the time specified by the benefit plan and in accordance with the plan's established claim procedures.

Insufficient Claims

Improperly Filed Pre-Service Claims

If a pre-service claim is incorrectly filed according to the plan's claim procedures, the participant will be notified as soon as possible, but no later than five days after the claim is received by the plan. If the incorrectly filed pre-service claim is an urgent care case, the participant will be notified within 24 hours. Notice of an improperly filed pre-service claim may be provided orally — or in writing, if the participant requests so. The notice will identify the proper procedures to be followed in filing the claim.

In order to receive notice of an improperly filed pre-service claim, the participant or an authorized representative must have provided a communication regarding the claim to the person or organizational unit that customarily handles benefit matters for the plan. The communication must include:

- The identity of the claimant;
- A specific medical condition or symptom; and
- A request for approval for a specific treatment, service or product

Incomplete Urgent Care Claims

If a properly filed urgent care claim is missing information needed for a coverage decision, the participant will be notified by the plan as soon as possible, but no later than 24 hours after the claim has been received by the plan. The participant will be notified of the specific information necessary to complete the claim. The participant will have a reasonable amount of time considering the circumstances (but not less than 48 hours) to provide the specific information. The plan will then provide notice of the claim decision as soon as possible, but no later than 48 hours after the earlier of the following:

- The date the plan receives the specified information; or
- The end of the additional time period given for providing the information

Notice of Benefits Determination

After the participant's claim is reviewed by the plan, the participant will receive a notice of benefit determination within the timeframes specified below. For urgent care and pre-service claims, the participant will receive a notice of benefit determination whether or not the plan makes an adverse decision on the participant's claim. For post-service and concurrent care claims, the participant is entitled to receive a notice of benefit determination if the plan makes an adverse decision on, or denies, the participant's claim.

The timeframes for providing notice of a benefit determination generally start when a written claim for benefits is received by the plan. Notice of a benefit determination may be provided in writing by in- hand, mail, or electronic delivery. However, in some urgent cases, the participant may first be provided notice orally, which will be followed by written or electronic notice within three days. Note, "days" means calendar (not business) days. The timeframes for providing a notice of benefit determination are as follows:

- **Urgent Care Claims:** As soon as possible considering the medical urgency, but no later than 72 hours after the plan receives the participant's claim.
- **Pre-service Claims:** Within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after the plan receives the participant's claim. This timeframe may be extended for up to 15 days for matters beyond the plan's control.

- **Post-service Claims:** In the case of an adverse decision, within a reasonable period of time, but no later than 30 days after the plan receives participant's claim. This timeframe may be extended for up to 15 days for matters beyond the plan's control.
- **Concurrent Care Decisions:** If an ongoing course of treatment will be reduced or terminated, the participant will be notified sufficiently in advance to provide an opportunity to appeal and obtain a decision on appeal before a benefit is reduced or terminated.

If the participant requests an extension of ongoing treatment in an urgent circumstance, the participant will be notified as soon as possible given the medical urgency, but no later than 24 hours after the plan receives the claim — provided the claim is submitted to the plan at least 24 hours before the expiration of the prescribed time period or number of treatments.

If the participant requests an extension of ongoing treatment in a non-urgent circumstance, the request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

For pre-service and post-service claims, the plan may extend the timeframe for making a decision on the participant's claim in certain cases. If an extension is necessary, the participant will be notified before the end of the initial timeframe (15 days for pre-service claims; 30 days for post-service claims) of the reasons for the delay and when the plan expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and the participant will be given an additional period of at least 45 days after receiving the notice to furnish the information.

The plan's extension period will begin when the participant responds to the request for additional information. The plan will then notify the participant of the benefit determination within 15 days after a response is received.

Appeal of Adverse Decision

If the participant disagrees with the decision on a claim, the participant (or an authorized representative) may file a written appeal with the plan within 180 days after receipt of the notice of adverse decision. If the participant does not appeal on time, the participant may lose the right to file suit in a state or federal court, as the participant will not have exhausted internal administrative appeal rights (which is generally a requirement before suing in state or federal court).

The participant should include the reasons he or she believes the claim was improperly denied, and all additional facts and documents the participant considers relevant in support of the appeal. The decision on the participant's appeal will consider all comments, documents, records, and other information submitted, even if they were not submitted or considered during the initial claim decision.

A new decision-maker will review the denied claim — the appeal will not be conducted by the individual who denied the initial claim or by that person's subordinate. The new decision-maker will not give deference to the original decision on the participant's claim. That is, the reviewer will give the claim a "fresh look" and make an independent decision about the claim.

If the participant's claim was denied based on medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the claim. The health care professional will not be the same person (and will not be a subordinate of the person) who was consulted on the initial decision. (A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) The plan will also identify any medical or other experts whose advice was obtained in considering the original decision on the claim, whether or not the plan relied on their advice.

For appeals of adverse benefit decisions involving urgent care claims, the plan will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between the plan and the participant or health plan providers by telephone, fax or other available expeditious methods.

Important: Second Level of Appeal

If a participant is dissatisfied with an appeal decision on a claim, he or she may:

- For urgent care claims, file a second level of appeal, and receive notification of a decision not later than 36 hours after the appeal is received.
- For pre-service or post-service claims, file a second level of appeal within 60 days of receipt of the level one appeal decision, and receive notification of a decision not later than 15 days (for pre-service claims) or 30 days (for post- service claims) after the appeal is received.

If a participant does not agree with the final determination on review, he or she has the right to bring a civil action under Section 501(a) of ERISA, if applicable.

Notice of Decision on Appeal

After the participant's appeal is reviewed by the plan, the participant will receive a notice of decision on appeal within the timeframes specified below. The participant will receive a notice of decision on appeal whether or not the plan makes an adverse decision on the appeal. The timeframes for providing a notice of decision on appeal generally start when a written appeal is received by the plan. Notice of decision on appeal may be provided in writing through in-hand, mail, or electronic delivery. Urgent care decisions may be delivered by telephone, fax, or other expeditious methods. Note, "days" means calendar (not business) days. The timeframes for

providing a notice of decision on appeal are as follows:

- **Urgent Care Appeals:** As soon as possible considering the medical urgency, no later than 72 hours after the plan receives the participant's appeal.
- **Pre-service Appeals:** Within a reasonable period of time appropriate to the medical circumstances, no later than 30 days after the plan receives participant's appeal.
- **Post-service Appeals:** Within a reasonable period of time appropriate to the medical circumstances, no later than 60 days after the plan receives participant's appeal.

A Participant's Right to Information

Upon request and free of charge, the participant has a right to reasonable access to and copies of all documents, records, and other information relevant to the plan's denial of a claim. Information is "relevant" information if it:

- Was relied upon in making the decision on participant's claim;
- Was submitted to, considered by, or generated by the plan in considering participant's claim;
- Demonstrates compliance with the plan's administrative processes for making claim decisions; Or
- In the case of a group health plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The participant is also entitled access to, and a copy of, any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on participant's denied claim upon request, free of charge. Similarly, if participant's claim is denied based on a determination involving a medical judgment, the participant is entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) In addition, if voluntary appeals or alternative dispute resolution options are available under the plan, the participant is entitled to receive information about the procedures for using these alternatives.

The participant can read the "ERISA Rights Statement" above for information on actions to take if the participant feels his or her rights to a benefit have been improperly denied.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) is a federal regulation that focuses on the portability, privacy and security of the participant and participant's dependent's health information. HIPAA protects the participant and participant's dependents by:

- Limiting exclusions for pre-existing medical conditions;
- Providing credit against maximum pre-existing condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer;
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married, or add a new dependent;
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors; and
- Ensuring the privacy of the participant's protected health information

Disclosure of Protected Information

The confidentiality of the participant's health information is important. Leidos is required to maintain the confidentiality of the participant's information and has policies and procedures and other safeguards to help protect the participant's information from improper use and disclosure.

Leidos is allowed by law to use and disclose certain information without the participant's written permission. For example, Leidos may share information with the participant's health care provider to determine whether he or she is enrolled in the plan or whether premiums have been paid on the participant's behalf. Leidos may also share the participant's information when legally required to do so — for example, in response to a subpoena or if the participant's medical safety may be at risk.

When the participant's authorization is required and the participant authorizes Leidos to use or disclose personal information for some purpose, the participant may revoke that authorization by notifying Leidos in writing at any time.

The participant's health care provider must have a Notice of Privacy Practices and provide the participant with a copy. For more information, contact Leidos Corporate Benefits.

Adding New Dependents

Under **HIPAA**, the participant has 31 days following marriage or the birth, adoption, or placement for adoption of a child to enroll a dependent in the health plans. The participant does not have to provide any medical or health information to enroll a dependent.

Continuing Health Care Coverage through COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) enables a participant and the participant's covered dependents to continue health insurance if coverage ceases 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 health insurance if their coverage ends due to the participant's death; entitlement to Medicare; divorce; legal separation; or when a covered child no longer qualifies as an eligible dependent. The participant must elect coverage according to the rules of the Leidos healthcare 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 health care 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.

Who Is Eligible For COBRA?

- A covered participant who loses coverage due to termination of employment (other than termination for gross misconduct) or reduction in work hours. Termination of employment includes, but is not limited to, voluntarily quitting, layoff, and lack of work due to a work location closure.
- The spouse and/or dependent children of a covered participant who are covered under the plan and who lose coverage as a result of any of the following qualifying events:
    - The death of a covered employee;
    - The termination of a covered employee (excluding termination due to gross misconduct);
    - The divorce or legal separation of the covered employee from his or her spouse;
    - A dependent's ceasing to qualify as a "dependent child" under the terms of the plan; or
    - The covered employee's becoming entitled to Medicare benefits.

To continue coverage, it is the participant's (or a family member's) responsibility to notify Employee Services within 31 days of a divorce, legal separation, or child's losing dependent status.

When COBRA Coverage Will End

The coverage period begins on the date of the qualifying event and ends upon the earliest of the following:

- 18 months in the case of termination of employment, layoff, or work force reduction;
- 29 months in the event of a disability*, according to Social Security;
- 36 months in the event of legal separation, divorce, or death of the employee;
- 36 months in the event of all other qualifying events;
- Failure to pay any required premium when due;
- The date a covered participant, under the continuation program, becomes covered under

another group plan or Medicare — one that does not impose any pre-existing condition limitations on the coverage; or

- The date that Leidos no longer provides a group medical plan to any of its employees.

If a participant wants to continue coverage, they can elect COBRA online or mail their election directly to the COBRA Administrator. Information to enroll will be included in the COBRA Notice mailed to that participant's home address on file. If a participant has any questions, they should contact the COBA Administrator's Member Support Team at the number indicated on the notification letter.

The participant must elect this coverage continuation within 60 days from the date the participant's Leidos medical coverage terminates or the date of notification, whichever is later. Once elected, the participant has 45 days from the date he or she elected COBRA to pay all of the premiums back to the date he or she would have lost plan coverage under the plan. The participant will be charged the plan's full cost of providing a continued coverage, plus an additional 2% administrative fee (102% of the premium).

*To be eligible for the additional 11 months coverage due to disability, the participant must provide the Plan Administrator with a Social Security Disability Award (SSDI) letter. This SSDI letter must be provided to the Plan Administrator during the first 18 months of COBRA; must indicate that the onset of the disability was within 60 days of losing coverage; and must be provided to the Plan Administrator within 60 days of your receipt of the Notice of Award letter from Social Security. A participant who qualifies for the disability extension will be charged the plan's full cost of providing a continued coverage, plus an additional 50% administrative fee (150% of the premium).

The following table summarizes COBRA benefits under the Leidos health care plans:

THE SITUATION:	OBTAINING INFORMATION:	WHO CAN BE COVERED:	HOW LONG COVERAGE CAN LAST:
The participant's employment with Leidos is terminated for reasons other than gross misconduct	A notification will be sent to the participant automatically by Leidos' COBRA administrator	The participant and the participant's dependents	18 months
There is a reduction in the participant's work hours and the participant no longer qualifies for benefits coverage	A notification will be sent to the participant automatically by Leidos' COBRA administrator	The participant and the participant's dependents	18 months

THE SITUATION:	OBTAINING INFORMATION:	WHO CAN BE COVERED:	HOW LONG COVERAGE CAN LAST:
The participant is disabled according to Social Security	The participant must notify Leidos' COBRA administrator and provide a copy of the SSDI letter (as described above)	The participant and the participant's dependents	29 months
The participant dies	A notification will be sent to the covered dependents automatically by Leidos' COBRA administrator	The participant's covered dependents	36 months
The participant becomes divorced or legally separated	A notification will be sent to the covered dependents automatically by Leidos' COBRA administrator.	The participant's former spouse	36 months
The participant's dependent reaches age 26	A notification will be sent to the over age dependent automatically by Leidos' COBRA administrator	The participant's dependent	36 months

Participants that lose health coverage as a result of an Open Enrollment action will not receive COBRA information.

Leidos Health & Welfare Plan Privacy Notice

This notice describes how medical information about you may be used and disclosed as well as how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) impose numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Leidos Health & Welfare Benefits Plan ("Plan") — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices the Plan follows in offering the benefit programs and services listed below:

- Healthy Focus Basic Plan
- Healthy Focus Essential Plan
- Healthy Focus Advantage Plan
- Healthy Focus Premier Plan
- Leidos Dental PPO Plans

- Leidos Vision Plans
- Health Care Flexible Spending Account
- Leidos Well-being Program

These benefit programs and services are administered by various carriers, vendors and service providers, including: Aetna, Delta Dental, Vision Service Plan, Express Scripts, HealthEquity and Virgin Pulse (collectively with other third parties who provide services to the Plan, “Benefit Service Providers”). The Benefit Service Providers may send, receive and store employee PHI on behalf of the Plan to achieve objectives related to health care operations and other purposes as permitted by HIPAA. Benefit Service Providers may continue to send, receive, and store employee PHI for a limited time after they have stopped providing services to the Plan for certain administrative purposes.

The Plan’s Duties With Respect to Personal Health Information

The Plan is required by law to maintain the privacy of your PHI and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your PHI. Such information is set forth below. If you participate in a fully insured plan option (such as an HMO plan) you will receive a HIPAA notice directly from your insurance provider.

It's important to understand that this Notice relates to the Plan, not Leidos as an employer — that's the way the HIPAA rules work. Different policies may apply to other Leidos programs or to data unrelated to the Plan’s benefits.

How the Plan May Use or Disclose Your Health Information with Third Parties

The HIPAA privacy regulations generally allow for the use and disclosure of your PHI without your permission (known as an “authorization”) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of such permitted uses or disclosures:

- **Treatment includes** providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your PHI with physicians who are treating you.

- **Payment** includes activities by this Plan and its administrators or providers to obtain premiums, make coverage determinations and provide reimbursement for healthcare. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.

- **Health care operations** include activities by this Plan (and in limited circumstances its Benefit Service Providers) and certain other activities as permitted by HIPAA: wellness and risk assessment programs, quality assessment and improvement activities, assessing and measuring health outcomes, cost savings objectives, customer service, and internal grievance resolution. Health care operations also include evaluation of the utilization and efficacy of third-party benefits-related services, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of Leidos wellness programs. The Plan may also disclose information to Benefit Service Providers about your claims. In addition to any other purposes identified in this Notice, such claims information may be 3 disclosed: 1) to help the Plan evaluate the treatment and prescribing practices of healthcare providers and/or 2) to conduct oversight of Plan performance.

The amount of PHI used or disclosed will be limited to the “minimum necessary” for these purposes, as defined under the HIPAA rules. The Plan, or its administrators, may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan May Use or Disclose Your Health Information

For plan administration purposes, the Plan may disclose your PHI to Leidos without your written authorization to support the health care operations described in the above paragraph, and to administer benefits under the Plan. However, Leidos agrees not to use or disclose your PHI other than as permitted or required by the Plan documents and by law.

Here's how additional information may be shared between the Plan and Leidos, as allowed under the HIPAA rules:

- The Plan, or Benefit Service Providers, may disclose "summary health information" to Leidos, if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but without participants’ names or other identifying information.

The Plan, or Benefit Service Providers, may disclose to Leidos whether an individual is eligible and/or participating in the Plan. Despite the limited circumstances described above, please note that Leidos cannot and will not use PHI obtained from the Plan for any employment-related actions. Please note that this limitation does not apply to health information Leidos collects from other sources, such as health information collected from third parties administering Leidos’ workers compensation benefits, disability benefits, and other benefit offerings that are not covered by HIPAA, or health information that Leidos collects in complying with the Family and Medical Leave Act, Americans with Disabilities Act, or

workers' compensation laws (although this type of information may be protected under other federal or state laws).

Other Allowable Uses or Disclosures of Your Health Information

In certain cases, the Plan may disclose your PHI without your authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. For example, the Plan may notify such persons of your location, general condition, or death. The Plan may also share this information with public or private entities that are authorized to assist in disaster relief efforts. Unless you are not present, you are incapacitated, or obtaining your consent would interfere with disaster 4 relief efforts by authorized organizations, you will be given the chance to agree or object to these disclosures.

The Plan may also use or disclose your PHI without your written authorization for the following activities:

Activity	Description
Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process. The Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information.

Activity	Description
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal conduct on the Plan premises.
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rules.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your Individual Rights

You have the following rights with respect to your PHI, as maintained by the Plan. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right.

Right to be Notified of a Breach

You have the right to be notified by the Plan or a Benefit Service Provider in the unlikely event of a security breach involving your unencrypted PHI.

Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information and the Plan’s Right to Refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You

also have the right to ask the Plan to request that the Plan not disclose your PHI as described in the "Other Allowable Uses or Disclosures of Your PHI" section above. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for PHI created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose PHI about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to Receive Confidential Communications of Your Health Information

If you think that disclosure of your PHI by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of PHI from the Plan by alternative means or at alternative locations. For example, if mailing documents containing your PHI to your home could endanger you, the Plan may be able to email these documents or mail them to your work location.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to Inspect and Copy Your Health Information

With certain exceptions, you have the right to inspect or obtain a copy of your PHI in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

If the Plan is unable to provide you with the above information within 30 days, we may extend the timeframe to respond to your request by an additional 30 days. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your PHI, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the PHI but knows where it is maintained, you will be informed of where to direct your request.

Right to Amend Your Health Information that Is Inaccurate or Incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. A Designated Record Set refers to the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Plan or any records the Plan, or a Benefits Service Provider acting on behalf of the Plan, uses, in whole or in part, to make decisions about Plan participants. The Plan may deny your request for a number of reasons. For example, the Plan may deny your request if the PHI is accurate and complete, is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings). The Plan may also deny your request if the PHI you would like the Plan to amend was created by another entity or person, unless that entity or person is no longer available, such as where the Plan received your PHI from your doctor, but your doctor’s office has since permanently closed.

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to Receive an Accounting of Disclosures of Your PHI

You have the right to a list of certain disclosures the Plan has made of your PHI. This is often referred to as an "accounting of disclosures."

If you request an accounting of disclosures, you may receive information on disclosures of your PHI going back for six (6) years from the date of your request. Your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days,

along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own PHI;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (PHI that excludes certain identifying information)

In addition, we may refuse to provide you with an accounting of the disclosures the Plan has provided to health oversight agencies or law enforcement officials if such agencies or officials direct the Plan to withhold this information.

Right to Obtain a Paper Copy of This Notice from the Plan Upon Request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the Information in this Notice

The Plan must abide by the terms of the Privacy Notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes PHI that was previously created or received, not just PHI created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be notified of the changes by electronic or U.S. Postal Service.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint.

To file a complaint, submit a written request to:

Leidos
Corporate Benefits Department
Attn: HIPAA Compliance Department
1750 Presidents Street
Reston, VA 20190

For more information on the Plan, its administrator's privacy policies or your rights under HIPAA, contact the Employee Services 855-553-4367, option #3.

Health Plan Regulations

The following federally mandated regulations are required of all group health plans and health insurance issuers.

Breast Reconstruction Following a Mastectomy

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy- related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please consult your group health benefits booklet for additional information. If you would like more information on WHCRA benefits, please call your plan administrator, at the contact information listed at the back of this SPD.

Hospitalization in Connection with Childbirth

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a vaginal delivery; or
- Less than 96 hours following a Caesarean section; or
- Require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

Federal law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours after delivery, as applicable.

Selection of Primary Care Provider

The plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator for your group medical benefit, as listed at the end of this SPD.

You do not need prior authorization for the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professionals, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contract the plan administrator for your group medical benefit, as listed at the end of this SPD.

Military Leave – Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If the participant is on a military leave of less than 31 days, health care coverage for the participant and the participant's eligible dependents continues as long as the participant continues paying the applicable portion of the cost of coverage. If the participant's leave is longer than 31 days, the participant may continue coverage under rules similar to those for **COBRA coverage**.

The participant may continue coverage for 24 months or the period of duty, whichever is less. (This period also counts toward COBRA coverage, if applicable.) The participant pays the full cost of coverage for him- or herself and his or her dependents plus a 2% administration fee (102% of the premium).

When the participant's leave ends, he or she will not be subject to a waiting or pre-existing condition period except for illnesses or injuries incurred or aggravated during the participant's leave duties.

If the participant is a member of the ready reserve of the armed forces and is called to active duty as a result of Executive Order 13223, special provisions regarding the participant's leave and health care coverage may apply. For more information, contact Employee Services.

Additional Information Regarding Coordination of Benefits

The following information pertains to group health care plans that may be coordinating how benefits are paid between a Leidos health care plan and another plan:

- Releasing and Obtaining Information
- Subrogation
- Recovery of Overpayment

Releasing and Obtaining Information

The health care plans reserve the right to release to, or obtain from, any other insurance company or other organization or person any information that, in its opinion, it needs for the purpose of coordination of benefits, provided that any and all determinations or actions described in the foregoing are subject to applicable law.

Subrogation and Reimbursement

This section applies when the Plan pays claims for the treatment of an illness, injury, or condition for which a third party is responsible (for example, when the Plan pays claims for the treatment of an illness, injury or condition caused by an automobile accident or another's negligence). For purposes of this section, the term "third party" may include, but will not be limited to, any one or more of the following:

- the party or parties who caused the illness, injury, or condition;
- the insurer, guarantor, or other indemnifier of the party or parties who caused the illness, injury, or condition;
- the covered participant or dependent's own insurer (for example, uninsured, underinsured, med-pay, no fault coverage, and homeowners);
- a worker's compensation insurer; and/or
- any other person, entity, policy, healthcare plan, or insurer that is liable or legally responsible in relation to the illness, injury, or condition.

Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that you or your covered Dependent may have against any third party.

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right.

The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, whether in the form of a settlement (either before or after any determination of liability) or judgment, and even if you or your covered Dependent has not been paid or fully reimbursed

for all of his or her damages or expenses. The proceeds available for reimbursement will include, but not be limited to, any and all amounts earmarked as non-economic damage settlement or judgment. You or your covered Dependent may not reduce the amount you owe the Plan to account for the payment of attorney's fees or other obligations.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your covered Dependent to assert a claim to any of the benefits to which you or your covered Dependent may be entitled. The Plan will not pay attorney's fees or costs associated with the claim or lawsuit without express written authorization from Leidos.

If the Plan should become aware that you or your covered Dependent has failed to comply with these provisions, the Plan, in its sole discretion, may (1) suspend all further benefits payments related to you or any of your Dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your covered Dependents, (2) terminate health benefits, or (3) institute legal action against you (or your covered Dependents, if applicable).

Reimbursement from Third Party Recoveries

The participant or dependent agrees to repay the Plan first from any money or other benefit recovered from the third party who is, or may be held to be, liable or legally responsible for the illness, injury, or condition giving rise to the paid benefits. The obligation to repay applies:

- whether the payment received from the third party is the result of a legal judgment, arbitration award, compromise, settlement, or any other arrangement;
- regardless of whether the third party has admitted liability for the payment;
- regardless of whether the charges are itemized in the third party's payment or whether the third party's payment is structured as a settlement for pain and suffering or in any other manner which does not itemize charges;
- regardless of whether the participant or dependent has incurred, or agreed to pay, any costs or charges in relation to seeming the recovery from the third party; and
- regardless of whether the participant or dependent is made whole by the payment.

If such a recovery is made and the Plan is not reimbursed as required herein, then the participant, dependent, estate, or legal representative will be liable to the Plan for the amount of the benefits paid under the Plan for such illness, injury, or condition.

Subrogation of Rights against Third Parties

Each participant and dependent transfers and assigns to the Plan the option, at the Plan's sole discretion, to exercise all rights to take legal action against third parties arising from any illness, injury, or condition for which such third parties are or may be held liable or legally responsible. That is, the Plan may take over the participant's and dependent's right to receive payments from the third party to the extent of the benefits paid or payable plus the Plan's reasonable costs of collection. This includes, without limitation, the right to any recovered funds paid by any other party to a participant or dependent or paid on behalf of a participant or dependent, or on behalf of the estate of any participant or dependent.

The participant or dependent agrees to cooperate fully in asserting the Plan's subrogation and recovery rights against the third party. The participant, dependent, or his or her legal representative will, within *5* days of receiving a request from the Plan, provide all information and sign and return all documents necessary to exercise the Plan's rights under this provision.

Other Provisions

Please note the following:

- Participants and dependents are required to abide by the terms of this section. Failure to do so may result in immediate termination of coverage.
- The Plan's rights to reimbursement and subrogation, and any recovery pursuant to those rights will not be reduced: (a) due to the participant's or dependent's own negligence; (b) due to the participant's or dependent's not being made whole; or (c) by any portion of a participant's or dependent's attorney's fees and costs.
- The Plan is not responsible for any attorney fees, attorney liens, or other expenses or costs.
- No equitable claims or defenses of any kind apply to the Plan's right to reimbursement and subrogation (or to any recovery pursuant to these rights), including but not limited to offset, detrimental reliance, equitable and promissory estoppel, the "make whole" doctrine, and the "common fund" doctrine.
- The participant and dependent will cooperate in assisting the Plan in protecting the Plan's rights to reimbursement and subrogation and will not act or fail to act at any time or in any manner that prejudices the Plan's rights under this provision (including settling a claim with a third party without advance notice to the Plan).
- The Plan has the right to recover interest at the rate of 1.5% per month or the maximum amount permitted by law, whichever is less, on the amount paid by the Plan because of the illness, injury, or condition.
- The Plan is secondary to any excess insurance policy including, but not limited to, school and/or athletic policies.
- If the participant or dependent resides in a state where no-fault coverage, or automobile personal injury protection or medical payment coverage, is mandatory, that coverage is primary, and the Plan

takes secondary status. The Plan will reduce benefits for an amount equal to, but not less than, the state's mandatory minimum personal injury protection or medical payment requirement.

- This provision also applies to any funds recovered from the third party by or on behalf of: (i) a minor dependent; (ii) the estate of any participant or dependent; and (iii) any incapacitated person.
- The Plan's lien exists at the time the Plan pays benefits, and if a participant or dependent files a petition for bankruptcy, he or she agrees that the Plan's lien existed prior to the creation of the bankruptcy estate.
- Failure by a participant or dependent to cooperate with the Plan in the exercise of these rights may also result, at the discretion of the Plan, in a reduction of future benefit payments available to a participant or dependent under the Plan by an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed. In certain circumstances, the Plan also may be entitled to recover any of the unsatisfied portions of the amount the Plan has paid or the amount of your recovery, whichever is less, directly from the medical providers to whom the Plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and the Plan will not have any obligation to pay the provider or reimburse you.

Assignment of Benefits

Except as otherwise provided in the Plan, in a Qualified Medical Child Support Order (“QMCSO”), or pursuant to a voluntary assignment of benefits to a health care provider or facility providing health care services covered by the Plan, no benefit, right or interest of any covered person under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities or other obligations of such person; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute or levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action, shall be void. Notwithstanding the Plan may choose to remit payments directly to health care providers with respect to covered services if authorized by the covered person, but only as a convenience to covered persons. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) covered persons under any circumstances.

Missing Persons

If the Plan Administrator or Claims Administrator (as applicable) cannot locate an individual covered under the Plan, after making a reasonably diligent effort, including by giving written notice addressed to the individual's last known address as shown by the records of the Plan, the amount payable to the individual is forfeited.

Uncashed Checks

If a check to you for benefits under the Plan remains uncashed for 90 days after issue, amounts attributable to such check shall be forfeited to the Plan. In such event, you shall have no further claim to such amount for any reason.

Access to Records

By enrolling for coverage under the Plan, you authorize the Plan Administrator, Claims Administrator and their representatives (collectively the "Administrators") to have access to any records and medical information held by any provider who delivers services to you under the Plan. You also authorize the Administrators to use your records and medical information for claims processing, including, without limitation, claims by the Company for reimbursement or subrogation under the Plan; medical care claims data evaluation; quality of care assessment; medical service utilization review; and evaluation of potential or actual claims against the Administrators.

Recovery of Overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from any participant, beneficiary, or dependent. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful. The Plan may also bring a lawsuit to enforce its rights to recover overpayments.

If the overpayment is made to a provider, the Plan may reduce or deny benefits, in the amount of the overpayment, for otherwise covered services for current or future claims with the provider on behalf of any participant, beneficiary, or dependent in the Plan.

No Surprises Act

The following terms will apply to applicable Plan coverage, to the extent not otherwise described in any Benefits Booklets/Summaries:

Emergency Medical Condition. For purposes of the Plan, emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of medical attention to result in a condition described in the federal Emergency Medical Treatment and Labor Act ("EMTALA"), including: (1) placing the health of the individual or with respect to a pregnant woman, the health of the woman or her unborn child, in serious

jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Visit. For purposes of the Plan, the scope of "visit" to a participating health care facility is expanded as necessary to include the furnishing of equipment and devises, telemedicine services, imaging services, laboratory services, and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.

Independent Dispute Resolution Process When Open Negotiations Fail to Result in an Agreed Upon Out of Network ("OON") Rate for OON Claims in Which Balance Billing is Prohibited. Providers, facilities and air ambulance providers will meet deadlines, attest to no conflicts of interest, choose a certified independent dispute resolution entity, submit a payment offer and provide additional information if needed. Providers, facilities and air ambulance providers agree to utilize the DOL's mandatory notices and use the federal independent dispute resolution ("IDR") internet-based portal.

Air Ambulance Billing. When a Plan participant receives air ambulance services from a nonparticipating provider and such services would be covered by the Plan if provided by a participating provider, the Plan shall: (i) calculate cost-sharing with respect to these services as though such services were obtained from a participating provider; (ii) calculate cost-sharing based on the lesser of the Qualifying Payment Amount ("QPA") or the billed amount for the services; (iii) count the cost-sharing amounts toward the in-network deductible and in-network out-of-pocket maximum; and (iv) pay to the provider an initial payment or send a notice off denial within 30 days after the bill is received and pay the total amount due directly to the provider. Any disputes between the air ambulance service provider and Plan shall be resolved through the open negotiation and IDR process.

Continuing Care Patient. A "continuing care patient" is defined as an individual with respect to a provider or facility who is: (i) undergoing a course of treatment for serious and complex condition from the provider or facility; (ii) undergoing a course of institutional or inpatient care from the provider of facility; (iii) scheduled to undergo non-elective surgery from the provider or facility, including postoperative care with respect to such facility; (iv) pregnant and undergoing a course of treatment for the pregnancy; or (v) determined to be terminally ill and is receiving treatment for such illness.
External Review. All external reviews shall, as applicable, be conducted in accordance with the requirements of the No Surprises Act (including all implementing guidance and regulations). Please contact the Plan Administrator for additional information about this external-review process.

Interpretation and Governance

The Plan Administrator has the exclusive discretionary authority to determine all matters relating to interpretation and operation of the plan, including eligibility, coverage and benefits. The Plan Administrator may delegate any of its duties and responsibilities to one or more persons or entities.

Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the Plan Administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

Leidos reserves the right to change, amend, suspend, or terminate any or all of the benefits under the plan, in whole or in part, at any time for any reason in its sole discretion, by action of a designated corporate officer or employee delegated authority for such actions by the Leidos Board of Directors. Leidos' rights include the right to obtain coverage and/or administrative services from additional or difference insurance carriers, third party administrators, etc., and the right to revise the amount of employee contributions. Employees will be notified of any material modifications to the plan. Nothing in this document says or implies that participation in the Plan is a guarantee of continue employment, nor is anything in this document intended to guarantee that benefit levels or costs will remain unchanged in future years.

Leidos cannot advise you regarding tax, investment or legal considerations relating to the plan. Therefore, if you have questions regarding benefit planning, you should seek advice from a personal advisor (e.g., legal counsel, tax advisor, investment advisor).

Questions concerning the plan can be directed to the Plan Administrator. A copy of the plan document is available for your inspection upon request.

Plan Administrative Information

Important administrative information for each Leidos benefit plan is described in this section. For a comprehensive contact information list, go to **Contact Information**.

Self-Insured Medical Plans

Leidos Benefit Plan:	• **Healthy Focus Basic Plan** • **Healthy Focus Essential Plan** • **Healthy Focus Advantage Plan** • **Healthy Focus Premier Plan**
Type of Plan:	Group health plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification No.:	95-3630868
Plan Administrator:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Group Number:	Aetna – 698685
Plan Number:	501
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	The plans are self-funded and self-administered by Leidos. Leidos and participants share the cost of coverage.
Claims Administrators:	**Aetna** PO Box 981106 El Paso TX, 79998-1106 800-843-9126 **Express Scripts (Rx)** P.O. Box 14711 Lexington, KY 40512 877-223-4721

Dental PPO Plans

Leidos Benefit Plan:	**Leidos Dental PPO Plan**
Type of Plan:	Group dental plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Group Number:	698685-50
Plan Number:	501
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	The plans are self-funded and self-administered by Leidos. Leidos and participants share the cost of coverage.
Claims Administrators:	Delta Dental of VA 4818 Starkey Road Roanoke, VA 24018

Vision Plans

Leidos Benefit Plan:	**Vision Plans**
Type of Plan:	Group vision plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800-852-7600
Group Number:	12180678
Plan Number:	514
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Fully insured. Participants pay the full cost of coverage. To be covered by benefits, participants make pre-tax contributions.
Claims Administrators:	Vision Service Plan P.O. Box 385018 Birmingham, AL 35238-5018 800-852-7600

Life and AD&D Insurance Plans

Leidos Benefit Plan:	**Basic Term Life Insurance**, **Group Universal Life Insurance**, **Basic AD&D Insurance**, and **Voluntary AD&D Insurance**
Type of Plan:	Group term life insurance plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	**Life Insurance:** Prudential Insurance Company of America P.O. Box 8517 Philadelphia, PA 19176 **Accidental Death & Dismemberment Insurance:** New York Life Group Benefit Solutions P.O. Box 22328 Pittsburgh, PA 15222-0328
Policy Number:	Life Ins: Control #52844 AD&D: OK 819515
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Fully insured. Leidos pays the full cost of Basic Term Life Insurance and Basic AD&D Insurance. Participants pay the full cost of coverage for Group Universal Life Insurance and Voluntary AD&D Insurance.
Claims Administrators:	**Life Insurance:** Prudential Insurance Company of America P.O. Box 8517 Philadelphia, PA 19176 **Accidental Death & Dismemberment Insurance:** New York Life Group Benefit Solutions P.O. Box 22328 Pittsburgh, PA 15222-0328

Business Travel Accident Insurance

Leidos Benefit Plan:	**Business Travel Accident Insurance**
Type of Plan:	Group business travel accident insurance plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	**New York Life Group Benefit Solutions** P.O. Box 22328 Pittsburgh, PA 15222-0328
Policy Number:	ABL-65 86 41
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Fully insured. Leidos pays the full cost of Business Travel Accident Insurance.
Claims Administrators:	New York Life Group Benefit Solutions P.O. Box 22328 Pittsburgh, PA 15222-0328
Claim Forms:	Claim forms are available from Employee Services. Completed claim forms, along with supporting documentation should be submitted directly to Employee Services P.O. Box 2502 Oak Ridge, TN 37831

Short-Term Disability Plan

Leidos Benefit Plan:	**Voluntary Short-Term Disability Insurance**
Type of Plan:	Disability plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Manager:	Sedgwick 3280 E. Foothill Blvd., Suite 250 Pasadena, CA 91107 800-939-4911
Plan Number:	515
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Employees pay the full cost of Voluntary Short-Term Disability Insurance.
Claims Administrators:	Sedgwick 3280 E. Foothill Blvd. Suite 250 Pasadena, CA 91107

Long-Term Disability Plan

Leidos Benefit Plan:	**Long-Term Disability Insurance**
Type of Plan:	Disability plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	**New York Life** P.O. Box 22328 Pittsburgh, PA 15222-0328
Plan Number:	LK-980003
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Fully insured. If elected, employees pay the full cost of Long- Term Disability Insurance.
Claims Administrators:	New York Life Group Benefit Solutions P.O. Box 22328 Pittsburgh, PA 15222-0328

Flexible Spending Accounts

Leidos Benefit Plan:	**Health Care Flexible Spending Account** and **Dependent (Day) Care Flexible Spending Account**
Type of Plan:	Group health and welfare plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Plan Administrator:	**Leidos** Attn: Corporate Benefits 1750 Presidents Street Reston, VA 20190
Plan Manager:	HealthEquity 15 W. Scenic Pointe Drive Suite 100 Draper, UT 84020 Customer Service: 1-844-373-6981 healthequity.com
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Self-funded. Benefits are funded with voluntary pre-tax contributions made by enrolled participants.
Claims Administrators:	HealthEquity 15 W. Scenic Pointe Drive Suite 100 Draper, UT 84020 Customer Service: 1-844-373-6981 healthequity.com