Client Vision Care Plan

Vision Care for Life

Client Name: **LEIDOS HOLDINGS INC.**
Client Number: **12180678**
Effective Date: **JANUARY 1, 2023**

EVIDENCE OF COVERAGE

Provided by:

VSP VISION CARE, INC.
3333 Quality Drive, Rancho Cordova, CA 95670
(916) 851-5000 (800) 877-7195

VSP VISION CARE, INC., is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1

Notice to Client: In the event this document is used to develop a Summary Plan Description, complete the information below, as applicable.

NAME OF CLIENT:

NAME OF PLAN:

PRIMARY ADDRESS OF CLIENT:

PLAN ADMINISTRATOR:

ADDRESS:

PHONE NUMBER:

This Evidence of Coverage is a summary of the Policy provisions and is presented as a matter of general information only. It is not a substitute for the provisions of the Policy itself. In the event of any dispute between this Evidence of Coverage and the Policy, the provisions of the Policy will prevail. A copy of the Policy will be furnished on request. If any changes are made to this document by anyone other than VSP, VSP disclaims responsibility for such changes and cannot guarantee this document will comply with any statutory requirements including but not limited to ERISA.

ELIGIBILITY FOR COVERAGE

Enrollees: To be covered, a person must currently be an employee or member of the Client, and meet the coverage criteria established by Client.

Eligible Dependents: Any dependent of an Enrollee of Client who meets the eligibility criteria established by Client, if such dependent coverage is provided.

HOW TO USE THIS PLAN

VSP provides Plan Benefits to Covered Persons based on the level of coverage purchased by the Client. Refer to the Schedule of Benefits and Additional Benefit Rider (if applicable) for specific Plan Benefits.

1. Contact VSP to obtain a list of participating providers, and/or to view available benefits, (see below for contact information).

2. Contact a VSP Preferred Provider's office to schedule an appointment and indicate that Covered Person is a VSP member. Should Covered Persons fail to identify themselves as VSP members, Plan Benefits shall be limited to those of an Open Access Provider, if such Plan Benefits are available.

3. Once the appointment is made, the VSP Preferred Provider will obtain benefit verification from VSP. The VSP Preferred Provider will bill VSP directly and the Covered Person is responsible for payment of any applicable Copayments, non-covered services or materials, or amounts which exceed plan allowances, and annual maximum benefits.

4. If the Policy includes Plan Benefits for Open Access Providers, Covered Person may be responsible for paying for all services and/or materials in full and submitting a claim to VSP. All reimbursement will be in accordance with the Open Access Provider fee schedule, less any applicable Copayment. Obtaining services from an Open Access Provider will typically result in higher out of pocket expenses for Covered Persons. All claims must be submitted to VSP within [365] calendar days from the date services are rendered and/or materials provided. Claims received by VSP after [365] days will be denied unless prohibited by applicable state or federal law.

TO OBTAIN FURTHER INFORMATION

Contact VSP at 800-877-7195 or www.vsp.com.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

This Plan is designed to cover visual needs rather than cosmetic materials.

Some vision care services and/or materials are not covered under this Plan and certain other limitations may apply. Please refer to the EXCLUSIONS AND LIMITATIONS OF BENEFITS section of the attached Schedule of Benefits and/or Additional Benefit Rider (when purchased by Client) for details.

COORDINATION OF BENEFITS

Covered Persons who are covered under two or more insurance plans that include vision care benefits may be eligible for Coordination of Benefits ("COB"). VSP will combine other insurance plans' claim payments or reimbursements, if any, with benefits available under Covered Person's VSP Plan, which may reduce or eliminate Covered Person's out-of-pocket expense. Covered Persons covered under more than one VSP Plan may also be able to take advantage of COB. In order to process claims involving COB, VSP may need to share personal information regarding Covered Persons with other parties (such as another insurance company). When this is necessary, VSP will only share such information with those persons or organizations having a legitimate interest in that information and only where such sharing is not prohibited by law.

URGENT VISION CARE

Services for conditions of a medical nature are covered by VSP only under specific supplemental eye care Plans purchased by Client. If Client purchased one of these plans, such coverage will be evidenced in an Additional Benefit Rider. When vision care is necessary for Urgent Conditions, Covered Persons with a supplemental eye care plan may obtain Plan Benefits by contacting a VSP Preferred Provider or Open Access Provider. No prior approval from VSP is required for the Covered Person to obtain vision care for Urgent Conditions of a medical nature. If Client has not purchased one of these plans, Covered Persons are not covered by VSP for medical services and should contact a physician under Covered Persons' medical insurance plan for care.

HOLD HARMLESS

Covered Persons shall be held harmless for any sums owed by VSP to the VSP Preferred Provider, other than those sums not covered by the Plan.

COMPLAINTS AND GRIEVANCES

Covered Persons have the right to expect quality care from VSP Preferred Providers. More information is available under "Patient's Rights and Responsibilities" on VSP's web site at www.vsp.com. Complaints and grievances are disagreements regarding access to care, quality of care, treatment or service. Covered Persons may submit any complaints and/or grievances, including appeals, in writing to VSP at 3333 Quality Drive, Rancho Cordova, CA 95670-7985 or verbally by calling VSP's Customer Care Division at 1-800-877-7195. VSP will resolve the complaint or grievance within thirty (30) calendar days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but not later than one hundred twenty (120) calendar days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within thirty (30) days, VSP will notify the Covered Person of the expected resolution date. Upon final resolution VSP will notify the Covered Person of the outcome in writing.

NOTICE: If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance at P.O. Box 1157, Richmond, Virginia 23218, (877)310-6560, ombudsman@scc.virginia.gov .

CLAIM PAYMENTS AND DENIALS

Initial Determination: VSP will pay or deny claims within thirty (30) calendar days of receipt. In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Claim Denial Appeals: If a claim is denied in whole or in part, under the terms of the Policy, Covered Person or Covered Person's authorized representative may submit a request for a full review of the denial. Covered Person may designate any person, including their provider, as their authorized representative. References in this section to "Covered Person" include Covered Person's authorized representative, where applicable.

Initial Appeal: The request for review must be made within one hundred eighty (180) calendar days following denial of a claim and should contain sufficient information to identify the claim and the Covered Person affected by the denial. The Covered Person may review, during normal working hours, any documents held by VSP pertinent to the denial. The Covered Person may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, shall be provided and communicated to the Covered Person within thirty (30) calendar days after receipt of a request for an appeal from the Covered Person.

Second Level Appeal: If Covered Person disagrees with the response to the initial appeal of the denied claim, Covered Person has the right to a second level appeal. Within sixty (60) calendar days after receipt of VSP's response to the initial appeal, Covered Person may submit a second appeal to VSP along with any pertinent documentation. VSP shall communicate its final determination to Covered Person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for the determination.

Other Remedies: When Covered Person has completed the appeals stated herein, additional voluntary alternative dispute resolution options may be available, including mediation or arbitration. Covered Person may contact the U. S. Department of Labor or the State insurance regulatory agency for details. Additionally, under the provisions of ERISA (Section 502(a) (1) (B) [29 U.S.C. 1132(a) (1) (B)], Covered Person has the right to bring a civil action when all available levels of reviews, including the appeal process, have been completed, the claims were not approved in whole or in part, and Covered Person disagrees with the outcome.

Time of Action: No action in law or in equity shall be brought to recover on the Policy prior to the Covered Person exhausting his/her grievance rights under the Policy and/or prior to the expiration of sixty (60) days after the claim and any applicable documentation have been filed with VSP. No such action shall be brought after the expiration of any applicable statute of limitations, in accordance with the terms of the Policy.

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact the insurance company issuing this insurance at the following address and telephone number:

VSP
3333 Quality Drive,
Rancho Cordova, CA 95670
(800) 852-7600

If you have been unable to contact or obtain satisfaction from VSP or your agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Virginia State Corporation Commission's Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218-1157

(800) 552-7945
(804) 371-9691
(877) 310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Bureau of Insurance, have your policy number available.

CONTINUATION OF BENEFITS FOR ENROLLEES

There are 2 options available to Client that provide for the continuation of benefits for Enrollees:

Option 1: If an Enrollee's coverage under this Policy ceases because of the termination of the Enrollee's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits, unless such termination is due to termination of this Policy under circumstances in which the Enrollee is insurable under other replacement group coverage without waiting periods and preexisting conditions, VSP will issue, without evidence of insurability, an individual insurance policy in the event VSP offers such policy. If Client elects option 1, the following requirements apply:

(a) The application for the individual policy shall be made, and the first premium paid to the VSP within thirty-one days after issuance of the written notice, but in no event beyond the 60 day period following the date of the termination of the person's eligibility;
(b) The premium on the individual policy shall be at VSP's then customary rate applicable: to such policies and to the class of risk to which the person then belongs.
(c) The individual policy will not result in over-insurance on the basis of the insurer's underwriting standards at the time of issue;
(d) The benefits under the individual policy shall not duplicate any benefits paid for the same injury or same sickness under the prior policy;
(e) The policy shall extend coverage to the same family members that were insured under this Policy; and
(f) Coverage under this option shall be effected in such a way as to result in continuous coverage from the date of the Enrollee's termination of eligibility for such insured if requested and paid for by the Enrollee.

Option 2: If a Enrollee's coverage under this Policy ceases because of the termination of the Enrollee's eligibility for coverage, prior to that person becoming eligible for Medicare or Medicaid benefits Enrollee shall continue his or her present coverage under this Policy for a period of twelve (12) months immediately following the date of the termination of the person's eligibility, without evidence of insurability. (Option 2 is not available if Client is required by federal law to provide continuation of coverage pursuant to COBRA.) If Client elects option 2, the following requirements apply:

(a) The application and payment for the extended coverage is made to Client within 31 days after issuance of written notice, but in no event beyond the 60 day period following the date of the termination of Enrollee's eligibility;
(b) Each premium for such extended coverage is timely paid to the Client on a monthly basis during the twelve-month period;
(c) The premium for continuing the group coverage shall be at VSP's current rate applicable to the group policy plus any applicable administrative fee not to exceed two percent of the current rate; and
(d) Continuation shall only be available to an employee or member who has been continuously insured under the group policy during the entire three months' period immediately preceding termination of eligibility.
(e) The Client shall provide each employee or other Enrollee under such a policy written notice of the availability of the option chosen and the procedures and timeframes for obtaining continuation or conversion of the group policy. Such notice shall be provided within 14 days of Client's knowledge of the employee's or other Enrollee's loss of eligibility under the policy.

THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that under certain circumstances health plan benefits be made available to eligible participants and their dependents upon the occurrence of a COBRA-qualifying event. If, and only to the extent, COBRA applies to Covered Person's Plan, VSP shall make the statutorily required continuation coverage available for purchase in accordance with COBRA.

DEFINITIONS:

ADDITIONAL BENEFIT RIDER	The document, attached as Exhibit C to the Policy, which lists selected vision care services and vision care materials which a Covered Person is entitled to receive under the Policy. Additional Benefits are only available when purchased by Client in conjunction with a Plan Benefit offered under the Schedule of Benefits.
ASSIGNMENT OF BENEFITS	A written order signed by a Covered Person eighteen (18) years of age or older and included with each claim, directing VSP to pay available Plan Benefits to a named Open Access Provider.
CLIENT	An employer or other entity which contracts with VSP for coverage under the Policy in order to provide vision care coverage to its Enrollees and their Eligible Dependents, if such dependent coverage is provided.
COORDINATION OF BENEFITS	Procedure which allows more than one insurance plan to consider Covered Persons' vision care claims for payment or reimbursement.
COPAYMENTS	Those amounts required to be paid by or on behalf of a Covered Person for Plan Benefits which are not fully covered, and which are payable at the time services are rendered or materials ordered.
COVERED PERSON	An Enrollee or Eligible Dependent who meets Client's eligibility criteria and on whose behalf premiums have been paid to VSP, and who is covered under the Plan.
ENROLLEE	An employee or member of Client who meets the criteria for eligibility established by Client.
PLAN OR PLAN BENEFITS	The vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under the Policy, as defined in the attached Schedule of Benefits and Additional Benefit Rider (when purchased by Client).
OPEN ACCESS PROVIDER	Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to Covered Persons of VSP.
PLAN ADMINISTRATOR	The person specifically so designated on the Client application, or if an administrator is not so designated, the Client. The Plan Administrator shall have authority to control and manage the operation and administration of the Plan on behalf of the Client.
POLICY	The contract between VSP and Client upon which this Plan is based.
SCHEDULE OF BENEFITS	The document(s), attached as Exhibit A to the Client Policy maintained by the Plan Administrator and to this Evidence of Coverage, which lists the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of the Plan.
VSP PREFERRED PROVIDER	An optometrist or ophthalmologist licensed and otherwise qualified to practice vision care and/or provide vision care materials who has contracted with VSP to Plan Benefits on behalf of Covered Persons of VSP.
URGENT CARE	Services for a condition with sudden onset and acute symptoms which requires the Covered Person to obtain immediate medical care, or an unforeseen occurrence requiring immediate, non-medical, action.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®
Basic

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, stepchild, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of intellectual disability or physical handicap, and chiefly dependent upon Enrollee for support and maintenance. The mental or physical disability must have existed while the child was covered under the plan and began before age 26. The Enrollee must provide periodic evidence of incapacity.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a maximum $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Corrective vision treatment of an experimental nature.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision	Up to $ 30.00* once every 12 months**
Bifocal	Up to $ 50.00* once every 12 months**
Trifocal	Up to $ 65.00* once every 12 months**
Lenticular	Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT A

SCHEDULE OF BENEFITS
VSP Choice Plan®
Plus

GENERAL

This Schedule of Benefits lists the vision care services and materials to which Covered Persons of VSP VISION CARE, INC.("VSP") are entitled, subject to any Copayments and other conditions, limitations and/or exclusions stated herein, and forms a part of the Policy or Evidence of Coverage to which it is attached.

VSP Preferred Providers are those doctors that have agreed to participate in VSP's Choice Network.

BENEFIT PERIOD

A twelve-month period beginning on January 1st and ending on December 31st.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to eligibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Any child of Enrollee, including a natural child from date of birth, stepchild, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Dependent children are covered up to the end of the month in which they turn age 26.

A dependent, unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of intellectual disability or physical handicap, and chiefly dependent upon Enrollee for support and maintenance. The mental or physical disability must have existed while the child was covered under the plan and began before age 26. The Enrollee must provide periodic evidence of incapacity.

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

COVERED SERVICES AND MATERIALS

EYE EXAMINATION- Covered in full* once every 12 months**

Comprehensive examination of visual functions and prescription of corrective eyewear.

LENSES - Covered in full* once every 12 months**

Lenses (Single, Lined Bifocal, Lined Trifocal or Lenticular)

Polycarbonate lenses are covered in full for dependent children up to the end of the month in which they turn age 26.

Standard Progressive Lenses covered in full

FRAMES - Covered up to the Plan allowance* once every 12 months**

The VSP Preferred Provider will prescribe and order Covered Person's lenses, verify the accuracy of finished lenses, and assist Covered Person with frame selection and adjustment.

EasyOption Upgrades:

Each Benefit Period, the Enrollee and each of the Enrollee's Covered Dependents are entitled to choose one of the following EasyOptions upgrades. The enrollee must select the desired EasyOptions upgrade at the time eyewear materials are ordered. The selected upgrade must be consistent with the eyewear materials ordered (glasses or contact lenses).

The EasyOptions feature is not available at Walmart, Sam's Club and Costco. If the enrollee purchases eyewear materials from these vendors, the EasyOptions feature will be forfeited and will not be available to redeem at other providers.

FRAMES: An Additional Allowance of $ 100.00 once every 12 **months****

OR

LENS ENHANCEMENT

Premium and Custom Progressive lenses: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT

Photochromic: Covered in full once every 12 months**.

OR

LENS ENHANCEMENT

Anti-reflective coating: Covered in full once every 12 months**.

OR

CONTACT LENSES

ELECTIVE: An Additional Allowance of $ 100.00 once every 12 **months****

*Less any applicable Copayment.

** beginning with the first day of the Benefit Period.

CONTACT LENSES

ELECTIVE

Elective Contact Lenses (materials only) are covered up to $150.00 once every 12 months**

The Elective Contact Lens fitting and evaluation services are covered in full once every 12 months**, after a maximum $60.00 Copayment.

NECESSARY
Necessary Contact Lenses are covered in full* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.
*Less any applicable Copayment.
** beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems not correctable with regular lenses, including:

Supplemental Testing: Covered in full*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Preferred Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Member Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

NOT COVERED

- Services and/or materials not specifically included in this Schedule as covered Plan Benefits.
- Plano lenses (lenses with refractive correction of less than ± .50 diopter), except as specifically allowed under the Suncare enhancement, if purchased by Client.
- Two pair of glasses instead of bifocals.
- Replacement of lenses, frames and/or contact lenses furnished under this Plan which are lost or damaged, except at the normal intervals when Plan Benefits are otherwise available.
- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Contact lens modification, polishing or cleaning.
- Local, state and/or federal taxes, except where VSP is required by law to pay.
- Corrective vision treatment of an experimental nature.

REIMBURSEMENT SCHEDULE
OPEN ACCESS PROVIDERS

COPAYMENT

A Copayment amount of $20.00 shall be payable by the Covered Person at the time services are rendered.

EYE EXAMINATION: Up to $ 45.00* once every 12 months**
Comprehensive examination of visual functions and prescription of corrective eyewear.

SPECTACLE LENSES

Single Vision	Up to $ 30.00* once every 12 months**
Bifocal	Up to $ 50.00* once every 12 months**
Trifocal	Up to $ 65.00* once every 12 months**
Lenticular	Up to $100.00* once every 12 months**

FRAMES: Covered up to $ 70.00* once every 12 months**

CONTACT LENSES

Elective
Elective Contact Lenses are covered up to $105.00 once every 12 months**

The Elective Contact Lens allowance applies to both the doctor's fitting and evaluation fees, and to materials.

Necessary
Necessary Contact Lenses are covered up to $210.00* once every 12 months**

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's Doctor.

Contact Lenses are provided in place of spectacle lens and frame benefits available herein.

*Less any applicable Copayment.
**beginning with the first day of the Benefit Period.

LOW VISION

Professional services for severe visual problems that cannot be corrected with regular lenses, including:

Supplemental Testing: Up to $125.00*.

-Includes evaluation, diagnosis and prescription of vision aids where indicated.

Supplemental Aids: 75% of VSP Open Access Provider's fee, up to $1000.00*

*Maximum benefit for all Low Vision services and materials is $1000.00 every two (2) years and a maximum of two supplemental tests within a two-year period.

Low Vision Services are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Covered Person's VSP Preferred Provider.

OPEN ACCESS PROVIDERS

- Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
- Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
- There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
- VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

ADDITIONAL BENEFIT RIDER
ESSENTIAL MEDICAL EYE CARE (EMEC) PLAN

GENERAL

This Rider lists additional vision care benefits to which Covered Persons of VSP are entitled, subject to any applicable Copayments and other conditions, limitations and/or exclusions stated herein. The Essential Medical Eye Care Plan is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the Plan, Eyecare Professionals provide treatment and management of urgent and follow-up services. EMEC also involves management of conditions which require monitoring to prevent future vision loss. This Rider forms a part of the Policy and Evidence of Coverage to which it is attached.

ELIGIBILITY

The following are Covered Persons under this Plan, pursuant to elgibility criteria established by Client:

- Enrollee
- Legal Spouse of Enrollee
- Domestic Partner
- Dependent Parent
- Any unmarried child of Enrollee, including a natural child from date of birth, stepchild, legally adopted child from the date of placement for adoption with the Enrollee, or other child for whom a court or administrative agency holds the Enrollee responsible.

Unmarried dependent children are covered up to age 26 or to age 26 if full time students.

A dependent unmarried child over the limiting age may continue to be eligible as a dependent if the child is incapable of self-sustaining employment because of mental or physical disability, and chiefly dependent upon Enrollee for support and maintenance.

Plan Benefits under the Essential Medical Eye Care Plan are available to Covered Persons only after all other benefits under their group medical plan have been exhausted, or when Covered Person is not covered under a group medical plan.

Covered Persons with the following symptoms and/or conditions (see DEFINITIONS below) will be covered for certain primary eyecare services in accordance with the optometric scope of licensure in the Eyecare Professional's state.

SYMPTOMS

Examples of symptoms which may result in a Covered Person seeking services on an urgent basis under the EMEC Plan may include, but are not limited to:

- ocular discomfort or pain
- transient loss of vision
- flashes or floaters
- ocular trauma
- diplopia
- recent onset of eye muscle dysfunction
- ocular foreign body sensation
- pain in or around the eyes
- swollen lids
- red eyes

CONDITIONS

Examples of conditions which may require management under the EMEC Plan may include, but are not limited to:

- ocular hypertension
- retinal nevus
- glaucoma
- cataract
- pink eye
- macular degeneration
- corneal dystrophy
- corneal abrasion
- blepharitis
- sty

PROCEDURES FOR OBTAINING SUPPLEMENTAL ESSENTIAL MEDICAL EYE CARE SERVICES

COVERED PERSON HAS A GROUP MEDICAL PLAN

The Supplemental Essential Medical Eye Care Plan provides coverage for certain vision-related medical services as a supplement to Covered Person's group medical plan. Covered Persons should refer to the plan booklet, certificate of coverage or other benefits description for their group medical plan to determine how to obtain plan benefits.

The provider should first submit a claim to Covered Person's group medical insurance plan. Any amounts not paid by the medical plan may then be considered for payment by VSP. (This is referred to as "Coordination of Benefits" or "COB." Please refer to the Coordination of Benefits section of Covered Person's Evidence of Coverage for additional information regarding COB.)

COVERED PERSON DOES NOT HAVE A GROUP MEDICAL PLAN

When Covered Person does not have a group medical plan, the Essential Medical Eye Care Plan provides Plan Benefits as follows:

1. Covered Person contacts VSP Preferred Provider and makes an appointment.

2. Covered Person pays the applicable Copayment at the time of each Essential Medical Eye Care visit and amounts for any additional services not covered by the Plan.

REFERRALS

If Covered Services cannot be provided by Covered Person's VSP Preferred Provider, the doctor will refer the Covered Person to another VSP Preferred Provider or to a physician whose offices provide the necessary services.

If the Covered Person requires services beyond the scope of the EMEC Plan, the VSP Preferred Provider will refer the Covered Person to a physician.

Referrals are intended to insure that Covered Persons receive the appropriate level of care for their presenting condition. **Covered Persons do not require a referral from a VSP Preferred Provider in order to obtain Plan Benefits.**

PLAN BENEFITS
VSP PREFERRED PROVIDERS

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care:

Covered in Full after a Copayment of $ 20.00.

Special Ophthalmological Services: Covered in Full

Eye and Ocular Adnexa Services: Covered in Full

EXCLUSIONS AND LIMITATIONS OF BENEFITS

The Essential Medical Eye Care Plan provides coverage for limited vision-related medical services as a supplement to Covered Person's group medical plan. A current list of the covered procedures will be made available to Covered Persons upon request.

NOT COVERED

1. Services and/or materials not specifically included in this Rider as covered Plan Benefits.
2. Frames, spectacle lenses, contact lenses or any other ophthalmic materials.
3. Orthoptics or vision training and any associated supplemental testing.
4. Surgery, and any pre- or post-operative services, except as an adnexal service included herein.
5. Treatment for any pathological conditions.
6. An eye exam required as a condition of employment.
7. Insulin or any medications or supplies of any type.
8. Local, state and/or federal taxes, except where VSP is required by law to pay.

ESSENTIAL MEDICAL EYE CARE PLAN DEFINITIONS

Blepharitis	Inflammation of the eyelids.
Cataract	A cloudiness of the lens of the eye obstructing vision.
Conjunctiva	The mucous membrane that lines the inner surface of the eyelids and is continued over the forepart of the eye.
Conjunctivitis	See Pink Eye.
Corneal Abrasion	Irritation of the transparent, outermost layer of the eye.
Corneal Dystrophy	A disorder involving nervous and muscular tissue of the transparent, outermost layer of the eye.
Diplopia	The observance by a person of seeing double images of an object.
Eyecare Professional	Any duly licensed optometrist (O.D.), ophthalmologist or other doctor of medicine (M.D.), or doctor of osteopathy (D.O.).
Eye Muscle Dysfunction	A disorder or weakness of the muscles that control the eye movement.
Flashes or Floaters	The observance by a person of seeing flashing lights and/or spots.
Glaucoma	A disease of the eye marked by increased pressure within the eye which causes damage to the optic disc and gradual loss of vision.
Macula	The small, sensitive area of the central retina, which provides vision for fine work and reading.
Macular Degeneration	An acquired degenerative disease which affects the central retina.
Ocular	Of or pertaining to the eye or the eyesight.
Ocular Conditions	Any condition, problem or complaint relating to the eyes or eyesight.
Ocular Hypertension	Unusually high blood pressure within the eye.
Ocular Trauma	A forceful injury to the eye due to a foreign object.
Pink Eye	An acute, highly contagious inflammation of the conjunctiva. Also known as conjunctivitis.
Retinal Nevus	A pigmented birthmark on the sensory membrane lining the eye which receives the image formed by the lens.
Systemic Condition	Any condition of problem relating to a person's general health.
Sty	An inflamed swelling of the fatty material at the margin of the eyelid.
Transient Loss of Vision	Temporary loss of vision.

PLAN BENEFITS
OPEN ACCESS PROVIDERS

An Eyecare Professional that is an Open Access Provider may require Covered Person to pay for all services in full at the time of the visit. If so, Covered Person should then submit a claim to VSP for reimbursement.

COVERED SERVICES

Eye Examinations, Consultations, Urgent/Emergency Care: Covered up to $ 100.00 less a Copayment amount of $20.00.

Special Ophthalmological Services: Covered up to $ 120.00 per individual service.

Eye and Ocular Adnexa Services: Covered up to $ 120.00 per individual service.

EXCLUSIONS AND LIMITATIONS OF BENEFITS

1. Exclusions and limitations of benefits described above for VSP Preferred Providers shall also apply to services rendered by Open Access Providers.
2. Services from an Open Access Provider are in lieu of services from a VSP Preferred Provider.
3. There is no guarantee that the amount reimbursed will be sufficient to pay the cost of services or materials in full.
4. VSP is unable to require Open Access Providers to adhere to VSP's quality standards.

EXHIBIT C

LASER VISIONCARE℠ PREFERRED PROGRAM
SCHEDULE OF BENEFITS

VSP VISION CARE, INC.

Covered Persons who meet the eligibility requirements outlined under Eligibility herein are entitled to the following laser vision correction benefits, subject to the conditions, limitations and exclusions as stated herein.

DEFINITIONS

Primary Eye Care Doctor: A VSP participating doctor who performs consultation, preoperative examinations and postoperative examinations. Laser Vision Correction Primary Eye Care Doctors are doctors with special training in the co-management of laser vision correction patients.

Laser In Situ Keratomileusis (LASIK): A procedure performed with a laser light beam during which a small, thin flap is made on the cornea allowing the laser to reshape the exposed corneal tissue.
Participating Laser Vision Correction (LVC) Facilities: Facilities that have contracted with VSP to provide Laser Vision Correction services to Covered Persons in coordination with Participating Surgeons.
Participating Surgeon: A VSP participating provider who is licensed as a doctor of Ophthalmology in the State in which he/she practices and who is contracted with VSP to perform surgical and advanced eye care, including Laser Vision Correction services*.*

Photorefractive Keratectomy (PRK) Laser Refractive Surgery: A procedure to correct nearsightedness which is performed with an excimer laser using a laser light beam to reshape the surface of the cornea.
Laser Vision Correction Surgery: The surgical procedures used to correct vision problems (such as nearsightedness, farsightedness, and astigmatism) covered under this Plan and provided by a coordinated network of Primary Eye Care Doctors, Participating Surgeons and Participating LVC Facilities.

Custom LASIK: A type of technology used in LASIK surgery, also called wavefront-guided LASIK. This wavefront technology measures the eye from front to back to create a three-dimensional corneal map. This measurement then guides the laser to reshape the cornea.

ELIGIBILITY

Benefits are available to Employees and their Eligible Dependents. Only one Laser Vision Correction Surgery per eye per lifetime is covered.

COVERED SERVICES

Laser Vision Correction Surgery is used to correct vision problems such as nearsightedness, farsightedness, and astigmatism. Covered Persons are entitled to the following Laser Vision Correction benefits when obtained from VSP Primary Eye Care Doctors, Participating Surgeons and Participating LVC Facilities, subject to the payment responsibility of Covered Persons as noted in the second column:

Covered Service	Covered Person Benefit
Initial consultation	No cost
Preoperative Exams	No cost*
PRK, LASIK, Custom PRK, Bladeless or Custom LASIK Surgery	$100.00 per-eye allowance**
Postoperative examinations	No cost (included in surgery fee)

Enhancement surgery	No cost

(Only covered if needed and if performed within the time period specified by the Participating Laser Vision Correction Facility)

* If a Covered Person obtains initial consultation services and/or preoperative exams, but surgery is not indicated or performed, this Plan will cover the costs of one such round of preoperative services. Such costs will not count towards a Covered Person's benefit allowance for laser vision correction surgery, which may be obtained at a later date.

** This plan provides an allowance of $100.00 per eye (up to a $200 lifetime maximum) to be paid towards the above Laser Vision Correction Surgery services. VSP has contracted with the Participating Laser Vision Correction Facilities to provide discounts to VSP members. The discounted price will not exceed $1800 per eye for LASIK, $1500 per eye for PRK, and $2300 per eye for Custom LASIK. In the event that a Covered Person receives Laser Vision Correction services on one eye only, any remaining balance may not be applied towards the cost of surgery in the second eye.

HOW DOES THE PLAN WORK?

STEP ONE: Call VSP's Customer Service Department at (800) 877-7195 to locate a Primary Eye Care Doctor and identify yourself as a Covered Person. Your VSP participating doctor may be a Laser Vision Correction Primary Eye Care Doctor. When you call Customer Service, you may verify your doctor's participation.
STEP TWO: Call a Laser Vision Correction Primary Eye Care Doctor and identify yourself as a Covered Person. Tell the doctor that you are using the Laser VisionCare benefit. The doctor will need your identification number (usually Social Security Number) and your group name.
STEP THREE: The doctor will perform an examination to determine if you are a candidate for Laser Vision Correction Surgery and discuss the benefits, risks and alternatives to surgery. If you wear contact lenses, you may need to see the Co-Manager several times before you are ready for surgery, to ensure your vision is stable. If you are a candidate for Laser Vision Correction Surgery, the Co-Manager will refer you to a Participating LVC Surgeon/Facility.

STEP FOUR: Make an appointment with the VSP Participating LVC Surgeon/Facility. Your doctor may schedule this appointment for you. This appointment is usually at a Participating LVC Facility. The Participating Surgeon will:

- Discuss the procedure and answer any questions
- Have you review and sign the informed consent documentation
- Perform the surgery

Prior to the surgery, the Participating LVC Facility will collect your share of the surgery fee.
STEP FIVE: Post-surgical care will be coordinated by your Primary Eye Care Doctor and Participating Surgeon. You will likely visit the doctor several times after the surgery to ensure your eyes heal properly.

WHAT IF I USE A NON-PARTICIPATING DOCTOR?

VSP's Participating Primary Eye Care Doctors, Surgeons and LVC Facilities provide Covered Persons with quality laser vision correction services at competitive fees. By using participating doctors, you can be assured you are receiving the highest quality care.

You may obtain Laser Vision Correction Surgery services from Non-Member Providers and will receive an allowance of $100.00 per eye towards the surgery and any associated pre-and post-operative services.

THERE IS NO ASSURANCE THAT THE NON-MEMBER PROVIDER ALLOWANCE WILL BE SUFFICIENT TO PAY FOR THE ENTIRE COST OF SERVICES. FEES FOR LASER VISION CORRECTION SERVICES RECEIVED FROM NON-MEMBER PROVIDERS ARE NOT SUBJECT TO A NEGOTIATED DISCOUNT. ANY COSTS ABOVE THE NON-MEMBER PROVIDER ALLOWANCE ARE NOT NEGOTIATED BY VSP AND ARE THE RESPONSIBILITY OF THE MEMBER.

The Covered Person should pay the Non-Member Provider's full fee and request a copy of the bill and surgery report. Send a copy of the itemized bill(s) to VSP. Include the following information:

- Name and mailing address
- Identification number (typically Social Security number)
- Your Employer
- Please write "PRK", "LASIK", or "Custom LASIK" on all receipts.

The above information should be submitted to VSP along with a CMS-1500 form or any generic insurance claim form that may be available from the Non-Member Provider. Mail the information to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105

VSP will reimburse the Covered Person up to the Non-Member Provider Allowance amount for services received. Laser Vision Correction Surgery benefits obtained from a Non-Member Provider are subject to the same limitations as described below.

EXCLUSIONS AND LIMITATIONS

Limitations:
Covered Laser Vision Correction Surgery benefits are available to Covered Persons, once per eye per lifetime. Covered Persons are financially responsible for the costs of any additional professional and/or facility services received.
Exclusions:
The following services and/or supplies are not covered under your Laser Vision Correction benefits:

1. Forms of laser vision correction surgery other than PRK, LASIK, and Custom LASIK, including but not limited to Radial Keratotomy.
2. Prescription drugs.
3. Orthoptics or vision training and any associated supplemental testing.
4. Prescription glasses or contact lenses are not covered under this plan. Covered Persons may be eligible for routine vision materials under another VSP vision plan.
5. Pathological treatment.
6. Inpatient hospital and anesthesia costs for covered services not able to be provided on an outpatient basis.
7. Services provided by providers who are not contracted Primary Eye Care Doctors, Participating Surgeons or Participating LVC Facilities, except as provided above.
8. Services not indicated as covered Plan Benefits on this Summary of Benefits.

Summary of Benefits and Coverage
VSP Choice Plan

Prepared for: **LEIDOS HOLDINGS INC.**
Group ID: **12180678**
Effective Date: **JANUARY 1, 2021**

The Affordable Care Act requires that health insurance companies and group health plans provide consumers with a simple and consistent benefit and coverage information document, beginning September 23, 2012. This document is a Summary of Benefits and Coverage (SBC).

The grid below is being provided for your convenience and mirrors the sample SBC that the U.S. Department of Labor has published. All the information provided is relative to your plan and described in detail in the preceding Evidence of Coverage.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations and Exceptions
		In-Network Provider	Out-of-Network Provider	
If you or your dependents (if applicable) need eyecare	Eye Exam	*	Reimbursed up to $45.00	Exam covered in full every 12 months**
	Frames, Lenses or Contacts	* Up to $60.00 copay for Contact Lens Exam	Frames reimbursed up to $ 70.00 SV Lenses reimbursed up to $ 30.00 Bi-Focal Lenses reimbursed up to $ 50.00 Tri-Focal Lenses reimbursed up to $ 65.00 Lenticular Lenses reimbursed up to $100.00 ECL reimbursed up to $105.00	Frames covered every 12 months** Lenses covered every 12 months**
	Fees	$20.00 Copay		

* Fees copay applies to first service used.
** Beginning with the first day of the Benefit Period.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 800-877-7195.