Leidos Benefits Summary Plan Description

Leidos recognizes that benefits are an important part of your overall compensation. The SPD is designed to provide you with important information you need to know about your benefits at Leidos.

As an eligible Leidos employee, you have the flexibility to choose from a wide variety of benefits that offer you and your family important health and financial protection. Simply use the links to learn more about:

- Participating in the Plans
- Medical Plan Options
- Dental Plan Options
- Vision Plans Options
- Life and Accidental Death & Dismemberment (AD&D) Insurance
- Disability Program
- Flexible Spending Accounts
- Health Savings Account (HSA)
- Well-Being Programs
- ComPsych EAP
- Beneplace Voluntary Benefits Program
- Prudential Supplemental Health Benefits
- Plan Information

If you cannot find what you're looking for here or have further questions about your benefits, contact Employee Services.

We have also included a Life Events section, which can help you quickly find information about what to do and what benefit choices you can make when you experience life changing situations like getting married or entering into registered domestic partnership, having a child, moving to a new home, and more.

Please note: Although the information contained within this document has gone through extensive review by the plan insurance carriers, some portions may require additional confirmation and finalization, and may be subject to change. To verify whether certain information has been finalized, contact Corporate Benefits.

The benefits described in this document are not applicable to employees of Leidos Biomedical Research, Inc., Dynetics or QTC. This document contains only highlights of the Leidos benefit plans. Plan documents and insurance contracts contain full provisions. If there is a discrepancy between the information in this document and in plan documents/insurance contracts, the plan documents or insurance contracts will govern. Leidos reserves the right to amend, change or terminate the plans, programs and policies described in this document. Any payment of benefits depends on your eligibility to receive them.

Leidos Benefits Summary Plan Description

Participating in the Plans

Leidos' benefit programs are intended to provide a competitive and comprehensive level of protection for our employees and their families through health care plans, disability income protection, life insurance and other employee benefits.

The benefits described in this document are not applicable to employees of Leidos Biomedical Research, Inc., QTC or Dynetics.

Pre-existing condition clauses do not apply to any of Leidos' medical plans.

Please refer to the **Dental Plan** section of this SPD site for information on the dental plan exclusions. Additionally, the individual dental carriers should be contacted for information on the specific exclusions for dental work in progress.

Please review Life, AD&D and LTD plan types for language describing pre-existing conditions and exclusions.

For more information on participating in the plans, refer to the following sections:

- Eligibility
- When Coverage Begins
- Cost of Coverage
- Enrolling for Coverage
- Changing Coverage (Qualified Life Event Changes)
- When Coverage Ends
- Continuing Coverage

Eligibility

Participation in Leidos' benefit programs is available to eligible employees and their eligible dependents:

- Employees
- Dependents (including Spouse)
- Registered Domestic Partner

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Employees

A Leidos employee is eligible to enroll in Leidos benefit programs under the following conditions:

Employee Eligibility	
Type of Coverage	**Eligibility Requirements**
Medical, Dental, Vision, Employee Assistance Program, Flexible Spending Accounts, Health Savings Account, Wellness, Disability, and Life and Accidental Death and Dismemberment Insurance Programs	• Must be an active, regular full-time employee working at least 30 hours per week; or • Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; or • Consulting Employees (CEs) (eligible for Leidos-sponsored medical coverage only). • Must live in the geographic area served by a particular plan. • For salary-based plans (i.e., Disability, Life Insurance and Accidental Death & Dismemberment Insurance) the benefit is pro-rated for part-time employees working at least 12 hours per week
Cigna International Medical and Dental Plan	Available to expatriate employees scheduled to be overseas for at least six months or more.

Dependents

Participants may also enroll their eligible dependents in some Leidos benefit programs. Eligible dependents include:

- The participant's legal spouse or registered domestic partner (See "Registered Domestic Partners");
- Each child of the participant or registered domestic partner* younger than age 26**, including:
  - A natural child or stepchild***;
  - An adopted child (coverage begins as of the earlier of the date the child was placed in the participant's home or the date of final adoption); and
  - Any other child who depends on the participant for support and lives with the participant in a parent-child relationship, if the participant provides proof of legal guardianship.

- Unmarried children, age 26 and older who are incapable of self-sustaining employment because they are mentally or physically disabled, as long as:
  - The mental or physical disability existed while the child was covered under the plan and began before age 26;
  - The child is primarily dependent on the participant for support; and
  - The participant provides periodic evidence of incapacity.

Participants must update their enrollment in Workday within 31 days of any change in dependent eligibility. For questions on enrollment, please contact Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

** To qualify for coverage under Leidos' life insurance programs, a registered domestic partner's child must reside with the Leidos participant and be born to or legally adopted by the registered domestic partner.*

*** TRICARE Supplement coverage is available to unmarried dependent children under age 21 (or under age 23 if a full-time student). It is available to unmarried dependent children younger than age 26 if the participant is enrolled in the TRICARE Young Adult (TYA) program and as long as the children are not eligible for other employer-sponsored health coverage. Domestic partners and domestic partner children are not eligible for coverage under the TRICARE Supplement plan.*

**** To qualify for coverage under Leidos' life insurance programs, a stepchild must reside with the Leidos participant.*

Important: If a Participant's Spouse, Registered Domestic Partner or Dependent Is a Leidos Employee

"Double coverage" is not permitted under Leidos' benefit programs. Therefore, participants may not cover a spouse, registered domestic partner or dependent child if that spouse, registered domestic partner or child is also a Leidos employee and has elected his or her own coverage.

If a participant and his or her spouse or registered domestic partner are both Leidos employees, each can choose individual coverage, or one can cover the other as a dependent — but not both. In addition, if the participant has children, only the participant or spouse/registered domestic partner can choose coverage for dependent children.

Registered Domestic Partners

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

Dependent life insurance is also available to registered domestic partners and their children. To qualify for coverage under Leidos' life insurance programs, a registered domestic partner's child must reside with the Leidos participant and be born to or legally adopted by the registered domestic partner.

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

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

Proof of registration with a state or local domestic partner registry must be provided. Alternatively, a *Declaration of Domestic Partnership* form can be completed, notarized and submitted along with required proof of joint ownership in order to enroll a domestic partner. Contact Employee Services for additional information on enrolling a domestic partner.

Registered domestic partner coverage is different from spouse coverage. Differences include:

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

Dependent Eligibility Verification (DEV) Process

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

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

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

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

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

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

When Coverage Begins

The date coverage begins depends on whether the participant is a new employee or is currently enrolled.

New Employees

Newly hired employees must enroll within 31 days of the date they become eligible. Upon hire, the employee will receive a package of enrollment materials, including instructions on how to enroll. The effective date of coverage is the employee's date of hire. If the participant is disabled and away from work on the date coverage would begin, coverage will take effect on the day the participant returns to work. Coverage for enrolled dependents will take effect on the same date as the participant's coverage start date or as of the date the dependent becomes eligible for coverage.

Changes may not be made to benefit elections until the following Open Enrollment period unless a qualified life event occurs. Coverage changes are generally effective on the date of the qualified life event.

Current Employees

An Open Enrollment period is held every fall, during which all eligible employees can enroll in, change or drop coverage. Changes are effective on January 1 following the Open Enrollment period. Information, including instructions on how to enroll, will be provided during the Open Enrollment period each year.

Cost of Coverage

Leidos and the participant share the cost of benefit coverage. Leidos pays a large percentage of the cost for most benefits. As part of the enrollment process, participants authorize Leidos to deduct their share of the cost (premiums) for applicable benefits from their pay. The amount of the contribution depends on the benefit election. Contribution rates are reviewed annually and adjusted as necessary, generally at the beginning of the new year.

How Pre-Tax Premium Contributions Affect Take-Home Pay

Premiums for certain Leidos benefits are deducted from a participant's pay before Social Security taxes and federal, state, and local (where applicable) income taxes are deducted. Paying premiums before taxes are taken out reduces the amount of gross salary. This lowers taxable income and, therefore, lowers the amount of payable income tax.

In exchange for lowering a participant's taxable income, the IRS restricts his or her ability to change coverage during the year unless the participant or dependent experiences a qualified life event or changes coverage during an Open Enrollment period.

Enrolling In Coverage

Participants must make their benefit elections within 31 days of being hired, during the Open Enrollment period, or after a qualified life event.

Participants will select from a number of plan options prior to enrolling for coverage. The plan the participant chooses during enrollment will apply to the participant and any covered dependents and will remain in effect for the entire plan year. In the case of a qualified life event, under most circumstances, the participant will be able to change only the level of coverage (i.e., Employee Only, Family Coverage) but not change coverage options (switch from one plan to another). The participant may also choose to drop coverage. If a participant does not make an election during the Open Enrollment period, his or her current coverage choices will remain in effect for the next plan year, except for participation in Flexible Spending Accounts.

When enrolling for certain plans, participants must choose a level of coverage, which indicates who will be covered for benefits:

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

Levels of coverage may not be changed until the next Open Enrollment period unless the participant or dependents experience a qualified life event (see *Changing Coverage (Qualified Life Event Changes)* for more information).

Open Enrollment

Open Enrollment is generally held in the fall for a coverage effective date of January 1. Participants may enroll in, change or drop coverage. Participants should review the Open Enrollment information carefully for information about benefit changes for the following year, including changes in benefit levels and participant contribution rates.

Important: **Annual enrollment required for Health Savings Accounts and Flexible Spending Accounts**

If a participant does not make an election during the Open Enrollment period, his or her current coverage choices will remain in effect for the next plan year, except for Health Savings Account (HSA), Flexible Spending Accounts (FSA) elections and Group Universal Life (GUL) - Cash Accumulation Fund (CAF) contributions. Employees who wish to contribute to an HSA, FSA and/or CAF, must re-enroll each year. If they do not re-enroll each plan year, they will not be able to participate and will have to wait until the following Open Enrollment period to re-enroll.

Changing Coverage (Qualified Life Event Changes)

Because contributions for most benefits are deducted on a pre-tax basis, IRS regulations require that a participant, once enrolled, may not change elections until the next Open Enrollment period unless a qualified life event occurs.

Experiencing a qualified life event change allows a participant to change the level of coverage (but not to switch plans) within 31 days of the event. Qualified status changes include, but are not limited to:

- *Adding a dependent* through marriage, registered domestic partnership, birth, adoption or legal guardianship;
- *Losing a dependent* through legal separation, annulment, divorce, dissolving of a registered domestic partnership or death;
- *Dependent's loss of eligibility* by attaining age 26;
- *Loss of other health insurance* coverage through the employer of a spouse or registered domestic partner (for example, because of layoff, termination, disability, severance, substantial reduction in benefits or reduction in work hours);
- *Gaining eligibility for other coverage* through the Health Insurance Marketplace, a spouse's or registered domestic partner's plan, COBRA or Medicare (or MediCal in California);
- *Receiving a court order* — a **Qualified Medical Child Support Order (QMCSO)** — requiring the addition of medical coverage for children not in the participant's custody;
- *Changing residence* and thereby affecting access to a plan service area; and
- *Changing child or adult care situations*, such as providers or costs.

Important: Benefit Change Must be Consistent with Qualified Life Event.

Any changes made outside of the Open Enrollment period must be consistent with the qualified life event. The participant may add a spouse as a dependent, for example, after a marriage, but may not change from one plan to another. A qualified life event does not occur when a participant's provider leaves a plan or network.

Participants must update enrollment in Workday within 31 days of a qualified life event. For questions about enrollment, please contact Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

When Coverage Ends

Coverage for most benefits will end as of the last day of the pay period for:

- Termination of employment;*
- Failure to pay required premiums;
- Commencement of a leave of absence;
- Loss of eligibility status
- Strikes**

In the case where the participant is still covered but the dependent loses eligibility, coverage for dependents end on the date they no longer meet the definition of **dependent** under Leidos' plan.
If the participant is divorcing, or is granted a legal separation, coverage for the spouse ends on the day the divorce is final or the effective date of the legal separation. If dissolving a registered domestic partnership, coverage for the registered domestic partner ends on the date reflected as the Termination of Domestic Partnership.

Coverage for children ends on the last day of the month of their 26th birthday.

Coverage for a permanently disabled child continues as long as the child qualifies as a disabled dependent as determined by the plan. Periodic proof of continued disability (generally once every 24 months) will be required.

**If a participant's disability started prior to termination of employment, disability benefits will continue to be paid up to the maximum duration approved under the plan.*
*** For collectively bargained participants, disability benefits will continue to be paid if a strike occurs and the disability started prior to the strike. Benefits will be paid up to the maximum duration approved under the plan.*

Family and Medical Leave

Federal law and Leidos policy determine eligibility for family and medical leave. Eligible employees may take up to 12 weeks of unpaid family and medical leave. Leidos will continue health care coverage for a participant and covered dependents while the participant is on approved family or medical leave unless the participant elects to suspend coverage during the leave. If continued coverage is elected, the participant is responsible for the same contribution paid while working. If suspension of coverage is elected, the same elections in effect prior to the leave will be reinstated when the participant returns to work, unless the participant experiences a qualified life event change.

Disability

If a participant is totally disabled and the disability continues for more than 180 days, disability benefits may continue but health coverage under the active group plan will end. Participants may choose to continue medical, dental, and/or vision coverage at their own expense under COBRA. Under certain circumstances, the participant may participate in the Health Care Flexible Spending Account, on an after-tax basis, under COBRA.

If an employee's disability extends beyond 180 days, life insurance benefits will continue until the earliest of the following dates:

- The date the employee is no longer disabled;
- The date the maximum benefit period ends:
    - For **Basic Term Life Insurance**, the maximum benefit period is 24 months from the commencement of long-term disability benefits;
    - For **Group Universal Life Insurance**, coverage ends on the date placed on disability. Continuation of coverage may be available through Prudential;
    - For **Basic Dependent Life Insurance**, the maximum benefit period is 24 months from the commencement of long-term disability benefits;
- The day after the period for which premiums are paid.

Military Leave

If a participant is on a military leave of absence, he or she is eligible to elect COBRA continuation coverage.

COBRA coverage may continue for 24 months or until the day after the participant fails to return to work after the end of the leave, whichever is sooner. Coverage will also end if the participant fails to make any required contributions on a timely basis. See "**Continuing Health Care Coverage Through COBRA**" in the Plan Information section.

Reinstatement of Benefits

Termination and Rehire Within 30 Days

If a participant terminates employment and is rehired within 30 days, prior elections are reinstated unless another event has occurred that allows a change. A participant that is rehired after 30 days will be treated as a new employee and may make new elections – see "New Employees" section.

Leave of Absence

If a participant returns to work after a leave of absence, and coverage ended during the absence, coverage will be reinstated on the first day the participant returns to active work in an eligible status. If the participant is returning to work in a new plan year, new benefit elections may be required for certain plans, such as the Flexible Spending Accounts.

Continuing Coverage

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

In accordance with COBRA, a participant and covered family members have important rights concerning the continuation of group health care benefits if that coverage ceases.

Participants that lose health coverage as a result of an Open Enrollment action will not be eligible to continue coverage under COBRA.

Eligibility for COBRA

Who is eligible for COBRA:

- A covered participant who loses coverage due to termination (other than termination for gross misconduct) or reduction in work hours. Termination includes, but is not limited to voluntarily quitting, layoff, and lack of work due to a work location closure.
- The spouse, registered domestic partner 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, legal separation, or dissolution of a domestic partnership of the covered employee from his or her spouse or domestic partner;

- 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

Continuing Coverage Through COBRA

To continue coverage, it is the employee’s responsibility to update Workday or notify Employee Services within 31 days of a divorce, legal separation, dissolution of domestic partnership, or a child losing dependent status.

COBRA End Date

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;
- 24 months in the case of military leave of absence;
- 29 months in the event of a disability, according to Social Security;
- 36 months in the event of legal separation, divorce; dissolution of domestic partnership 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. The participant will be charged the plan's full cost of providing continued coverage, plus an additional 2% administrative fee (102% of the premium).

Disability

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

Second Qualifying Life Events

If a current COBRA covered participant experiences a second qualifying life event during the initial 18- or 29-month COBRA coverage period, the covered spouse/domestic partner and/or dependent children may receive up to a maximum of 36 months of coverage from the initial qualifying event date. A participant will only be entitled to an extension if the same event would have caused a loss of coverage under the Plan if it were the original event. The extension may be available to the covered spouse/domestic partner and /or dependent children for one of the following reasons:

1. divorce or legal separation from the covered employee;
2. the dependent child no longer meets the definition of a “dependent” according to the terms of the Plan(s); or
3. the death of a covered employee.

You must notify the COBRA administrator of the second qualifying event within 60 days of the event. You will not be entitled to the extension if you fail to provide timely notice.

Leidos Benefits Summary Plan Description

Medical Plans

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

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

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

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

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

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

Eligibility

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

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Dependents

Participants may also enroll their eligible dependents in the Leidos medical plans. Eligible dependents include:

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

Participants must update their enrollment in Workday within 31 days of any change in dependent eligibility. For questions, please contact Employee Services at 855-553-4367, option 3 or via email at ASKHR@Leidos.com.

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

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

Registered Domestic Partners

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

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

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

Proof of registration with a state or local domestic partner registry must be provided. Alternatively, a *Declaration of Domestic Partnership* form can be completed, notarized and submitted along with required proof of joint ownership in order to enroll a domestic partner. Contact Employee Services for additional information on enrolling a domestic partner. The *Declaration of Domestic Partnership* form can be found on Leidos SPD website.

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

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

Dependent Eligibility Verification (DEV) Process

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

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

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

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

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

Questions about the DEV process may be directed to Budco at 866-488-2001, or Employee Services at 855-553- 4367, option 3 or via email at AskHR@Leidos.com.

Healthy Focus Basic Plan

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

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

Healthy Focus Basic Plan: Cost of Coverage

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

Employee Contributions

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

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

Annual Deductible

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

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE.

Eligible health services applied to the in-network deductible will not be applied to satisfy the out-of- network deductible. Eligible health services applied to the out-of-network deductible will not be used to satisfy the in-network deductible.

Coinsurance

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

Annual Out-Of-Pocket Maximum

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

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

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

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Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of-pocket maximum applies. The individual (employee only coverage) annual out-of-pocket maximum is $6,750; the family annual out-of-pocket maximum is $13,500 (with an embedded in-network individual maximum of $8,550). The embedded individual maximum within the family coverage level means that once a member incurs $8,550 in eligible expenses, the Plan will pay 100% of that member's eligible claims for the remainder of the plan year.

Eligible health services applied to the in-network out-of-pocket maximum will not be applied to satisfy the out-of-network out-of-pocket maximum. Eligible health services applied to the out-of-network out- of-pocket maximum will not be used to satisfy the in-network out-of-pocket maximum.

Healthy Focus Basic Plan: Plan Design

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

Network Benefits

Participants generally save money by choosing an in-network provider because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, the participant pays a percentage of the provider's negotiated rate (coinsurance) for subsequent medical services. The plan pays the remaining amount.

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

Out-of-Network Benefits

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

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

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

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Recognized Charge – Voluntary Services

The recognized charge is the amount of an out-of-network provider's charge that is eligible for coverage. You may be responsible for paying the difference between the recognized charge and the amount billed. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage. See below *Involuntary Services and Surprise Bills* for more information.

Involuntary Services and Surprise Bills

There may be times when you unknowingly receive services from an out-of-network provider, even when you try to stay in the network for your covered services. You may then get a bill at a rate that you did not expect. This is called a surprise bill.

A federal law called the No Surprises Act protects you from surprise bills in situations where you do not have a choice in providers by limiting cost sharing and prohibiting balance billing by out-of-network providers. This includes:

- Emergency services at out-of-network facilities
- Services provided by out-of-network providers (e.g., anesthesiologists) at in-network facilities
- Air ambulance services from out-of-network providers

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in-network rate or such other data resources or factors as determined by Aetna.

Multiple and Bilateral Surgical Procedures

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

- Major (first) procedure–Covered at 100% of recognized charge
- Second procedure–You pay 50% of recognized charge
- Subsequent procedure–You pay 75% of recognized charge

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

Multiple Scan / Images Procedure

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

- Initial scan/imaging– Covered at 100% of recognized charge
- Subsequent scan/imaging –You pay 50% of recognized charge

Healthy Focus Essential Plan

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

Most in-network services are covered at 65% after the deductible, while most out-of-network services are covered at 50% after the deductible. Regardless of whether a participant uses a network or out-of-network provider, the Healthy Focus Essential plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers prescription drugs purchased at a retail pharmacy or through the mail-order program.

Healthy Focus Essential Plan: Cost of Coverage

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

Employee Contributions

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

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

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Annual Deductible

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

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE.

Eligible health services applied to the in-network deductible will not be applied to satisfy the out-of-network deductible. Eligible health services applied to the out-of-network deductible will not be used to satisfy the in-network deductible.

Coinsurance

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

Annual Out-Of-Pocket Maximum

The "out-of-pocket maximum" is the amount of deductible and coinsurance payments a participant must pay each calendar year before the Healthy Focus Essential planbeginspaying100%of eligible expenses up to the negotiated rate (for in-network providers) or recognized charge (for out-of-network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "Network Benefits" in the *Healthy Focus Essential Plan: Plan Design* section for more information about negotiated rates and "Out-of-Network Benefits" for more information about recognized charge limits.

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

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

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum applies. The individual (employee only coverage) annual out-of-pocket maximum is

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$5,000; the family annual out-of- pocket maximum is $10,000 (with an embedded in-network individual maximum of $8,550). The embedded individual maximum within the family coverage level means that once a member incurs $8,550 in eligible expenses, the Plan will pay 100% of that member's eligible claims for the remainder of the plan year.

Eligible health services applied to the in-network out-of-pocket maximum will not be applied to satisfy the out-of-network out-of-pocket maximum. Eligible health services applied to the out-of-network out-of-pocket maximum will not be used to satisfy the in-network out-of-pocket maximum.

Healthy Focus Essential Plan: Plan Design

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

Network Benefits

Participants generally save money by choosing an in-network provider because providers in the CDHP network have agreed to charge patients lower, negotiated rates.

The participant must meet the annual deductible for most services. Then, the participant pays a percentage of the provider's negotiated rate (coinsurance) for subsequent medical services. The plan pays the remaining amount.

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

Out-of-Network Benefits

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

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

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

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Recognized Charge – Voluntary Services

The recognized charge is the amount of an out-of-network provider's charge that is eligible for coverage. You may be responsible for paying the difference between the recognized charge and the amount billed. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage. See below *Involuntary Services and Surprise Bills* for more information.

Involuntary Services and Surprise Bills

There may be times when you unknowingly receive services from an out-of-network provider, even when you try to stay in the network for your covered services. You may then get a bill at a rate that you did not expect. This is called a surprise bill.

A federal law called the No Surprises Act protects you from surprise bills in situations where you do not have a choice in providers by limiting cost sharing and prohibiting balance billing by out-of-network providers. This includes:

- Emergency services at out-of-network facilities
- Services provided by out-of-network providers (e.g., anesthesiologists) at in-network facilities
- Air ambulance services from out-of-network providers

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in-network rate or such other data resources or factors as determined by Aetna.

Multiple and Bilateral Surgical Procedures

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

- Major (first) procedure–Covered at 100% of recognized charge
- Second procedure–You pay 50% of recognized charge
- Subsequent procedure–You pay 75% of recognized charge

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

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Multiple Scan / Images Procedure

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

- Initial scan/imaging– Covered at 100% of recognized charge
- Subsequent scan/imaging –You pay 50% of recognized charge

Healthy Focus Advantage Plan

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

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

Healthy Focus Advantage Plan: Cost of Coverage

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

Employee Contributions

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

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

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Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The in-network individual (employee only coverage) deductible is $1,500; the family deductible is $3,000.

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE.

Eligible health services applied to the in-network deductible will not be applied to satisfy the out-of-network deductible. Eligible health services applied to the out-of-network deductible will not be used to satisfy the in-network deductible.

Coinsurance

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

Annual Out-Of-Pocket Maximum

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

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

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

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Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum must be met before the plan begins paying 100 percent for any individual. The in-network individual (employee only coverage) annual out-of-pocket maximum is $3,200; the family annual out-of- pocket maximum is $6,400. The family out-of-pocket maximum can be met by a combination of family members or by any single individual within the family.

Eligible health services applied to the in-network out-of-pocket maximum will not be applied to satisfy the out-of-network out-of-pocket maximum. Eligible health services applied to the out-of-network out-of-pocket maximum will not be used to satisfy the in-network out-of-pocket maximum.

Healthy Focus Advantage Plan: Plan Design

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

Network Benefits

Participants generally save money by choosing an in-network provider because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, the participant pays a percentage of the provider's negotiated rate (coinsurance) for subsequent medical services. The plan pays the remaining amount.

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

Out-of-Network Benefits

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

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

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

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Recognized Charge – Voluntary Services

The recognized charge is the amount of an out-of-network provider's charge that is eligible for coverage. You may be responsible for paying the difference between the recognized charge and the amount billed. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage. See below *Involuntary Services and Surprise Bills* for more information.

Involuntary Services and Surprise Bills

There may be times when you unknowingly receive services from an out-of-network provider, even when you try to stay in the network for your covered services. You may then get a bill at a rate that you did not expect. This is called a surprise bill.

A federal law called the No Surprises Act protects you from surprise bills in situations where you do not have a choice in providers by limiting cost sharing and prohibiting balance billing by out-of-network providers. This includes:

- Emergency services at out-of-network facilities
- Services provided by out-of-network providers (e.g., anesthesiologists) at in-network facilities
- Air ambulance services from out-of-network providers

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in- network rate or such other data resources or factors as determined by Aetna.

Multiple and Bilateral Surgical Procedures

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

- Major(first)procedure–Covered at 100% of recognized charge
- Second procedure–You pay 50% of recognized charge
- Subsequent procedure–You pay 25% of recognized charge

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

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Multiple Scan / Images Procedure

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

- Initial scan/imaging– Covered at 100% of recognized charge
- Subsequent scan/imaging –You pay 50% of recognized charge

Healthy Focus Premier Plan

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

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

Healthy Focus Premier Plan: Cost of Coverage

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

Employee Contributions

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

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

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The in-network individual (employee only coverage) deductible is $1,500; the family deductible is $3,000.

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The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-childcare, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE.

Eligible health services applied to the in-network deductible will not be applied to satisfy the out-of-network deductible. Eligible health services applied to the out-of-network deductible will not be used to satisfy the in-network deductible.

Coinsurance

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

Annual Out-Of-Pocket Maximum

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

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

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

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of- pocket maximum must be met before the plan begins paying 100 percent for any individual. The in-network individual (employee only coverage) annual out-of-pocket maximum is $1,500; the family annual out-of- pocket maximum is $3,000. The family out-of-pocket maximum can be met by a combination of family members or by any single individual within a family.

Eligible health services applied to the in-network out-of-pocket maximum will not be applied to satisfy the out-of-network out-of-pocket maximum. Eligible health services applied to the out-of-network out-of-pocket maximum will not be used to satisfy the in-network out-of-pocket maximum.

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Healthy Focus Premier Plan: Plan Design

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

Network Benefits

Participants generally save money by choosing in-network providers because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, the participant pays a percentage of the provider's negotiated rate (coinsurance) for subsequent medical services. The plan pays the remaining amount.

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

Out-of-Network Benefits

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

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

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

Recognized Charge – Voluntary Services

The recognized charge is the amount of an out-of-network provider's charge that is eligible for coverage. You may be responsible for paying the difference between the recognized charge and the amount billed. However, there are some types of claims for which a provider may not bill you for amounts above what is eligible for coverage. See below *Involuntary Services and Surprise Bills* for more information.

Involuntary Services and Surprise Bills

There may be times when you unknowingly receive services from an out-of-network provider, even where you try to stay in the network for your covered services. You may then get a bill at a rate that you did not expect. This is called a surprise bill.

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A federal law called the No Surprises Act protects you from surprise bills in situations where you do not have a choice in providers by limiting cost sharing and prohibiting balance billing by out-of-network providers. This includes:

- Emergency services at out-of-network facilities
- Services provided by out-of-network providers (e.g., anesthesiologists) at in-network facilities
- Air ambulance services from out-of-network providers

Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in- network rate or such other data resources or factors as determined by Aetna.

Multiple and Bilateral Surgical Procedures

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

- Major(first)procedure–Covered at 100% of recognized charge
- Second procedure–You pay 50% of recognized charge
- Subsequent procedure–You pay 25% of recognized charge

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

Multiple Scan / Images Procedure

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

- Initial scan/imaging– Covered at 100% of recognized charge
- Subsequent scan/imaging –You pay 50% of recognized charge

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Comparing the Healthy Focus Medical Plans

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

Self-Insured Medical Plans (Healthy Focus)								
	Healthy Focus Basic Plan		Healthy Focus Essential Plan		Healthy Focus Advantage Plan		Healthy Focus Premier Plan	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**
Annual Deductible • **Employee Only** • **Family**	$4,000 $8,000	$8,000 $16,000	$2,000 $4,000	$4,000 $8,000	$1,500 $3,000	$3,000 $6,000	$1,500 $3,000	$3,000 $6,000
Annual Out-of-Pocket (OOP) Maximum (includes deductible) • **Employee Only** • **Family** • **Embedded OOP**	$6,750 $13,500 $8,550 individual within family	$13,000 $27,000 N/A	$5,000 $10,000 $8,550 individual within family	$10,000 $20,000 N/A	$3,200 $6,400 N/A	$6,400 $12,800 N/A	$1,500 $3,000 N/A	$3,000 $6,000 N/A
Office Visits – Preventive Care	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	Covered at 100% after deductible
Office Visits – Non-Preventive Care	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Office Visits – Well-Child Preventive Care	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	Covered at 100% after deductible
Emergency Room	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible ***	You pay 35% after deductible ***	You pay 20% after deductible ***	You pay 20% after deductible ***	You pay 0% after deductible	You pay 0% after deductible

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	Healthy Focus Basic Plan		Healthy Focus Essential Plan		Healthy Focus Advantage Plan		Healthy Focus Premier Plan	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**
Hospital Admission	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Lab and X-ray	You pay 50% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 35% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 20% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 0% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 0% after deductible
Outpatient Surgery	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Routine Mammograms (Over age 40)	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%: maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	Covered at 100% after deductible
Prostate Screening (Over age 40)	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%: maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	You pay 50% after deductible	Covered at 100%; maximum one per calendar year	Covered at 100% after deductible
Skilled Nursing Facility	You pay 50% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 35% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 20% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 0% after deductible for up to 60 days per confinement	You pay 0% after deductible for up to 60 days per confinement
Home Health Care (maximum visits combined with Private Duty Nursing)	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 35% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 20% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 0% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 0% after deductible for up to 100 visits per year, up to 4 hours = 1 visit
Hospice Care	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible

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	Healthy Focus Basic Plan		Healthy Focus Essential Plan		Healthy Focus Advantage Plan		Healthy Focus Premier Plan	
	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**	In-Network*	Out-of-Network**
Outpatient Rehabilitation – Physical and Speech Therapy (as medically necessary) Limited to 60 combined visits per year	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Durable Medical Equipment	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Hearing Aid Exam	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Hearing Aids	You pay 50% after deductible $2,500 max every 3 years	You pay 50% after deductible $2,500 max every 3 years	You pay 35% after deductible $2,500 max every 3 years	You pay 35% after deductible $2,500 max every 3 years	You pay 20% after deductible $2,500 max every 3 years	You pay 20% after deductible $2,500 max every 3 years	You pay 0% after deductible $2,500 max every 3 years	You pay 0% after deductible $2,500 max every 3 years
Mental Health and Substance Abuse – Inpatient	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Mental Health & Substance Abuse – Outpatient	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Autism Spectrum Disorder Treatment	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible
Applied Behavioral Analysis	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible	You pay 20% after deductible	You pay 50% after deductible	You pay 0% after deductible	You pay 0% after deductible

*Covered services received from a network provider will be paid based on the negotiated rate.
** Covered services received from an out-of-network provider will be paid based on the recognized charge.
*** For non-emergent use of the emergency room, employee pays 50% after deductible.

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How the Medical Plans Work

The Healthy Focus Medical Plans are Consumer Directed Health Plans (CDHP). For all non-preventive care, the plans pay the majority of the cost for in-network coverage after you meet the annual deductible.

Your share is a percentage called coinsurance. In-network preventive care is covered 100 percent, no deductible. Once you meet the out-of-pocket maximum, the plan pays 100 percent of covered costs. All of the CDHP plans feature Health Savings Account (HSA) to help save and budget for eligible healthcare expenses, with tax-free advantages.

Pre-existing condition clauses do not apply to the Leidos medical plans.

Precertification

If a participant is enrolled in the Healthy Focus Plan, precertification is required for the following types of services: hospitalization, skilled nursing care, home healthcare, hospice care, residential treatment facility or partial hospitalization for mental health disorders or substance abuse, bariatric surgery, gene therapy, gender affirming treatment, stays in a rehabilitation facility, comprehensive infertility services, Advanced Reproductive Technology (ART) services, injectables (immunoglobulins, growth hormones, etc.), kidney dialysis, knee surgery, wrist surgery, outpatient back surgery, private duty nursing, applied behavioral analysis, cosmetic and reconstructive surgery, transcranial magnetic stimulation and emergency transportation by airplane.

For in-network services, the in-network providers are responsible for obtaining pre-certification. For out-of-network services, the participant is responsible for obtaining precertification.

Aetna will certify the medical necessity and length of any applicable hospital confinement for inpatient care. Inpatient precertification must be requested at least 14 days before admission. Aetna will work with a participant’s doctor to ensure that the hospitalization is appropriate, medically necessary, and timely, and then let the participant know the number of days for which admission has been certified.

If an emergency occurs, and it is not possible to get advance authorization, the participant or provider must notify Aetna of all inpatient treatment within 48 hours of the admission. The participant or provider must contact Aetna regarding an emergency admission, regardless of whether the facility is in-network or out-of-network.

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If the participant fails to obtain the required precertification, benefits may be reduced, or the Plan may not pay any benefits.

What the Healthy Focus Medical Plans Cover

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

The Leidos self-insured medical plan covers:

- Physician's office visits;
- Other physician's services;
- Emergency or urgent care;
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given;
- Hearing aids up to a $2,500 allowance per pair, every three years;
- Hospital expenses including:
  - Inpatient hospital expenses: Charges for room and board, and other hospital services and supplies fora person confined as a full-time inpatient;
  - Outpatient hospital expenses: Charges for hospital services and supplies for a person who is not confined as a full-time inpatient; and
- Skilled Nursing Facility care services including room and board up to the semi-private room rate and applicable services and supplies (up to 60-day maximum limit per confinement);
- Routine physical exams (preventive care) include one exam every calendar year;
- Immunizations;
- Home healthcare expenses when the charge is made by a home health care agency, the care is given under a home health care plan, and the care is given to a person in his or her home for part- time or intermittent care by an R.N. (or L.P.N. when an R.N. is not available); part-time or intermittent home health aide patient care services; and physical, occupational and speech therapy. There is a maximum of 100 visits covered in a plan year and a visit equates to up to four hours by a home health aide;
- Hospice care expenses at an inpatient facility or outpatient care. Outpatient hospice care is covered for part-time or intermittent care by an R.N. (or L.P.N. when an R.N. isn't available) up to eight hours a day, medical social services under the direction of a physician, psychological and dietary counseling, consultation or case management services by a

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physician, and physical and occupational therapy. This includes charges for bereavement counseling if it is given to the person's immediate family, is given for three months following the person's death, and is directly related to the person's death;

- Drugs and medicines which by law need a physician's prescription, including medically necessary weight control drugs;
- Acupuncture when performed by a physician or certified acupuncturist; limited to 10 visits per year
- Diagnostic lab work and X-rays- routine and non-routine; frequency limits may apply
- X-ray, radium and radioactive isotope therapy;
- Anesthetics and oxygen;
- Rental of durable medical or surgical equipment, including repair of such equipment or replacement when it is proved that it is needed due to a change in the person's physical condition;
- Maternity;
- Mammograms;
- Routine pap smears-one diagnostic test per calendar year for ages 21 and older;
- Chiropractic care, if medically necessary;
- Prostate specific antigen (PSA)age40+;
- Infertility treatment for a female employee, the wife or registered domestic partner of a Leidos employee, including invitro fertilization, embryo transfer, gamete intra fallopian tube transfer (GIFT) and zygote intra fallopian tube transfer (ZIFT) will be covered up to $5,000 per lifetime. The following conditions must be met:
  - The female participant must have been unable to conceive after having unprotected intercourse for one year or more (6 months or more if over age 35);
  - The female participant must have been unable to attain a successful pregnancy through less costly treatment covered under the plan;
  - The female participant must have FSH levels which are less than 19 miU on day 3 of her menstrual cycle;
  - The procedure cannot involve surrogates; and
  - The procedure must be performed at a medical facility that conforms to generally accepted medical standards.
- Artificial insemination;
- Voluntary sterilization
- Private duty nursing from an R.N. or L.P.N. for up to eight hours if the person's condition requires skilled nursing services. Private duty nursing benefit is combined with home healthcare benefits with a maximum of 100 visits per year. Each visit by a nurse is considered one visit;

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- Spinal disorders;
- Treatment of the mouth, jaws and teeth due to a medical condition affecting the teeth, mouth, jaws, jaw joints or supporting tissue (including bones, muscles and nerves) based on medical, not dental, necessity;
- TMJ or malocclusion involving the joints or muscles (includes medically necessary, non- dental, bite blocks, splints, arch bars, and occlusal guards);
- Physical therapy, speech therapy and occupational therapy determined to be medically necessary, up to a combined limit of 60 visits per calendar year;
- Prosthetic devices that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects;
- Gender affirmation surgery or any treatment of gender identity disorders;
- Wigs for hair loss due to injury, disease or treatment of disease, including costs for repair or replacement
- Listed transplants are covered only if performed by the Administrator's contracted Institutes (or Centers) of Excellence (IOE) facilities. List of IOE Procedure and Treatment types - heart transplant, lung transplant, liver transplant, bone marrow transplant, heart/lung transplant, kidney transplant, pancreas transplant, kidney/pancreas transplant.
- IOE transplant procedures/treatments and Gene-Based, Cellular and Innovative Therapies (GCIT)
  - The Plan will pay for transportation and lodging between participant's home and the IOE or designated GCIT provider to receive services in connection with the procedure or treatment. Travel and lodging expenses for the patient and one companion/parent/guardian traveling with the patient must be approved in advance by the Administrator. When pre- authorized, the Plan will reimburse a maximum of $50 per person per night for lodging expenses.
  - The Plan will reimburse travel and lodging expenses incurred up to a maximum of $10,000 per transplant/episode of care. The Plan will pay expenses incurred during a period which begins on the day a participant becomes an IOE patient and ends on the earlier of one year after the day the procedure is performed or the date the IOE patient ceases to receive any service from the IOE in connection with the procedure.
  - This travel and lodging benefit is available if the IOE or the designated GCIT provider is not available within 100 miles of the participant's home.
- Autism diagnosis and Applied Behavioral Analysis (ABA) Therapy, including habilitative physical, occupational, speech, behavioral and ABA therapy for autism spectrum disorder; no age, visit or dollar limits.
- Mental Health and Substance related disorders treatment.

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- Treatment under an approved clinical trial only when the member has cancer or a terminal illness.
- Diabetic services, supplies and equipment.
- Infant formula and low protein modified food products ordered by a physician to treat phenylketonuria or an inherited disease of amino and organic acids.
- Obesity surgery for a morbidly obese patient.
- Travel and lodging in cases of network deficiency: if covered services are not available from a network provider within 100 miles of your home, the following travel and lodging expenses are covered under the plan:
    - U.S. domestic travel and lodging expenses for you and one companion, to travel from your home to receive the covered services from a network provider (coach class air fare, train or bus travel are examples of covered services)
        - The maximum lodging benefit is $50 per person per night, up to a total maximum lodging benefit of $100
        - Total maximum travel and lodging benefit is $2,500 per year
    - This travel and lodging benefit is not available for the following:
        - Covered services coordinated through the Institutes of Excellence™, Institutes of Quality, National Medical Excellence® or Gene-based, Cellular and other Innovative Therapies (GCIT) programs
    - To be eligible for travel and lodging reimbursement, your Aetna One Advisor must first confirm a network provider is not available within 100 miles of your home and a travel and lodging claim form must be completed. To obtain this confirmation and the travel and lodging claim form, and for detailed information about these covered services, including specific eligibility requirements and any limitations, contact Aetna One Advisor at the toll-free number on your ID card
    - The claim form must be submitted to Aetna within 6 months of the date of service

What the Healthy Focus Medical Plans Do Not Cover

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

- Treatment for the mouth, jaws and teeth when an injury or illness is dental in nature, including restorative dental and/or surgical treatment of the mouth or jaw, including but not limited to:
    - Non-accident-related diagnosis and treatment of teeth and their supporting structures;
    - Treatment relating to or secondary to treatment of dental caries(cavities);
    - Extraction of diseased or decayed tooth or for surgical removal or impacted teeth; and
    - Root canal therapy, periodontal surgery or X-rays and other diagnostic tests;

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- Cosmetic surgery, unless required because of an accidental injury that takes place while the participant is covered by the plan, or the congenital malformation of a child born to the participant or his or her spouse or registered domestic partner while the participant has dependent coverage under the plan;
- Charges above the recognized charge limits as determined by the applicable Claims Administrator;
- Custodial care;
- Eye care exams and eyeglasses;
- Orthopedic shoes or other devices to support the feet;
- Experimental, investigational or educational treatment or services as determined by the Claims Administrator;
- Treatment for accidents related to employment or an illness covered under Workers' Compensation or similar laws;
- Assistant surgeon services when the services of an assistant surgeon are not medically necessary for the surgical procedure;
- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment;
- Skilled nursing care that does not require the education, training and technical skills of an R.N. or L.P.N. (such as transportation, meal preparation, charting of vital signs), any private duty nursing care given while the person is an inpatient in a hospital or other healthcare facility, care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting or care provided solely for skilled observation. Any service provided solely to administer oral medicines except where applicable law requires that such medicines be administered by a R.N. or LPN.
- Foot treatment for:
  - Weak, strained, flat, unstable or unbalanced feet; metatarsalgia; or bunions, except open cutting operations; and
  - Corns, calluses or toenails, except the removal of nail roots and medically necessary services prescribed by a doctor (MD or DO) in the treatment of metabolic or peripheral-vascular disease;
- Services, treatment, education testing or training related to learning disabilities or developmental delays;
- Care furnished mainly to provide a surrounding free from exposure that can worsen the participant's illness or injury;
- Treatments involving:
  - Bioenergetic therapy;

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  - Carbon dioxide therapy;
  - Megavitamin therapy;
  - Primal therapy;
  - Psychodrama;
  - Rolfing; or
  - Vision perception training;
- Treatment of covered healthcare providers who specialize in the mental healthcare field and who receive treatment as part of their training in that field;
- Services of a resident doctor or intern rendered in that capacity;
- Education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment;
- Career, social adjustment, pastoral or financial counseling;
- Speech therapy except for loss of speech, or speech impairment or developmentally delayed speech due to a diagnosed disease, injury or congenital defect;
- Reversal of a sterilization procedure;
- Medical services performed or provided by a close relative;
- Services of "standby" surgeons;
- Services received before coverage begins or after coverage ends;
- Charges that participants are not legally required to pay or charges that would not have been made if the plans were not available;
- Charges above any maximum amounts shown;
- Convenience or personal care services, such as use of a telephone or television;
- Blood, blood plasma, synthetic blood, blood derivatives or substitutes (e.g., the provision of blood to the hospital other than blood derived clotting factors, any related services such as processing and storage, the service of blood donors);
- Growth/height care (e.g., surgical procedures, devices and growth hormones to stimulate growth);
- Any cost resulting from missed appointments;
- Payment for charges that Medicare or another party is responsible for as the primary payer;
- Non-emergency medical services received outside of the United States;
- Therapies and tests including full body CT scans; hair analysis; hypnosis and hypnotherapy; massage therapy (except when used for physical therapy treatment); sensory or hearing and sound integration therapy; and
- Medical expense not specifically described in the plans

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Mental Health and Drug or Alcohol Treatment

The Healthy Focus Plans include mental health and substance abuse benefits.

How Mental Health and Substance Abuse Benefits Work

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

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

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

Mental Health Network Benefits

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

For both inpatient and outpatient care, you pay as follows:

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

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

Mental Health Out-of-Network Benefits

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

- Healthy Focus Basic Plan: 50% of recognized charge after deductible
- Healthy Focus Essential Plan: 50% of recognized charge after deductible
- Healthy Focus Advantage Plan: 50% of recognized charge after deductible
- Healthy Focus Premier Plan: 0% recognized charge after deductible

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

Mental Health and Substance Abuse Coverage

Services or supplies must be considered medically necessary by the Administrator, be delivered for the treatment of illness or injury, and be performed or prescribed by a licensed physician to be covered by the Leidos self-insured medical plans. The services are subject to any applicable annual deductibles, coinsurance, and co-payments. See *Comparing the Healthy Focus Medical Plans* for more detail.
In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

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

What is Not Covered - Mental Health and Substance Abuse Benefits

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

- Educational services - any service or supply for education, training, retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
  - Educational services, schooling or any such related or similar program including therapeutic programs within a school setting;
- Residential treatment facilities that do not meet Aetna medical necessity; requirements; Custodial care;
- Treatment for personal or professional growth development, or training or professional certification;
- Evaluations, consultations or therapy for educational or professional training or for investigational purposes relating to employment;
- Therapies which do not meet national standards for mental health professional practice;
- Experimental or investigational therapies;
- Court-ordered psychiatric or substance abuse treatment, except when certified by Aetna as medically necessary;

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- Psychological testing, except when considered medically necessary by Aetna;
- Private duty nursing, except when pre-certified by Aetna as medically necessary;
- Services, treatment or supplies:
  - Provided as a result of Worker's Compensation laws or similar legislation;
  - Obtained through, or required by, any governmental agency or program whether federal, state or any subdivision thereof (exclusive of Medicaid/Medi-Cal); or
  - Caused by the conduct or omission of a third-party for which the Member has a claim for damages or relief, unless the participant provides Aetna with a lien against such claim for damages or relief in a form and manner satisfactory to Aetna;
- Treatment or consultations provided by the member's parents, siblings, children or current or former spouse or domiciliary partner, in-law or any household member;
- Sexual therapy programs;
- Remedial education beyond evaluation and diagnosis of learning disabilities, education rehabilitation, academic education, and educational therapy for learning disabilities;
- Marital therapy;
- Treatment for caffeine or nicotine intoxication, withdrawal or dependence;
- Stay in a facility for treatment for dementia and amnesia without a behavioral disturbance that necessitates mental health treatment;

Hearing Aids

Aetna provides access to discounted hearing aids through their partnership with these hearing aid provider networks: Hearing Care Solutions (HCS), Amplifon Hearing Health Care and Lifemart.
To find an in-network hearing aid device provider:

- Log into the Aetna portal: www.aetna.com or www.innovationhealth.com
- Click on *Health & Wellness*
- Under *Health & Wellness Discounts*, click on *Hearing*

Coordination of Benefits

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

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

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

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

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

Determining Which Plan Pays First

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

Employees

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

Dependents

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

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

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

- The plan of the parent who has financial responsibility for health coverage by court decree
- Birthday rule applies if both parents are responsible or have joint custody in court order
- Custodial parent’s plan if there is no court order

When none of these rules establishes order, benefits are paid first by the plan that has covered the

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person for the longer period of time. An exception is a plan that covers a laid-off or retired employee. That plan is secondary to a plan that covers a person as an active employee.

Leidos Healthy Focus Medical Plan Administrator

Aetna Inc. administers the Leidos Consumer Directed Healthcare Plans (CDHP):

- **Product Name:** Aetna Open Access Plans– Aetna Choice POSII network
- **Leidos Group Number:** 698685, 868856
- **Aetna Customer Service (Aetna One Advisor) Phone:** 800-843-9126
- **Web site:** **Aetna** (www.aetna.com)

Filing Claims

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

Aetna out-of-network claims should be submitted on the Aetna Medical claim form and mailed to:
Aetna Inc.
P.O. Box 981106
El Paso, TX 79998-1106

If a participant has concerns about how a claim has been administered or wishes to appeal a claims decision, the participant may refer to information on relevant procedures available in the *Claims and Appeals Review Procedure Under ERISA* in the *Plan Information* section.

Healthy Focus Prescription Drug Program

Prescription drug coverage under the Healthy Focus medical plans is provided through Express Scripts (ESI). Prescription drugs are covered when they are purchased from an in-network retail pharmacy or through the ESI mail order program.

Retail Pharmacies

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

To locate an in-network retail pharmacy, participants can log onto the ESI website (https://www.express-scripts.com) or call ESI Customer Service at 877-223-4721.

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Mail Order

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

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

For refills, participants can submit requests directly to ESI:

- Through the ESI website (www.express-scripts.com)
- By phone 877-223-4721
- Through the ESI mobile app

Prescription Drug Coverage

The amount a participant pays for a prescription depends on the type of drug the covered participant purchases. The chart below provides basic information for Network (includes in-network retail pharmacies and mail order), and Out-of-Network coverage.

<table>
<tr><th></th><th colspan="2">Healthy Focus Basic Plan</th><th colspan="2">Healthy Focus Essential Plan</th><th colspan="2">Healthy Focus Advantage Plan</th><th colspan="2">Healthy Focus Premier Plan</th></tr>
<tr><th></th><th>Network</th><th>Out-of-Network</th><th>Network</th><th>Out-of-Network</th><th>Network</th><th>Out-of-Network</th><th>Network</th><th>Out-of-Network</th></tr>
<tr><td>Generic</td><td>50%</td><td rowspan="3">Not Covered</td><td>$5</td><td rowspan="3">Not Covered</td><td>$5</td><td rowspan="3">Not Covered</td><td>0%</td><td rowspan="3">Not Covered</td></tr>
<tr><td>Preferred Brand</td><td>50%</td><td>30%</td><td>30%</td><td>0%</td></tr>
<tr><td>Non-Preferred Brand</td><td>50%</td><td>50%</td><td>50%</td><td>0%</td></tr>
</table>

- **Generic drugs** have the same chemical composition and potency as brand-name equivalents but are usually less costly.
- **Brand formulary drugs** are on a preferred list of prescriptions (called a formulary) because they are safe and effective and help to control costs.
- **Brand non-formulary drugs** are brand-name drugs that cost more than generic or preferred drugs and are not included on the list of preferred drugs (formulary). Brand-name drugs that are not on the formulary require the highest co-insurance.

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Prescription drug formularies are subject to change. For up-to-date formulary information, participants should visit the ESI website (https://www.express-scripts.com) or call ESI at 877- 223-4721.

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

Prescription Drug Clinical Management Programs

Prior Authorization

Prior Authorization is a feature of the prescription drug plan that helps ensure the appropriate use of selected prescription medications. Certain prescription drugs require your doctor to provide information for you to gain approval before the drug is covered. This process helps make sure you receive the right medicine for your condition in the correct dose.

Step Therapy

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

Smart90

As part of the Smart90 program, you have two ways to get a 90-day supply of your long-term maintenance medication — drugs you take regularly for ongoing conditions. You can conveniently fill these prescriptions through the ESI mail order program or any Walgreens network pharmacy. Your copay/coinsurance for your 90-day supply of medication will be the same whether you fill your prescriptions through ESI home delivery or at a Walgreens network pharmacy.

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

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Health Maintenance Organizations (HMOs)

HMOs offer healthcare for participants and their families through an exclusive network of healthcare providers.

How the Kaiser HMO Plan Works

The Kaiser HMO Plan requires that participants receive all medical care exclusively from the HMO's network of providers in order for them to receive benefits. When a participant enrolls in an HMO, he or she, as well as his or her covered dependents should see their primary care physician (PCP) for all routine medical care and will need a referral toa network specialist whenever he or she needs specialty care.

For a Kaiser Permanente member, coverage includes exclusive access to top-notch doctors and hospitals. A physician-led team works together to make sure the care a member receives is tailored to his or her needs. The care team is connected to the member's electronic health record, which makes it easy to share information, see the member's health history, and deliver high-quality, personalized.

The Kaiser Permanente HMO plan makes it simple and convenient to get the care you need. Kaiser combines care and coverage – which makes them different than other health care options. Doctors, hospitals, and health plans work together to help make exceptional health care easy to get. That means member's will have peace of mind knowing care for their total health is there whenever they need it.

When you go in for care, you pay just a copay or coinsurance for most services covered by your plan. Many preventive care services are covered at little or no charge. After you reach your out-of-pocket maximum, you won't have to pay copays or coinsurance for most covered services for the rest of the calendar year. This can help protect you financially if you have a serious illness or injury. The Kaiser Permanente plan includes a prescription drug benefit.

Care Options While You Are Away From Home

If something unexpected happens while a member is away from home, it's easier than ever to get care. Members can get urgent care anywhere in the world. At many locations outside Kaiser Permanente states, the member will only pay a copay or coinsurance for care or prescriptions related to their urgent care visit. For emergency care, a member can simply go to the nearest hospital emergency room. If it's a Kaiser Permanente location or Cigna PPO provider, the member will only pay your normal copay or coinsurance.

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For more information about how the Kaiser plan works, participants should refer to the evidence of coverage booklet.

What the Kaiser Permanente HMO Plans Cover and Do Not Cover

Generally, Kaiser covers preventive, wellness, emergency, surgical, and hospital services. For a complete list of what is covered, participants should refer to the Kaiser **Evidence of Coverage** for their region.

Cigna Global Medical Plan

If an employee is an expatriate* and scheduled to be overseas for a minimum of ninety consecutive days in a rolling twelve-month period, he or she may be eligible to elect coverage through the CIGNA Global medical plan.

*Expatriates means a Member who is working outside his Country of Citizenship (for U.S. citizens, a Member working outside their Home Country or outside the United States for at least 180 days in a consecutive 12-month period that overlaps with the plan year and their covered dependents).

How the Cigna Plan Works

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

Additionally, vision coverage is included in the Cigna Global medical plan.

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

Triple-S Optimo Plus Medical Plan

Participants located in Puerto Rico are eligible to enroll in the Optimo Plus Medical Plan through Triple S.

How the Optimo Plus Plan Works

Participants covered under the Triple-S Optimo Plus Plan do not have to meet a deductible. However, participants must meet an annual out-of-pocket maximum of $6,350 (Individual) or $12,700 (Family). Once the out-of-pocket maximum is met, Triple S will pay 100% of the member's remaining covered health care expenses for the rest of the plan year.

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Participants may access care within the Triple S provider network without a referral from a primary care physician.

Services provided by out-of-network doctors and providers in Puerto Rico will only be paid at the rate payable to in-network providers, minus the applicable participant copayment or coinsurance. Participants will be responsible for the difference between the provider's billed amount and the Triple S established fees for participating providers. Certain services are covered in the U.S through the Blue Cross Blue Shield (BCBS) network if the participant receives prior authorization. Non-participating providers in the U.S. are covered only in emergencies and Triple S will pay these services according to the fees established by the local BCBS plan for non-participating providers.

For more information on benefit coverage and how the Plan works, refer to the Triple S Optimo Plus Certificate of Insurance.

Medical Plan Benefit Charts

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

Self-Insured Medical Plans		
Plan Name	**Benefit Summary**	**Detailed Information**
Healthy Focus Basic Plan	2023 Benefit Summary	2023 Evidence of Coverage
Healthy Focus Essential Plan	2023 Benefit Summary	2023 Evidence of Coverage
Healthy Focus Advantage Plan	2023 Benefit Summary	2023 Evidence of Coverage
Healthy Focus Premier Plan	2023 Benefit Summary	2023 Evidence of Coverage
Fully Insured Medical Plans		
Plan Name	**Benefit Summary**	**Detailed Plan Information**
Cigna International Plan	2023 Benefit Summary	2023 Evidence of Coverage
HMSA Hawaii Plan	2023 Benefit Summary	2023 Evidence of Coverage
Kaiser Permanente Hawaii Plan	2023 Benefit Summary	2023 Evidence of Coverage
Kaiser Permanente California Plan	2023 Benefit Summary	2023 Evidence of Coverage
Kaiser Permanente Mid-Atlantic Plan	2023 Benefit Summary	2023 Evidence of Coverage
Tricare Supplement Plan	2023 Benefit Summary	N/A
Triple S (Puerto Rico)	2023 Benefit Summary	2023 Evidence of Coverage

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Medicare Part D Notice of Creditable Coverage

Important Notice from Leidos About Your Prescription Drug Coverage and Medicare

The key purpose of this notice is to advise you that the prescription drug coverage you have under your Leidos medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2023. (This is known as "creditable coverage.")

The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Leidos and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Leidos has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Leidos coverage will not be affected. You can keep your current Leidos coverage if you elect a Medicare Part D drug plan.

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

When Will You Pay A Higher Premium (Penalty) to Join A Medicare Drug Plan?

You should also know that if you drop or lose your coverage with Leidos and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium will go up at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

- Visit the Leidos Summary Plan Description (SPD) web site (https://benefits.leidos.com/)
- Contact Employee Services
  - Phone: 1-855-553-4367, Select Option 3
  - Email: AskHR@leidos.com

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You will get a notice each year during Leidos' annual Open Enrollment period. You will also get it if this coverage through Leidos changes.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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Continuing Medical Coverage After Plan Coverage Ends

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

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

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

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

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Leidos offers two types of dental plans. A participant may be able to choose between the following plans depending on home zip code:

- The **Leidos Dental PPO (Plus Premier) Plans**, which allow participants to see any dentist; and
- **Dental Maintenance Organization** (DMO), which has a network of dentists that participants can choose from to provide all of their care.

Eligibility

A Leidos employee is eligible to enroll in Leidos benefit programs under the following conditions:

Type of Coverage	Eligibility Requirements
Dental Program	• Must be an active, regular full-time employee working at least 30 hours per week or a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and • Must live in the geographic area served by a particular plan.

Dependents

Participants may also enroll their eligible dependents in the Leidos dental plans. Eligible dependents include:

- The participant's legal spouse or registered domestic partner (see "Registered Domestic Partners")
- Each child of the participant or registered domestic partner younger than age 26, including:
  - A natural child or stepchild;
  - An adopted child (coverage begins as of the earlier of the date the child was placed in the participant's home or the date of final adoption); and
  - Any other child who depends on the participant for support and lives with the participant in a parent-child relationship, if the participant provides proof of legal guardianship.

- Unmarried children, age26 and older whoare incapable of self-sustaining employment because they are mentally or physically disabled, as long as:
  - The mental or physical disability existed while the child was covered under the plan and began before age 26;
  - The child is primarily dependent on the participant for support; and
  - The participant provides periodic evidence of incapacity.

Participants must update enrollment in Workday within 31 days of any change in dependent eligibility. For questions on enrollment, please contact Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

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

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

Registered Domestic Partners

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

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

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

Employees must provide proof of Domestic Partnership Registration from a state or local domestic partner registry or submit a notarized *Declaration of Domestic Partnership* and any other required documents in order to enroll a registered domestic partner. The Declaration must be presented to insurers upon request. Contact Employee Services for additional information on enrolling a registered domestic partner.

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

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

Dependent Eligibility Verification (DEV) Process

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

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

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

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

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

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

How the Dental Plans Work

Leidos offers participants a choice when it comes to the type of dental plan that works best for the participant and his or her family.

With the **Leidos Dental PPO (Plus Premier) Plans**, a participant can use any dentist. However, when a participant uses dentists in the Delta Dental PPO (Plus Premier) network, the participant will receive a higher level of benefits and pay lower out-of-pocket costs. This is because Delta Dental PPO (Plus Premier) network providers have agreed to charge lower, negotiated fees for services. When a participant uses dentists outside the Delta Dental PPO (Plus Premier) network, the participant will receive a lower level of benefits and pay higher total out-of-pocket costs.

A **Dental Maintenance Organization (DMO)** works just like a health maintenance organization, or HMO. There is no deductible, and there are no claim forms to file. Participants must choose a network provider, who will coordinate and provide dental care services at a fixed cost. If a participant does not coordinate his or her care through the primary care dentist, the plan will not pay benefits. DMOs are available only in areas where there are participating dentists.

Please carefully review the sections pertaining to what the dental plans will and will not cover to find information on the dental plan exclusions. Additionally, the individual dental plan carriers should be contacted for information on the specific exclusions for dental work in progress.

Leidos Dental PPO (Plus Premier) Plans

Leidos offers two Dental PPO (Plus Premier) plan options: the Dental PPO High and the Dental PPO Low. These plans allow participants to choose any provider they wish and receive benefits.

Whether a participant sees a network provider or an out-of-network provider, the plans cover a broad range of dental services and supplies.

Paying for Care

This section will help participants understand how they pay for care under the Leidos Dental PPO (Plus Premier) plans.

Employee Contributions

Leidos and participants share the cost of coverage. Each pay period, a participant who enrolls in the Leidos Dental PPO (Plus Premier) plans contributes a set dollar amount to help pay for the cost of the plan. The contribution amount will vary based on the coverage level the participant has elected: employee only, employee plus spouse, employee plus one or more children or family coverage. These contributions are taken automatically from the participant's paycheck on a pre-tax basis. Premiums for domestic partners are paid by the participant on an after-tax basis.

Annual Deductible

The deductible is the initial $50 each participant must pay for basic and major dental services each calendar year before the plan begins to pay benefits.

Coinsurance

Coinsurance is the percentage of eligible expenses a participant pays for dental services after the deductible is met.

Annual Maximum Benefit

The annual maximum benefit is the total amount a plan will pay for covered dental services for a participant each plan year. Once a participant meets this yearly maximum, the plan will not pay any more benefits until the next plan year. Preventive care and diagnostic services (typically x-rays, exams and cleanings) do not count against the annual benefit maximum.

Each year, the Leidos Dental PPO High Plan will pay a maximum of $1,500 per participant. **Note:** There is a separate $1,500 lifetime maximum for orthodontic services per participant.

The Dental PPO Low Plan will pay a maximum of $1,000 per participant per plan year.

Plan Design

This section will help participants understand how the Leidos Dental PPO (Plus Premier) Plan pays benefits.

Network Benefits

By visiting a network dentist, a participant saves money because dentists in the network have agreed to charge discounted fees. For most services, the participant must first meet the $50 annual deductible. Then, whenever the participant receives dental services, the Leidos Dental PPO (Plus Premier) Plans pay a percentage of the cost. The participant pays the remaining amount (the coinsurance).

Participants have access to both of Delta's PPO and Premier networks. Thus, participants have a wider selection of in-network dentists. However, participants will generally have a higher out-of-pocket cost if they use a dentist in the Delta Dental Premier network. For more information, visit https://deltadentalva.com/members/leidos

There are no claim forms to file because the Delta Dental PPO (Plus Premier) network dentist submits claims for the participant.

Out-of-Network Benefits

When a participant uses a dentist who does not participate in the Delta Dental PPO (Plus Premier) network, that dentist is considered to be out of network.

For most services, each participant must first meet the $50 annual deductible. Note that the in-network and out-of-network dental deductible cross accumulates. This means that the deductible for in-network services will satisfy the deductible for out-of-network services (or vice versa). Once the deductible is satisfied, the Leidos Dental PPO (Plus Premier) Plans pay a percentage of the cost of services, up to the non- participating provider allowance. The participant pays the remaining percentage (the coinsurance) plus any amount above the non-participating provider allowance.

Participants who go to out-of-network providers may be responsible for filing their own claims for reimbursement from the Leidos Dental PPO (Plus Premier) Plans. Check with your provider for information on their payment and claim filing policies.

Non-Participating Provider Allowance

Delta Dental's Non-Participating Provider Allowance is the maximum amount the Leidos Dental PPO (Plus Premier) Plan will pay for a covered service rendered by an out-of-network provider. The allowance for a specific dental procedure is within the sole discretion of Delta Dental and is not subject to challenge or review.

What the Leidos Dental PPO (Plus Premier) Plan Covers

The Leidos Dental PPO (Plus Premier) plan includes only services in the list below.

- Preventive and Diagnostic Services
- Basic Services
- Major Services
- Orthodontic Services

Preventive and Diagnostic Services

The Leidos Dental PPO (Plus Premier) Plans cover the following preventive services:

- Oral exam (two per participant per calendar year);
- Teeth cleaning (prophylaxis treatment to include scaling and polishing; two per participant per calendar year);
- Topical fluoride (limited to participants age 18 and under; two per participant per calendar year);
- Bitewing X-rays (two per participant per calendar year);
- Full mouth X-rays (one per participant every 60 consecutive months);
- Diagnostic X-rays used to diagnose a condition;
- Single X-ray films;
- Additional X-ray films;
- Sealants and preventive resin restorations (limited to participants under the age of 16; once per participant every three calendar years); and
- Palliative emergency treatment of dental pain- minor procedure

Basic Services

The Leidos Dental PPO (Plus Premier) Plans cover the following basic services:

- Simple extractions;
- Surgical extractions (soft tissue impaction, partial bony impaction, complete bony impaction);
- Impactions;
- General anesthesia—only eligible in conjunction with the following:
    - Removal of one or more impacted teeth on the same day;
    - The extraction of three or more teeth;
    - More than one surgical extraction involving more than one quadrant on the same day

- Amalgam restoration of primary or permanent teeth;
- Composite restoration;
- Root canal therapy— any X-ray, test, lab exam, or follow-up care is part of the allowance for root canal therapy and not a separate dental service;
- Pulp capping;
- Pulpotomy;
- Apicoectomy and retro fill;
- Apicoectomy and retro fill on separate appointment;
- Subgingival curettage;
- Gingivectomy; and
- Space maintainers, fixed unilateral (limited to non-orthodontic treatment)
- Recementation:
  - Inlay;
  - Crown; or
  - Bridge
- Stainless steel crowns
- Adjustments to complete and partial dentures;
- Repairs to complete and partial dentures
- Adding teeth or clasps to partial denture

Major Services

The Leidos Dental PPO (Plus Premier) Plans also provide benefits for the following restorative services:

- Crowns (including, but not limited to, porcelain with gold, cast gold);
- Bridges;
- Complete upper or lower denture;
- Partial upper or lower denture;
- Denture reline;
- Implants;
- Temporomandibular Joint (TMJ) Dysfunction

Orthodontic Services

The Leidos Dental PPO High Plan covers the following orthodontic services:

- X-rays and records;
- Initial banding;

- Periodic visits for comprehensive(usually24months) treatment for adults and children;
- Interceptive (extension of preventive orthodontics that may localize tooth movement) treatment; and
- Orthodontic retention (removal of appliances, construction and placement of retainers(s))

Temporomandibular Joint Dysfunction (TMJ) Appliances

The Leidos Dental PPO (Plus Premier) Plans cover TMJ appliances. The plan will cover TMJ appliances at 60% in-network/ 50% out- of-network under the PPO High Plan and 50% in-network/40% out-of-network under the PPO Low Plan. This is covered subject to the deductible and annual benefit maximum.

Predetermination of Benefits

If a participant needs extensive dental work and the total charges will be in excess of $250, a Predetermination of Benefits is strongly recommended. This will help the participant and the dentist understand what is covered under the plan and what the participant's share of the costs will be before services are provided.

To request an advanced claims review, dentists may submit their treatment plan to Delta Dental for review and estimation of coverage before procedures are started. Delta Dental advises the patient and the dentist of what services are covered and what the payment would be. The actual payment for these predetermined services depends on eligibility, any plan limitations, coordination of benefits and the remaining maximum at the time services are performed.

A predetermination plan is subject to change based on the dentist's participation status at the time of treatment and does not guarantee direct payment. Of course, predetermination is optional, but it is strongly recommended for dental services expected to exceed $250.

What the Leidos Dental PPO (Plus Premier) Plan Does Not Cover

The Leidos Dental PPO (Plus Premier) Plans do not cover, or provide any payment for the following unless specifically identified as a covered benefit:

- Services and supplies not necessary, as determined by Delta Dental, for the diagnosis, care or treatment of the disease or injury involved. This applies even if the service or supply is prescribed, recommended or approved by the person's attending physician or dentist;
- Care, treatment, services or supplies that are not prescribed, recommended and approved by the person's attending dentist;

- Services or supplies that are determined by Delta Dental to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if:
  - Insufficient outcomes data is available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - Approval has not been granted for marketing, if required by the Food and Drug Administration (www.fda.gov); or
  - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
  - The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes
- Dental services for restoring tooth structure lost from wear (abrasion, erosion, attrition or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include but are not limited to equilibration and periodontal splinting;
- Services provided by someone other than a licensed dentist or a qualified dental hygienist working under the supervision of a dentist;
- Charges that are not reasonable, as determined by Delta Dental;
- Charges that are made only because there is health coverage;
- Charges that a covered person is not legally obliged to pay;
- Services that Delta Dental determines are for correcting congenital malformations; also, surgery for cosmetic purposes;
- Dental expense not specifically described in the plan;
- Services for injuries or conditions that may be covered under workers' compensation or similar employer liability laws or other medical plan coverage;
- Services provided before the date the participant enrolled under the Plan. Except as otherwise provided under the Plan, benefits for a course of treatment that began before the participant was enrolled under the Plan;
- Dental services provided after the date you are no longer enrolled or eligible for coverage, except as otherwise provided under the Plan;

- Prescription and non-prescription drugs, pre-medications, preventive control programs, oral hygiene instructions and relative analgesia, except as provided for under the Plan;
- General anesthesia when less than three (3) teeth will be routinely extracted during the same office visit;
- Splinting or devices used to support, protect or immobilize oral structures that have loosened or been re-implanted, fractured or traumatized;
- Charges to complete a claim form, copy records, or respond to Delta Dental's request for information;
- Charges for failure to keep a scheduled appointment;
- Services or treatment provided to an immediate family member by the treating Dentist. This would include the Dentist's parent, spouse or child;
- Dental services and supplies for the replacement device or repeat treatment for lost, misplaced or stolen prosthetic devices including space maintainers, bridges and dentures (among other devices);
- Services billed under multiple procedure codes in which Delta Dental, in its sole discretion, determines that the service was either a component part of or inclusive of a more comprehensive or primary procedure code. This exclusion is subject to any and all internal and external appeals available. Delta Dental bases its payment on the Plan Allowance for the primary code, not the Plan Allowance for the underlying component code;
- Services billed under a dental procedure code that Delta Dental, in its sole discretion, determines should have been billed under a code that more accurately describes the dental service. Delta Dental bases its payments in its determination of the more accurate dental service code;
- Amounts that exceed the Plan Allowance for covered benefits
- Replacement retainers

Filing Claims

If a participant receives dental care from an out-of-network provider, he or she may need to submit their own claim. To do so, complete a Delta Dental claim form. Submit all claims to:

Delta Dental of Virginia
4818 Starkey Road
Roanoke, VA 24018-8510

The participant may also download the claim form by visiting https://deltadentalva.com/members/leidos. The form can be submitted via email to CustomerService.HelpDesk@DeltaDentalVA.com. Participants must submit all claims for dental benefits within twelve (12) months of the date services are completed. For orthodontic services, a claim for benefits should be filed at the time of banding.

If a participant has concerns about how a claim has been administered or wishes to appeal a claims decision, information on relevant procedures is available in **Claims Appeal and Review Procedures under ERISA** in the Plan Information section.

Coordination of Benefits

If a participant or a participant's dependents are covered under another dental plan, then that plan and the Leidos Dental PPO (Plus Premier) Plan will work together to pay up to 100% of the charges or the normal level of benefits, whichever is less.

When the Leidos Dental PPO (Plus Premier) Plan is the primary plan, benefits are paid without regard to any other plans. The participant is responsible for coordinating any benefits by submitting the Explanation of Benefits and itemized bill to the secondary plan.

Determining Which Plan Pays First

Leidos uses the following insuranceindustry guidelines for determining the primary and secondary payers for employees and dependents. The Plan without a coordination provision is always the primary Plan; otherwise:

Employees

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

Dependents

For an employee’s spouse or registered domestic partner, a plan that covers the spouse or registered domestic partner as an employee is the primary payer for his or her claims. If an employee has elected coverage for his or her spouse or registered domestic partner as a dependent and the spouse or registered domestic partner has coverage through another employer, the Leidos Dental PPO (Plus Premier) Plan is the secondary payer.

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

In the case of divorced or separated parents, the primary plan is determined in the following order:

- The plan of the parent who has financial responsibility by court decree;
- If there is no court order, the Plan of the natural parent with legal custody.
- If one parent re-marries or both parents re-marry, the Plan of the natural parent with legal custody is the primary plan. The Plan of the child's custodial step-parent is the secondary plan. Plan benefits for the child's parent without legal custody are determined third. The non-custodial step-parent's plan benefits are determined fourth.

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

Dental Maintenance Organization (DMO)

A DMO is a network of dentists and specialists who provide dental care services at a fixed cost. With the DMO, a participant does not have to meet a deductible or file any claim forms. The DMO plans are available only in areas where there are participating dentists.

How the DMO Plan Works

Participants, including dependents, who enroll in a DMO plan must choose a primary care dentist. Each covered person may select his or her own primary care dentist. This primary care dentist will provide all routine dental care and will refer the participant to a network specialist when specialty care is needed.

For routine dental care — such as check-ups or fillings — a participant should make an appointment with the primary care dentist. When visiting a dentist, the participant will pay the required copayment for covered services. The participant does not have to file a claim form after receiving care.

If a participant receives dental care without going through his or her primary care dentist first, or if the participant's care is not authorized by the plan, the DMO plan will not pay any benefits. The participant will pay the full cost of any out-of-network or unauthorized care.

Choosing a Primary Care Dentist

The participant and each dependent must select a primary care dentist from the DMO's network of providers.

Each participant can change his or her primary care dentist at any time during the year. To select or change a primary care dentist, participants can call the Member Services number on their ID card.

ID Cards

Participants enrolled in the DMO plan will not receive an ID card. However, the participant will receive a welcome letter that will contain the participant ID number and information regarding the plan. The participant can register on the website and print out a paper ID card if they so choose.

What the DMO Plans Cover

The DMO plans cover preventive, basic and major services as well as orthodontia services.

Refer to the DMO's Benefit Summary or Evidence of Coverage for a complete list of what is covered by the plan.

Comparing the Dental Plans

The chart below provides an overview of covered dental services in the PPO and DMO plans. For a complete list of benefits, a participant should refer to the plans' Certificate of Coverage.

Dental Benefits				
	Delta Dental PPO (Plus Premier) Low Plan	Delta Dental PPO (Plus Premier) High Plan	Aetna DMO	Cigna International Dental
Group Number:	700273	700273	698685-51	0666A
Member Services Phone:	800-237-6060	800-237-6060	877-238-6200	800-441-2668 or 302-797-3100 (collect)
Plan Website	https://deltadentalva.com/members/leidos	https://deltadentalva.com/members/leidos	www.aetna.com	www.cignaenvoy.com
Availability:	Nationwide. Also available in Puerto Rico, Guam and U.S. Virgin Islands	Nationwide. Also available in Puerto Rico, Guam and U.S. Virgin Islands	Nationwide except for Alabama, Alaska, Arkansas, Louisiana, Maine, Mississippi, Montana, New Hampshire, North Dakota, South Carolina, South Dakota, Vermont and Wyoming. Service area based on dental plan's zip code eligibility criteria[5].	Available for participants on international assignments of 6 months or more
Choice of Dentist:	Any dentist	Any dentist	Select a dentist from a list of participating dentists in your area[5]	Any Dentist – Online directory available to search for dentists in 450+ countries
Annual Deductible	$50 per person	$50 per person	No deductible	$25 per person $75 per family
Annual Maximum Benefit	$1,000 per person	$1,500 per person	N/A	$1,500 per person

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Preventive Services[3]	**Plan pays:**				**Plan pays 100% After**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Periodic Oral Examination (2 per participant per calendar year)	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible	100% Not subject to deductible	$0 Copay	$0 copay
Prophylaxis / Cleaning, including scaling and polishing (2 per year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	$0 copay (Limit 2 per calendar year)	$0 copay (2 per participant per calendar year)
X-rays – Complete Series	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	100% Not subject to deductible (1 per participant every 5 years)	$0 copay	$0 copay (1 per participant every 3 years)
X-rays – Bitewings (One Set)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	100% Not subject to deductible (2 per participant per calendar year)	$0 copay	$0 copay (2 per participant per calendar year)
Topical application of fluoride	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	100% Not subject to deductible (ages 18 and younger; 2 per participant per calendar year)	$0 copay	$0 copay (Up to age 18; 1 per participant per calendar year)

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Diagnostic Services[4]	**Plan pays:**				**Plan pays 100% After**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Diagnostic X-rays	100%	100%	100%	100%	$0 Copay	$0 Copay
Single Film	100%	100%	100%	100%	$0 Copay	$0 Copay
Fissure Sealant (per tooth; once every 3 calendar years)	100% (under age 16)	100% (under age 16)	100% (under age 16)	100% (under age 16)	$5 copay (under age 16)	$0 Copay
Oral Surgery	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Simple Extraction	80%	70%	90%	80%	$0 Copay	Plan pays 80%
Surgical Extraction	80%	70%	90%	80%	$28 Copay	Plan pays 80%
Impactions	80%	70%	90%	80%	$46 soft tissue; $58 partially bony; $100 completely bony	Plan pays 80%
General Anesthesia (only for Surgical Extraction)	80%	70%	90%	80%	General Anesthesia (deep sedation) or Conscious IV Sedation (first 15 min): $104 copay; $83 copay for each additional 15 min	Plan pays 80% when determined to be medically necessary
Fillings	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Amalgam Restoration of Primary Teeth/Permanent Teeth	80%	70%	90%	80%	$0 Copay	Plan pays 80%
Composite Restoration	80%	70%	90%	80%	$0-50 Copay	Plan pays 80%

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Endodontics	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Root Canal Therapy	80%	70%	90%	80%	Anterior: $70 Copay; Bicuspid: $85 Copay; Molar: $240 Copay	Plan pays 80%
Pulpotomy	80%	70%	90%	80%	$14 Copay	Plan pays 80%
Apicoectomy and Retro Fill	80%	70%	90%	80%	Anterior $85 copay; Bicuspid (1st root) $85 copay; Molar (1st root) $90 Copay; each additional root $55 copay	Plan pays 80%
Periodontics	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Periodontal Planing and Root Scaling	80%	70%	90%	80%	$55 Copay 4 separate quadrants per calendar year	Plan pays 80%
Gingivectomy (per quadrant)	80%	70%	90%	80%	$100 Copay	Plan pays 80%
Restorative Services	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Crowns (per unit)	50%	40%	60%	50%	$176 - $220 copay depending on type	Plan pays 50%
Bridges (per unit)	50%	40%	60%	50%	$210 copay per unit	Plan pays 50%
Stainless Steel Crowns	80%	70%	90%	80%	$35-$50 copay	Plan pays 50%
Recementation	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Inlay	80%	70%	90%	80%	$10 copay	Plan pays 50%
Crown	80%	70%	90%	80%	$10 copay	Plan pays 50%
Bridge	80%	70%	90%	80%	$15 copay	Plan pays 50%

	Delta Dental PPO (Plus Premier) Low Plan		Delta Dental PPO (Plus Premier) High Plan		Aetna DMO (Plan 58)	Cigna International Dental
Prosthetics (Dentures)	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Complete Upper or Lower Denture	50%	40%	60%	50%	$275 Copay	Plan pays 50% (1 per participant every 5 years)
Partial Upper or Lower Denture	50%	40%	60%	50%	$275 - $403 Copay	Plan pays 50%
Denture and Partial Adjustment	80%	70%	90%	80%	$10 Copay	Plan pays 50%
Denture Reline	50%	40%	60%	50%	$45 Copay (Chair Side) $85 Copay (Laboratory)	Plan pays 50%
Denture Duplication	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not covered
Denture and Partial Repairs	80%	70%	90%	80%	$20 - $86 Copay	Plan pays 80%
Adding Teeth or Clasps to Partial Denture (per unit)	80%	70%	90%	80%	$35 - $40 Copay	Plan pays 80%
Orthodontia	**Plan pays:**				**You pay:**	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**		
Full-Banded Case	Not covered	Not Covered	50% up to a separate $1,500 lifetime max per participant; includes invisible braces; Not subject to deductible	50% up to a separate $1,500 lifetime max per participant; includes invisible braces; Not subject to deductible	$1,545 Copay, plus $30 orthodontic screening exam; $150 diagnostic records; $275 retention fee. Other fees may apply per Aetna's Dental Care Schedule	Plan pays 50% after separate $50 lifetime deductible; $1,500 lifetime max coverage; includes invisible braces
Partial-Banded Case	Not Covered	Not Covered	50% up to a separate $1,500 lifetime max per participant Not subject to deductible	50% up to a separate $1,500 lifetime max per participant Not subject to deductible	Not covered	Plan pays 50% after separate $50 lifetime deductible; $1,500 lifetime max includes invisible braces

[1]Covered services received from a network provider will be paid based on the negotiated rate.
[2]Covered services received from an out-of-network provider will be paid based on Non-Participating Provider Allowance.
[3]Preventive services are not subject to the annual deductible and annual benefit maximum.
[4]Diagnostic services are not subject to the annual benefit maximum.
[5]Services provided by a non-participating dental provider may be available in the case of an emergency condition.

Continuing Dental Coverage After Plan Coverage Ends

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

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

Leidos offers two vision plans – VSP Basic and VSP Plus. Participants may elect coverage for themselves and their families under the **Vision Service Plan (VSP)**. These plans are designed to provide a variety of eye care services.

- **Eligibility**
- **Paying for Care**
- **Plan Design**
- **What the VSP Basic Plan Covers**
- **What the VSP Plus Plan covers**
- **What VSP Does Not Cover**
- **Filing Claims**
- **Continuing Vision Insurance After Plan Coverage Ends**

Eligibility

A Leidos employee is eligible to enroll in Leidos benefit programs under the following conditions:

Employee Eligibility	
Type of Coverage	**Eligibility Requirements**
Vision Plan	• Must be an active, regular full-time employee working at least 30 hours per week; or • Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week;

Dependents

Participants may enroll their eligible dependents in the Leidos Vision plans. Eligible dependents include:

- The participant's legal spouse or registered domestic partner (See "Registered Domestic Partners");

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

Participants must update enrollment in Workday within 31 days of any change in dependent eligibility.

Important: If a Participant's Spouse, Registered Domestic Partner or Dependent Is a Leidos Employee

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

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

Registered Domestic Partners

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

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

- Live together at the same address and have lived together continuously for at least one year;

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

Employees must submit proof of Domestic Partnership Registration from a state or local domestic partner registry or submit a notarized *Declaration of Domestic Partnership* and any other required documents in order to enroll a registered domestic partner. The Declaration must be presented to insurers upon request. Contact Employee Services for additional information on enrolling a registered domestic partner.

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

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

Dependent Eligibility Verification (DEV) Process

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

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

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

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

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

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

Paying for Care

Participants are responsible for their share of the insurance premiums and applicable copayments for examinations and eyewear. Premiums are paid via pretax payroll deductions. The plan generally pays for prescription glasses, contact lenses and laser eye surgery, up to the applicable allowance. Prices are discounted through VSP network doctors.

Copayments

When a participant receives an eye exam from a VSP network doctor or a non-VSP provider, or obtains glasses or contacts, the participant is subject to the applicable copayment as shown in the table below.

When a participant receives services from a non-VSP provider, the participant is responsible for paying the complete bill at the time of service and applying for reimbursement for the benefits (less applicable copayments) according to the summary of benefits in the table that follows. For more information, participants may contact VSP by calling 1-800-877-7195, or by visiting the VSP website – https://leidos.vspforme.com/.

Plan Design

The vision plans through VSP offers participants the flexibility to receive services from a VSP network doctor or a non-VSP provider. No referrals or identification cards are needed to see a VSP doctor.

VSP Network Doctors

Vision care services and eyewear may be obtained from any licensed optometrist, ophthalmologist or dispensing optician. However, the plan generally pays maximum benefits and offers additional discounts when participants receive services and eyewear from VSP network doctors.

Participants pay only a copayment to a VSP doctor for services. VSP will pay the VSP doctor directly according to the plan's agreement with the doctor.

VSP doctors offer additional savings including a 20% discount on additional pairs of prescription glasses (lenses and frame) and sunglasses. Services must be received within 12 months of a participant's last covered eye exam and provided by the same VSP doctor who conducted the exam. Participants can also save 15% off the cost of a contact lens exam when they receive contact lens services from a VSP doctor. (This discount does not apply to the purchase of contacts.)

Scheduling an Appointment with a VSP Network Doctor

When calling to schedule an appointment with a VSP doctor, participants should identify themselves as a VSP member.

To locate a VSP doctor near a participant's home or office:

- Visit the VSP website at https://leidos.vspforme.com/ to search for a doctor by name or location.
- Call VSP's Member Services at 1-800-877-7195. VSP's automated service allows participants to search for a doctor by Zip Code or name.

Non-VSP Providers

To receive the best value from the VSP benefit, a participant should visit a VSP network doctor. If benefits are obtained from a non-VSP provider, the participant must pay the

provider in full at the time of service. The participant will be reimbursed by VSP according to the reimbursement schedule listed in the Schedule of Benefits. Services obtained from non-VSP providers are subject to the same copayments and limitations as services obtained from VSP providers.

Laser Surgery Discount

VSP has contracted with many laser surgery facilities and doctors, offering participants access to laser vision correction surgery for hundreds of dollars less than they might pay privately.
Visit https://leidos.vspforme.com/ to learn more about the laser surgery program.

What the VSP Basic Plan Covers

Benefits generally covered under the Basic Plan include:

- Vision examination, including the test necessary to ensure visual wellness and to detect potential eye-related medical problems;
- Prescription of corrective lenses when indicated;
- Single vision, lined bifocal or lined trifocal lenses in glass or plastic;
- Standard progressive lenses
- A selection of frames to choose from, up to the plan allowance;
- Contact lenses in place of prescription glasses;
- Discounts and allowances on lenses and frames, contact lens exam and laser eye surgery;
- Type 2 diabetes follow-up services and contact lens exams (evaluation and fitting)

What the VSP Plus Plan Covers

The VSP Plus Plan coverage is inclusive of the benefits under the Basic Plan; however, each covered member may select one of the following enhancements when purchasing their eyewear:

- Additional $100 frame allowance
- Additional $100 contact lens allowance
- Fully-covered premium or custom progressive lenses

- Fully-covered anti-reflective coating
- Fully-covered light reactive lenses

What VSP Does Not Cover

VSP covers the participant's visual needs rather than optional extras or "cosmetic" materials. If a participant selects any of the following cosmetic options listed below, the participant will pay a negotiated VSP member price:

- Blended lenses:
- Oversize lenses;
- UV (ultraviolet protection) lenses;
- Progressive multifocal lenses;
- Coating of a lens or lenses;
- Laminating of a lens or lenses;
- Cosmetic lenses; and
- Optional cosmetic processes

In addition, services and eyewear that aren't covered include:

- Orthoptics or vision training and any associated supplemental testing;
- Planolenses (non-prescription lenses);
- Two pairs of glasses in lieu of bifocals;
- Replacement of lenses, frames and/or contact lenses under the plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above benefit allowances;
- Refitting of contact lenses after the initial (90-day) fitting period;
- Contact lens modification, polishing or cleaning;
- Services/eyewear not indicated as covered plan benefits

Comparing the Vision Plans

	VSP Basic		VSP Plus	
	VSP Provider	**Non-VSP Provider**	**VSP Provider**	**Non-VSP Provider**
Examination – One (1) per calendar year				
Routine Well Vision Exam	$20 Copay for exam and glasses	Plan pays up to $45 (minus $20 copay)	$20 Copay for exam and glasses	Plan pays up to $45 (minus $20 copay)
Contact Lens Exam (fitting and evaluation)	Up to $60 Copay	N/A	Up to $60 Copay	N/A
Lenses – per calendar year				
Single Vision Lenses	Included	Plan reimburses up to $30	Included	Plan reimburses up to $30
Lined Bifocal Lenses	Included	Plan reimburses up to $50	Included	Plan reimburses up to $50
Lined Trifocal Lenses	Included	Plan reimburses up to $65	Included	Plan reimburses up to $65
Lenticular	Included	Plan reimburses up to $100	Included	Plan reimburses up to $100
Frames – per calendar year				
Wide selection of frames	$150 Allowance	Plan reimburses up to $70	$150 Allowance	Plan reimburses up to $70
Featured frame brands	$200 Allowance	Plan reimburses up to $70	$200 Allowance	Plan reimburses up to $70
Walmart / Sam's Club / Costco	$150 Allowance	Plan reimburses up to $70	$150 Allowance	Plan reimburses up to $70
Savings on the amount over your allowance	20% off overage	Plan reimburses up to $70	20% off overage	Plan reimburses up to $70
Contact Lenses (in lieu of glasses) – per calendar year				
Elective Contact Lenses	$150 Allowance	Plan reimburses up to $105	$150 Allowance	Plan reimburses up to $105
Medical Necessary Contact Lenses	Included	Plan reimburses up to $210	Included	Plan reimburses up to $210

	VSP Basic		VSP Plus	
	VSP Provider	**Non-VSP Provider**	**VSP Provider**	**Non-VSP Provider**
VSP EasyOptions[1] – per calendar year				
	N/A	N/A	Each covered plan member may select one of the following enhancements when purchasing their eyewear: • Additional $100 frame allowance • Additional $100 contact lens allowance • Fully-covered premium or custom progressive lenses • Fully-covered anti-reflective coating • Fully-covered light-reactive lenses	N/A
Covered Lens Enhancements				
Standard Progressive Lenses	Covered	Reimbursed up to $50	Covered	Reimbursed up to $50
Polycarbonate for children	Covered	N/A	Covered	N/A
Non-Covered Lens Enhancements				
Other Add-Ons & Services	Average of 30% discount off the regular price	N/A	Average of 30% discount off the regular price	N/A

	VSP Basic		VSP Plus	
	VSP Provider	**Non-VSP Provider**	**VSP Provider**	**Non-VSP Provider**
Supplemental Essential Medical Eye Care Plan				
Retinal Screening for members with diabetes	$0 per screening	N/A	$0 per screening	N/A
Medical Eye Care Treatment	$20 Copay[2]	N/A	$20 Copay[2]	N/A
Essential Medical Eye Care provides supplemental coverage for urgent and medical eye care. The program provides additional exams and services beyond routine care to treat immediate issues or to monitor ongoing conditions. Examples of symptoms for which a participant may seek services under EMEC: • pain in or around the eyes • transient loss of vision • ocular trauma • flashes or floaters • recent onset of eye muscle dysfunction Examples of conditions which may require management under the EMEC plan: • diabetic eye disease • ocular hypertension • retinal nevus • glaucoma • cataract • pink eye • macular degeneration • corneal dystrophy				
Laser VisionCare Preferred Program – per lifetime				
Custom LASIK, Custom PRK, Bladeless LASIK, LASIK, or PRK	$100 allowance per eye up to $200 lifetime maximum. Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	Plan reimburses up to $100 per eye up to $200 lifetime maximum	$100 allowance per eye up to $200 lifetime maximum. Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	Plan reimburses up to $100 per eye up to $200 lifetime maximum
Additional Discounts & Savings				
20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last well vision exam. Routine Retinal Screening, no more than a $39 copay as an enhancement to a well vision exam.				

[1]EasyOptions is not covered at Walmart, Sam's Club, or Costco.
[2]If you have medical coverage and your eye doctor participates in your medical plan network, the eye doctor will process your EMEC claim through your medical plan first and VSP will supplement that coverage. If you do not have medical coverage or if your eye doctor does not participate in your medical plan network, you will pay the $20 copay and the EMEC claim will be processed under the VSP plan.

Filing Claims

For out-of-network reimbursement, the participant must pay the entire bill at the time of service and then send the following information to VSP:

- An itemized receipt listing:
  - Date of service
  - Doctor's name or office name
  - Each service received and the amount paid;
- The participant's name, Social Security Number, phone number and address;
- The group number (#12180678);
- The patient's name, date of birth, phone number and address; and
- The patient's relationship to the participant (such as "self," "spouse," "child," etc.)

To submit a claim online:

- Log in to your VSP account
- Click on "View Your Benefits" then "My Benefits"
- Scroll down and click "Submit an Out-of-Network Claim
- Complete the fields and follow the prompts
- Upload your receipts
- Click Submit

To submit a claim by mail:

- Contact VSP Member Services at 800-877-7195 to request a VSP Member Reimbursement Form. Complete the form and mail to:

  Vision Service Plan (VSP)
  Attention: Claims Services
  P.O. Box 385018
  Birmingham, AL 35238-
  5018

Claims for reimbursement must be submitted within 365 days of the date of service. Participants should keep a copy of the information for their records and send the originals to VSP.

Contact VSP with any questions about coverage at 1-800-877-7195.

Continuing Vision Insurance After Plan Coverage Ends

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

For more information about participants' rights under COBRA, the participant should refer to "**Continuing Health Care Coverage Through COBRA**" in the Plan Information section.

Leidos Benefits Summary Plan Description

Life and Accidental Death and Dismemberment Insurance Plans

Leidos offers several types of financial protection for participants and their families if they were to die or be injured in an accident, including:

- Basic Term Life Insurance,
- Group Universal Life (GUL) Insurance,
- Optional Dependent Life Insurance,
- Basic Accidental Death and Dismemberment (AD&D) Insurance,
- Voluntary Accidental Death and Dismember (VAD&D) Insurance, and
- Business Travel Accident (BTA) Insurance.

Prudential Insurance Company of America (Prudential) insures the Basic Term Life Insurance, Group Universal Life (GUL) and Optional Dependent Life Insurance plans. The GUL and Cash Accumulation Fund (CAF) plans are administered by Mercer Voluntary Benefits (Mercer).

New York Life Group Benefit Solutions Group Insurance (New York Life) insures the Accidental Death and Dismemberment (AD&D) and Business Travel Accident (BTA) plans. These plans are underwritten by the Life Insurance Company of North America.

Basic Term Life Insurance

Basic Term Life Insurance may provide a benefit to employees and their eligible dependents if any were to die while the employee was working for Leidos.

How Basic Term Life Insurance Works

Eligible employees automatically receive Basic Term Life Insurance coverage for themselves and their eligible dependents, including their spouse or registered domestic partner and their dependent children. Leidos pays the full cost of the Basic Term Life Insurance coverage.

Basic Term Life Insurance benefit amounts over $50,000 are subject to income tax. The value of an employee’s life insurance coverage over $50,000 will be added each year to his or her W-2 form as taxable income. This is called “imputed income.”

The employee may choose to waive any coverage over $50,000 at any time. However, if an employee waives coverage over $50,000, the employee may only increase to the one (1) times annual

compensation during a life event or during open enrollment without evidence of insurability. Also, the employee must be actively at work to increase this coverage.

Employee Coverage

The amount of coverage that an employee may receive is based on his or her classification, as follows:

Class	Basic Term Life Insurance Benefit
Class 1 – All regular full-time employees working at least 30 hours per week and regular part-time employees working 12 – 29 hours per week and who are benefits eligible	Greater of $50,000 or one (1) times annul compensation, rounded to the next higher multiple of $1,000 if not already a multiple of $1,000 prior to calculating your amount of insurance, to a maximum of $1 million
Class 5 – All eligible employees waiving Basic Term Life Insurance coverage amounts over $50,000	$50,000

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the work performed as of the date of loss. It does not include earnings received as bonuses, overtime pay or other extra compensation.

Employees Ages 70+

When an employee reaches age 70, the total amount of the employee's Basic Term Life Insurance benefit will be reduced by 35%. The amount lost due to the age reduction is not eligible for port or conversion.

Dependent Basic Life Coverage

Coverage for an employee's eligible dependents equals $2,000 per person. Under the Basic Term Life Insurance Plan, an eligible dependent may include the employee's spouse or registered domestic partner, natural child(ren), legally adopted child(ren), child(ren) placed with the employees for adoption prior to legal adoptions[1] and the employee's stepchild(ren)[2] and domestic partner's child(ren)[2].

Refer to Eligibility in the Participating in the Plans section for more information about eligibility requirements.

[1] *A child placed with an employee for adoption prior to legal adoption is considered a qualified dependent from the date of placement for adoption.*

[2] *To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.*

Additional Benefits

Basic Term Life Insurance also pays additional benefits, including:

- **Accelerated Benefits** – If an employee or his or her spouse or registered domestic partner becomes terminally ill and is not expected to live for more than 12 months, he or she may request an accelerated benefits equal to a maximum of 50% of his or her combined life insurance benefit (Basic Term Life Insurance, Optional Dependent Life Insurance - spouse or domestic partner coverage only, and GUL Insurance). The maximum accelerated benefit amount for Basic Term Life Insurance is $250,000. Any remaining benefit amount will be paid to the employee’s designated beneficiary upon their death or to the employee upon the death of a covered dependent.

Extraterritorial Information

Important Information for Residents of Certain States: There are state-specific requirements that may change the provisions under the coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your coverage(s) and are made a part of you Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of resident and your access code. Your access code is 52844.

Limitations and Exclusions

Benefits for part-time employees will be calculated by using their pay, prorated by their standard number of hours worked per week.

Group Universal Life Insurance

Employees can purchase an added measure of protection for themselves through Prudential. Group Universal Life (GUL) Insurance provides benefits that go beyond term life insurance. Any GUL coverage elected is in addition to Basic Term Life Insurance coverage.

Coverage Options

GUL pays a benefit if you die while covered. If you participate, you have the option to enroll in either:

- GUL only; or
- GUL and contribute to cash accumulation fund that earns tax-deferred interest at a guaranteed minimum rate.

Employees can purchase GUL in amounts equal to 1, 2, 3, 4, 5, 6, 7, or 8 times their annual compensation, to a maximum of $4 million. Employees who enroll in GUL pay the full cost of coverage on an after-tax basis.

Delay in Effective Date

Your coverage under GUL will be delayed if you do not meet the Active at Work Requirement on the day your insurance would otherwise begin. Instead, it will begin on the day that you meet the requirement. The same delay rule will apply to any change in your insurance if you do not meet the Active at Work Requirement on the day in which that change would take effect.

The Active at Work Requirement requires that you be actively at work at Leidos, or at any other place the Leidos requires you to go. You are considered actively at work during normal vacation if you were active at work on your last regular schedule workday.

Evidence of Insurability

When an employee enrolls for GUL Insurance, he or she will be required to provide evidence of insurability (EOI) if he or she:

- Elects coverage in excess of (the lesser of) three times annual compensation or $500,000 when first eligible to enroll;
- Elects to increase coverage by more than one benefit level or any amount exceeding three times annual compensation during Open Enrollment or within 31 days of a qualified life event; or

- Elects to enroll for coverage after having waived coverage when first eligible

If the elected amount requires EOI, an online EOI request will be generated as a To-Do task in Leidos' HR System, Workday. The task will require the employee logon to the Prudential EOIConnect website via Single Sign On (SSO) and complete the EOI request. The employee may be asked to provide additional information upon completing the initial EOI request. If required, the additional medical questions may be submitted online via EOIConnect. If the employee does not wish to submit EOI online, the employee can choose to email or print copies of the Health Statement(s) which can be faxed or mailed to Prudential.

Any EOI must be satisfactory to the plan's underwriter before coverage can be approved. The plan's underwriter uses standard underwriting rules and procedures for reviewing applications and has sole authority to approve or reject any application on the basis of health. GUL coverage will be provided at the existing level while the decision on the covered person's EOI is pending.

Additional Benefits

GUL also pays additional benefits, including:

- **Accelerated Benefits** — If an employee becomes terminally ill and is not expected to live for more than 12 months, he or she may request an accelerated benefit equal to a maximum of 50% of his or her combined life insurance benefit (Basic Life Term Insurance and GUL). The maximum accelerated benefit amount for GUL Insurance is $250,000.

Any remaining benefit amount will be paid to the employee's designated beneficiary upon his or her death.

Extraterritorial Information

Important Information for Residents of Certain States: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 52844.

Limitations and Exclusions

GUL will not be payable if the employee commits suicide within the first two years of being covered.

Benefits for part-time employees will be calculated by using their pay, prorated by their standard number of hours worked per week.

Cash Accumulation Fund

In addition to providing a life insurance benefit for your loved ones, the GUL features a Cash Accumulation Fund (CAF) that allows you to earn interest on a tax-deferred basis.

You can:

- **Earn guaranteed interest** – The CAF has a guaranteed interest rate that will never be less than four (4) percent.
- **Keep it even after your employment with Leidos ends** – Insurance can continue at the full coverage amount up to age 100, on a direct-bill basis.
- **Enjoy tax benefits –** Earnings and interest credited on contributions to the CAF are tax-deferred. The death benefit (typically the face amount of insurance plus the CAF) is generally income tax-free to beneficiaries.
- **Access funds easily** – You can take loans or make withdrawals from the CAF at any time and for any reason. You can also use the CAF to pay premiums or purchase fully paid-up coverage.
- **Qualify for special benefits if you become disabled or terminally ill** – The Waiver of Premium provision for qualifying disabled employees and the Accelerated Benefit Option for terminally ill employees provides extra support when it is needed most.

If you elect to cancel coverage or withdraw from your CAF, you must complete the Owner Transaction Form.

Withdrawals

You can make a full or partial withdrawal from your CAF for any reason. You can make up to 12 cash withdrawals per year. The minimum amount you can withdraw is $200 (or your total balance if your total balance is less than $200). If you make a cash withdrawal, the CAF will be reduced by the amount of that withdrawal.

The maximum partial withdrawal you can make is equal to your fund balance less any loan, loan

interest and unpaid cost of premium due. If you make a partial withdrawal request for an amount greater than this, it will be treated as a full cash withdrawal.

Under current tax laws, the interest earned on your CAF is not taxed until you withdraw more than your "cost basis." Generally, the cost basis is equal to your contributions made (including cost of insurance premium and contributions to your CAF), less any untaxed portion of amounts previously withdrawn. Tax laws may change from time to time. It is advised that you consult your tax advisor for information on taxability. To make a withdrawal, submit a written request to Mercer, the program administrator.

Loans

You may borrow up to the current value of your CAF, subject to plan limitations. The minimum loan amount allowed under the plan is $200. The maximum loan amount is 90% of your CAF minus the cost of premium for one month of insurance. You will be charged up to 2% more than the interest rate earned. You may take one loan per year and only one loan can be in effect at any time.

You may repay all or part of your loan with interest by making payments directly to the Program Manager, Mercer. You cannot repay a loan through payroll deductions.

Optional Dependent Life Insurance

If an employee elects GUL, he or she can also elect to purchase Dependent Life Insurance for their eligible dependents.

In no case may covered employees also be covered as dependents of another covered Leidos employees. Therefore, if you are married or in a domestic partnership to another Leidos employee, you cannot be covered as both an employee and a dependent for Optional Life insurance (which includes GUL insurance).

In addition, any eligible dependent child(ren) can only be covered by one Leidos employee — so either you or your spouse (or domestic partner) may cover the eligible dependent child(ren).

Spouse Life Insurance

Employees can purchase Spouse Life Insurance for their spouse or registered domestic partner.

Coverage is available in the amount of:

- $10,000;
- $25,000;
- $50,000**;
- $100,000**;
- $150,000**;
- $200,000**
- $250,000**

** If you elect coverage to exceed the Guaranteed Issue, your spouse/domestic partner will be subject to EOI. Refer to the Evidence of Insurability section for more information.

Child Life Insurance

Under the Optional Dependent Life Insurance, employees can purchase Child Life Insurance for their eligible dependents which include the employee's natural child(ren), legally adopted child(ren), child(ren) placed with the employees for adoption prior to legal adoptions[1] and the employee's stepchild(ren)[2] and domestic partner's child(ren)[2].

Coverage is available in the amount of:

- $5,000;
- $10,000
- $25,000

[1] A child placed with an employee for adoption prior to legal adoption is considered a qualified dependent from the date of placement for adoption.

[2] To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.

Requirements for Dependent Coverage

On the date life insurance would otherwise be effective, if an eligible spouse, registered domestic partner or dependent child is:

- an inpatient in a hospital, hospice, rehabilitation center, convalescence center, custodial care facility, or
- confined to his or her home under the care of a physician

then life insurance will become effective on the date he or she is no longer an inpatient in these facilities or confined at home.

Evidence of Insurability

When an employee enrolls for Optional Dependent Life Insurance for their spouse or registered domestic partner, he or she will be required to provide evidence of insurability (EOI) if he or she:

- Elects Spouse Life coverage in excess of $25,000 for his or her spouse or registered domestic partner when first eligible to enroll;
- Elects more than one level increase to Spouse Life coverage during a qualified life event or Open Enrollment

If the elected amount requires EOI, an online EOI request will be generated as a To-Do task in Leidos' HR System, Workday. The task will require the employee logon to the Prudential EOIConnect website via SSO and complete the EOI request. Additional information may be requested upon completing the initial EOI request. If required, the additional medical questions may be submitted online via EOIConnect. If the employee does not wish to submit EOI online, the employee can choose to email or print copies of the Health Statement(s) for their spouse to complete which can be faxed or mailed to Prudential.

Any EOI must be satisfactory to the plan's underwriter before coverage can be approved. The plan's underwriter uses standard underwriting rules and procedures for reviewing applications and has sole

authority to approve or reject any application on the basis of health. Optional Spouse Life Insurance coverage will be provided at the existing level while the decision on the participant's EOI is pending.

Additional Benefits

Spouse Life Insurance also pays additional benefits, including:

- **Accelerated Benefits** — If an employee's spouse or registered domestic partner becomes terminally ill and is not expected to live for more than 12 months, he or she may request an accelerated benefit equal to a maximum of 50% of his or her Spouse Life Insurance benefit. The maximum accelerated benefit amount is $250,000.

Any remaining benefit amount will be paid to the employee upon the spouse or registered domestic partners death. (The employee is automatically the beneficiary for any covered dependent). For a covered person to qualify for an accelerated benefit, a doctor must certify his or her condition.

Extraterritorial Information

Important Information for Residents of certain States: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 52844.

Limitations and Exclusions

Spouse Life Insurance will not be payable if the spouse or registered domestic partner commits suicide within the first two years of being covered.

Basic Accidental Death and Dismemberment (AD&D) Insurance

Basic AD&D insurance provides additional benefits to employees if they were to die or suffer dismemberment in an accident while employed by Leidos and in an eligible fringe package.

How Basic AD&D Insurance Works

Eligible employees automatically receive coverage equal to one times their annual compensation, rounded to the next higher $1,000 if not already a multiple of $1,000. This is known as the "principal sum." The maximum Basic AD&D Insurance benefit is $250,000.

Class	Basic AD&D Insurance Benefit
Class 1 – All active regular full-time benefit eligible Employees of Leidos Inc. working a minimum of 30 hours per week or a regular part-time benefit eligible Employee scheduled to work between 12 and 30 hours per week for the Employer.	• Eligible employees automatically receive coverage equal to one times their annual compensation, rounded to the next higher $1,000 if not already a multiple of $1,000. This is known as the "principal sum." The maximum Basic AD&D Insurance benefit is $250,000. • Age reduction does not apply.

Leidos pays the full cost of Basic AD&D Insurance.

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the work performed as of the date of loss. It does not include earnings received as bonuses, overtime pay or other extra compensation.

Annual Compensation includes: A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid. ***Commissions*** will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Schedule of Benefits

In the event of an employee's death, benefits will be paid to the employee's beneficiary. If an employee accidentally suffers dismemberment, the benefits will be paid directly to the employee. The chart below shows the benefit payments under the Basic AD&D Insurance plan:

Schedule of Benefits	
Basic Accidental Death and Dismemberment (AD&D) Insurance	
Covered Loss: *	**Benefit Received:**
• Life • Two or more members • One hand or one foot and sight in one eye • Both upper and lower limbs (quadriplegia)** • Speech and hearing in both ears	100% of the principal sum
• One member (uniplegia) • Both lower limbs (paraplegia)** • Upper and lower limbs on one side of the body (hemiplegia)** • Speech • Hearing in both ears	50% of the principal sum
• Thumb and index finger of the same hand • All four fingers of the same hand • All toes of the same foot	25% of the principal sum

*An employee's loss must occur within 365 days of the date of the accident. "Member" means hand, foot or eye. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total, permanent and irrevocable loss by natural, surgical or artificial means. "Loss of speech" means total, permanent and irrevocable loss of audible communication. "Loss of hearing" means total and permanent loss of hearing in both ears which cannot be corrected by any means. "Loss of a thumb and index finger" means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

** These injuries - or paralyses - mean the loss of use, without severance, of a limb. Such a loss must be determined by a doctor to be complete and not reversible.

If more than one loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest will be paid.

Additional Benefits

Basic AD&D Insurance also pays additional benefits, including:

- **Accidental Burn and Disfigurement Benefit** - If a covered person suffers a covered injury that leaves him/her disfigured, and that covered injury resulted directly and independently of all other causes from a covered accident, and the disfigurement satisfies the following conditions below:

1. reconstructive or cosmetic surgery is required to restore the employee's physical abilities or correct disfigurement, and must be performed within twelve months of the covered accident;
2. a Physician must determine that the burn satisfies all of the following:
   a. involves the minimum percentage shown below;
   b. be classified as shown below; and
   c. results in disfigurement or loss of physical abilities.
      - 75-100% Body Disfigurement 100% of the Principal Sum
      - 50-74% Body Disfigurement 50% of the Principal Sum
      - 25-49% Body Disfigurement 10% of the Principal Sum
      - Burn Classification Third Degree

For purposes of this benefit: **Disfigurement or Disfigured** means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- **Brain Damage** — If a covered person becomes brain damaged within 30 days and as a result of a covered accident, the plan will pay 100% of the principal sum. The covered person must be hospitalized for treatment of the brain damage at least 7 of the first 30 days of the injury, and the brain damage must continue for at least 12 consecutive months.

  If, after 12 consecutive months of continuous brain damage, a physician determines that the covered person is permanently and totally disabled due to the brain damage, benefits will be paid in a lump sum at the beginning of the 13th month following the original date of the injury. The amount payable will not exceed the AD&D Principal Sum for the covered person whose covered accident is the basis for the claim.

- **Carjacking Benefits** - If the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a carjacking of an automobile that the covered person was operating, getting into or out of, or riding in as a passenger. A carjacking benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of $25,000.

  Verification of the carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

- **Felonious Assault and Violent Crime Benefit** - If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault as described below. A police report detailing the

felonious assault or violent crime must be provided before any benefits will be paid. The covered accident must occur while the covered person is on the business or premises of the Employer.

To qualify for benefit payment, the covered accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

The insurance company will pay a hospital stay benefit, subject to the following conditions and exclusions, when the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

1. the covered person is covered for hospital stay benefits under this Policy;
2. the hospital stay begins within 30 days of the violent crime/felonious assault;
3. the hospital stay is at the direction and under the care of a Physician;
4. the covered person provides proof satisfactory to New York Life Group Benefit Solutions that his/her hospital stay was necessitated to treat covered injuries sustained in a covered accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the covered person's insurance is in effect

A felonious assault/violent crime benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of $25,000 as well as a hospital stay benefit of $100 per day to a maximum benefit period of 365 days per hospital stay, per covered accident.

- **Exposure and Disappearance Coverage** - If a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident benefits for Accidental Death and Dismemberment will be payable.

  If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the covered person was riding in the course of a trip which would otherwise be covered, it will be presumed that the covered person's death resulted directly and independently of all other causes from a covered accident.

- **Home Alterations and Vehicle Modifications** — If a covered person suffers a covered loss, other than a loss of life, due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of $10,000, for home alterations and vehicle modifications to accommodate the participant's injury.

  This benefit will be payable if all of the following conditions are met:
  1. Prior to the date of the Covered Accident causing such Covered Loss, the Covered Person did not require the use of any adaptive devices or adaptation of residence and/or vehicle;
  2. As a direct result of such Covered Loss, the Covered Person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle;
  3. The Covered Person requires home alteration or vehicle modification within one year of the date of the Covered Accident

- **Monthly Coma Benefit** — If an employee is in a coma for at least 31 consecutive days as a result of an accident, a monthly coma benefit of 1% of the principal sum will be paid. This benefit will be paid until the employee's recovery, the 11th month of payment, or the employee's death, whichever is earliest.

  If the employee dies while in a coma or remains comatose after 11 months of benefit payments, the plan will pay a lump sum to the employee's beneficiary equal to the principal sum.

- **Owned Aircraft Coverage –** If the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by Leidos, Inc. or any of its subsidiaries or affiliates benefits will be payable.

- **Pilot Coverage –** If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs while the covered person is flying as a licensed pilot or member of the crew of an aircraft the accidental death and dismemberment benefit will be payable if the covered person meets all of the following requirements:
  1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by New York Life Group Benefit Solutions;
  2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by New York Life Group Benefit Solutions;

3. completes and maintains a combined minimum of 200 hours of military, private or professional logged flight hours;
4. is flying as a pilot or member of the crew of an Aircraft for which he is qualified and is on a list of eligible Aircraft maintained by the Subscriber, including a substitute Aircraft with no greater seating capacity while a listed Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction; or
5. is flying as a pilot or member of the crew of an Aircraft that is not owned, leased, operated or controlled by the Policyholder, Subscriber
6. is not giving or receiving flight instruction

- **Rehabilitation** — If a covered person suffers a covered loss due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of $10,000, for covered rehabilitative expenses. The covered person must require rehabilitation within two years of the covered loss.

- **Seat Belt(s) and Airbag Benefit** — If an employee dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile and he or she was wearing a seat belt, New York Life Group Benefit Solutions will pay a seat belt benefit to the designated beneficiary.

  The seat belt benefit will be at least $1,000, to a maximum of 25% of the employee's benefit or $25,000, whichever is less. An employee's beneficiary will receive the seat belt benefit if:
  1. The automobile the employee was driving/riding in was equipped with seat belts;
  2. The seat belt(s) was in actual use and properly fastened at the time of the covered accident; and
  3. The position of the seat belt(s) was certified in the official report of the covered accident or by the investigating officer. A copy of the police accident report must be submitted with the claim. If certification is not available but it is clear that the employee was properly wearing a seat belt, New York Life Group Benefit Solutions will pay the additional benefit. If, however, certification is not available and it is not certain that the employee was wearing a seat belt, then the benefit will be fixed at $1,000.

  Additionally, New York Life Group Benefit Solutions will pay an additional 10% of the employee's, benefit, to a maximum of $12,500, if a seat belt benefit is payable to him or her, and he or she was positioned in a seat that was protected by a properly functioning, original, factory-installed supplemental restraint system (airbag) that inflates on impact.

  Verification of the proper inflation of the supplemental restraint system at the time of impact must be part of the official accident report or be certified, in writing, by the investigating officers.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highway of any state or country. Automobiles include but are not limited to sedans, station wagons, sport utility vehicles, Jeeps, pickups, vans, campers or motor homes. Automobiles do not include mobile homes or motor vehicles used for mass or public transportation.

No benefit will be paid if the accident causing the employee's death occurred as a result of participation in a race, or a speed or endurance test.

- **Secure Travel** — New York Life Group Benefit Solutions Secure Travel is a comprehensive worldwide travel assistance program including pre-trip planning, assistance while traveling and emergency assistance. All of the program services are available when the covered person is traveling 100 miles or more from home. Services for medically necessary transport, return of dependent children, return of a traveling companion, visit of a family member/friend and repatriation of remains are covered by the program. Expenses for local ambulance or medical care are not covered under the program.

- **Terrorism Benefits** — If a covered person suffers a covered loss caused directly and independently of all other causes while the victim of a Terrorist Act the amount payable is the Principal Sum multiplied by the percentage of the covered loss.

  "Act of terrorism" refers to a hostile or violent act carried out by a group of persons having political, military or territorial goals, but who are not operating on behalf of a sovereign state. Their purpose is to compel an act or omission by any other person or any government entity.

- **War Risk Benefits** — If a covered person suffers a covered loss of life or dismemberment due to war or an act of war, whether declared or undeclared, and such loss occurs within 365 days of the covered accident, benefits are payable. For more information about these benefits and any provisions, refer to the plan's certificate of coverage.

  War risk benefits do not apply if the loss occurs in the United States or in any nation in which the covered person is a citizen.

Limitations and Exclusions

Basic AD&D Insurance will not pay benefits for death or dismemberment resulting directly or indirectly from:

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;

2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface as follows:
    a. being flown by the covered person or in which the covered person is a member of the crew;
    b. being used for crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, racing, stunt or acrobatic flying; or
    c. an ultra-light or glider;
    d. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. Travel in any aircraft owned, leased or controlled by Leidos, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Leidos if the Aircraft may be used as Leidos wishes for more than 10 straight days, or more than 15 days in any year;
8. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. A covered accident that occurs while engaged in the activities of active-duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Only one amount, the largest to which the employee is entitled, will be payable for all losses resulting from one covered accident.

Voluntary Accidental Death and Dismemberment (VAD&D) Insurance Coverage

There are two types of coverage under VAD&D Insurance:

- Employee coverage, which covers the employee only; and
- Family coverage, which covers the employee, the employee's spouse or registered domestic partner and/or their eligible dependent children.

Employees pay the full cost of coverage of any VAD&D Insurance, which they purchase on a pre- tax basis.

How Voluntary Accidental Death and Dismemberment (VAD&D) Insurance Works

Employee Coverage

Class	Voluntary AD&D Insurance Benefit
Class 1 – All active regular full-time benefit-eligible Employees of Leidos Inc. working a minimum of 30 hours per week or a regular part-time benefit-eligible Employee scheduled to work between 12 and 30 hours per week.	• Employees can purchase VAD&D Insurance in increments beginning at 0.5 times annual compensation, up to 10 times annual compensation to a maximum of $1,000,000. • Coverage is rounded to the next higher $1,000 if not already a multiple of $1,000. • Age reduction does not apply.

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the work performed as of the date of loss. It includes earnings received as commissions, but does not include earnings received as bonuses, overtime pay or other extra compensation.

Annual Compensation includes: A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid. ***Commissions*** will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Dependent Coverage

Under the VAD&D Plan, employees can purchase VAD&D for his or her eligible dependents, including spouse or registered domestic partner, the employee’s natural child(ren), legally adopted child(ren), child(ren) placed with the employees for adoption prior to legal adoptions[1] and the employee’s stepchild(ren)[2] and domestic partner’s child(ren)[2].

Coverage for each dependent is equal to a percentage of an employee's VAD&D Insurance coverage amount as follows:

Dependent Coverage		
Eligible Dependent	**Percentage of Employee Coverage**	**Maximum Dependent Coverage**
Spouse or Registered Domestic Partner Only *(No eligible children)*	60%	$500,000
Spouse or Registered Domestic Partner and Child(ren)		
• Spouse or Registered Domestic Partner	50%	$500,000
• Each Child	10%	$50,000
Child(ren) Only *(No eligible spouse or domestic partner)*	25%	$50,000

[1] A child placed with an employee for adoption prior to legal adoption is considered a qualified dependent from the date of placement for adoption.
[2] To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.

Schedule of Benefits

Voluntary Accidental Death and Dismemberment (VAD&D) Insurance Schedule of Benefits	
Covered Loss: *	**Benefit Received:**
• Life • Two or more hands or feet • One hand or one foot and sight in one eye • Both upper and lower limbs (quadriplegia)** • Speech and hearing in both ears	100% of the principal sum
• One member (uniplegia) • Both lower limbs (paraplegia)** • Upper and lower limbs on one side of the body (hemiplegia)** • Speech • Hearing in both ears	50% of the principal sum
• Thumb and index finger of the same hand • All four fingers of the same hand • All toes of the same foot	25% of the principal sum

*A covered person's loss must occur within 365 days of the date of the accident. "Member" means hand, foot or eye. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total, permanent and irrevocable loss by natural, surgical or artificial means. "Loss of speech" means total, permanent and irrevocable loss of audible communication. "Loss of hearing" means total and permanent loss of hearing in both ears which cannot be corrected by any means. "Loss of a thumb and index finger" means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

** These injuries - or paralyses - mean the loss of use, without severance, of a limb. Such a loss must be determined by a doctor to be complete and not reversible.

If more than one loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest will be paid.

Additional Benefits

VAD&D Insurance also pays additional benefits, including:

- **Accidental Burn and Disfigurement Benefit** - If a covered person suffers a covered injury that leaves him/her disfigured, and that covered injury resulted directly and independently of all other causes from a covered accident, and the disfigurement satisfies the following conditions, then an accidental burn and disfigurement benefit will be paid.
  1. reconstructive or cosmetic surgery is required to restore the employee's physical abilities or correct Disfigurement, and must be performed within twelve months of the covered accident;
  2. a Physician must determine that the burn satisfies all of the following:
     a. involves the minimum percentage shown below;
     b. be classified as shown below; and
     c. results in disfigurement or loss of physical abilities.
        - 75-100% Body Disfigurement 100% of the Principal Sum
        - 50-74% Body Disfigurement 50% of the Principal Sum
        - 25-49% Body Disfigurement 10% of the Principal Sum
        - Burn Classification Third Degree

  For purposes of this benefit: **Disfigurement or Disfigured** means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- **Bereavement/Trauma Counseling** — If a covered person suffers a covered loss, the plan will pay a benefit for bereavement and trauma counseling equal to $150 per session for a maximum of 10 sessions. The covered person and/or his or her immediate family members are eligible.

- **Brain Damage** — If a covered person becomes brain damaged within 30 days and as a result of a covered accident, the plan will pay 100% of the principal sum. The covered person must be hospitalized for treatment of the brain damage at least 7 of the first 30 days of the injury, and the brain damage must continue for at least 12 months.

  If, after 12 months of continuous brain damage, a physician determines that the covered person is permanently and totally disabled due to the brain damage, benefits will be paid in a lump sum at the beginning of the 13th month following the original date of the injury.

- **Carjacking Benefits -** If the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a carjacking of an automobile that the employee was operating, getting into or out of, or riding in as a passenger. A carjacking benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of $25,000.

  Verification of the carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

- **Child Care Center Benefit** — If a covered person dies as the result of a covered accident, the plan will pay childcare center benefits for each covered dependent under age 13 equal to 10% of the employee's benefit amount, to a maximum of $5,000 a year. The plan will pay benefits for five consecutive years, or until the child turns age 13, whichever happens first. Toreceive benefits, the covered child must be enrolled in a childcare center on the date of the covered person's death or enrolls within 365 days after the covered person's date of death.

  If, at the time of the accident, coverage for a dependent child is in force but there is no dependent who qualifies, the plan will pay a benefit of $1,500 to the covered person's beneficiary.

  "Childcare center" means a facility that is licensed; is operated according to law, including laws and regulations applicable to childcare facilities; and provides care and supervision for children in a group setting on a regular daily basis. It does not include hospitals, the child's home or care provided during normal school hours while a child is attending grades one through twelve.

- **Common Accident Benefit** — If a covered person and his or her covered spouse or registered domestic partner die as a result of a common accident directly and independently of all other causes from a common accident and are survived by one or more dependent children, the spouse's or registered domestic partner's benefit amount will increase to 100% of the employee's principal sum, to a maximum of $500,000.

  "Common accident" means the same or separate accidents occurring within the same 24-hour period.

- **Exposure and Disappearance Coverage** - If a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident benefits for Accidental Death and Dismemberment will be payable.

If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the covered person was riding in the course of a trip which would otherwise be covered, it will be presumed that the covered person's death resulted directly and independently of all other causes from a covered accident.

- **Felonious Assault and Violent Crime Benefit -** If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The covered accident must occur while the covered person is on the business or premises of the Employer.

  To qualify for benefit payment, the covered accident must occur during any of the following:
  1. actual or attempted robbery or holdup;
  2. actual or attempted kidnapping;
  3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

  The insurance company will pay a hospital stay benefit, subject to the following conditions and exclusions, when the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault if all of the following conditions are met:
  1. the covered person is covered for hospital stay benefits under this Policy;
  2. the hospital stay begins within 30 days of the violent crime/felonious assault;
  3. the hospital stay is at the direction and under the care of a Physician;
  4. the covered person provides proof satisfactory to New York Life Group Benefit Solutions that his/her hospital stay was necessitated to treat covered injuries sustained in a covered accident caused solely by a violent crime or felonious assault;
  5. the Hospital Stay begins while the covered person's insurance is in effect.

  A felonious assault/violent crime benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of $25,000 as well as a hospital stay benefit of $100 per day to a maximum benefit period of 365 days per hospital stay, per covered accident.

- **Home Alterations and Vehicle Modifications** — If a covered person suffers a covered loss, other than a loss of life, due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of $10,000, for home alterations and vehicle modifications to

accommodate the covered person's injury.

- **Increased Dependent Child Dismemberment Benefits** — If a covered person's covered child suffers a covered accidental injury, the plan will pay 100% multiplied by the percentage of the Child's Principal Sum applicable to the covered loss, to a maximum of $100,000. If the child subsequently dies within 365 days of the same covered accident, the loss of life benefit will not be reduced by the dismemberment benefit received under the increased dependent dismemberment benefit.

  If a covered child sustains more than one covered loss from a single covered accident, the plan will pay double the benefit amount only for the largest amount to which the child is entitled.

- **Insurance Continuation Expense Benefit -** The insurance provider will pay 3% of the Employee's Principal Sum, up to a $3,000 Maximum Benefit per year for up to a Maximum Benefit Period of 3 years, if a surviving covered Spouse or Registered Domestic Partner or a surviving covered Dependent Child(ren) elects to continue group medical and dental insurance provided by the Employer of an Employee who died, subject to all of the following conditions and exclusions:
  1. the covered Employee's death results directly and independently of all other causes from a Covered Accident;
  2. the covered Employee is survived by a covered Spouse or covered Dependent Child(ren) who were insured under this Policy on the date the Employee died;
  3. the covered Spouse or covered Dependent Child(ren) is also covered under a medical or dental plan sponsored by the Employer at the time of the covered Employee's death;
  4. the covered Spouse or covered Dependent Child(ren) notifies Us of his or her election, within 60 days of the covered Employee's death, to continue his or her ting coverage under group insurance plans sponsored by the Subscriber as permitted by state or federal continuation law.

  This benefit, payable annually, equals premiums required to continue insurance described above, as long as the total of Insurance Continuation Benefits paid for a surviving Spouse or Registered Domestic Partner and/or Dependent Child(ren) does not exceed the Maximum Benefit. The benefit will be paid at the end of each year during which medical and dental insurance is continued, if this insurance provider receives a request for reimbursement and proof of premiums paid during that year. Benefits will continue to be paid until the earliest of the following dates:
  1. the date a surviving Spouse or Registered Domestic Partner and/or surviving Dependent

Child(ren) is no longer eligible to continue medical and dental insurance coverage;
2. the date Insurance Continuation Expense Benefits paid total the Maximum Benefit; and
3. the end of the Maximum Benefit Period.

Benefits are payable to the surviving covered Spouse or Registered Domestic Partner, or the person who actually paid the premium on the surviving covered Spouse's or Registered Domestic Partner's or Dependent Child(ren)'s behalf, if other than the surviving covered Spouse or Registered Domestic Partner.

- **Monthly Coma Benefit** — If a covered person is in a coma for at least 31 consecutive days as a result of an accident, a monthly coma benefit of 1% of the principal sum will be paid. This benefit will be paid until the covered person's recovery, the 11th month of payment, or the covered person's death, whichever is earliest.

  If the covered person dies while in a coma or remains comatose after 11 months of benefit payments, the plan will pay a lump sum to the covered person's beneficiary equal to the principal sum.

- **Owned Aircraft Coverage** – If the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by Leidos, Inc. or any of its subsidiaries or affiliates benefits will be payable.

- **Pilot Coverage** – If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs while the covered person is flying as a licensed pilot or member of the crew of an aircraft the accidental death and dismemberment benefit will be payable if the covered person meets all of the following requirements:
  1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by New York Life Group Benefit Solutions;
  2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by New York Life Group Benefit Solutions;
  3. completes and maintains a combined minimum of 200 hours of military, private or professional logged flight hours;
  4. is flying as a pilot or member of the crew of an Aircraft for which he is qualified and is on a list of eligible Aircraft maintained by the Subscriber, including a substitute Aircraft with no greater seating capacity while a listed Aircraft is withdrawn from normal use due to breakdown, repair, servicing, loss or destruction; or

5. is flying as a pilot or member of the crew of an Aircraft that is not owned, leased, operated or controlled by the Policyholder, Subscriber.
6. is not giving or receiving flight instruction, or

- **Rehabilitation** — If a covered person suffers a covered loss due to an accident, the plan will pay a benefit equal to 20% of the principal sum, to a maximum of $10,000, for covered rehabilitative expenses. Rehabilitative expenses must be incurred within two years of the covered accident.
- **Seat Belt(s) and Airbag Benefit** — If a covered person dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile and he or she was wearing a seat belt, New York Life Group Benefit Solutions will pay a seat belt benefit to the designated beneficiary. The benefit will be at least $1,000, to a maximum of 25% of the covered person's benefit or $25,000, whichever is less. A covered person's beneficiary will receive the seat belt benefit if:
    - the automobile the covered person was driving/riding in was equipped with seat belt;
    - The seat belt(s) was in actual use and properly fastened at the time of the covered accident; and;
    - The position of the seat belt(s) was certified in the official report of the covered accident or by the investigating officer. A copy of the police accident report must be submitted with the claim. If certification is not available but it is clear that the covered person was properly wearing a seat belt, New York Life Group Benefit Solutions will pay the additional benefit. If, however, certification is not available and it is not certain that the covered person was wearing a seat belt, then the benefit will be fixed at $1,000.

In the case of a child, "seat belt" means a child restraint — as required by state law and approved by the National Highway Traffic Safety Administration — that is properly secured at the time of the accident and is being used as recommended by its manufacturer for children of like age and weight.

Additionally, the insurance provider will pay an additional 10% of the covered person's benefit, to a maximum of $12,500, if a seat belt benefit is payable to him or her, and he or she was positioned in a seat that was protected by a properly functioning, original, factory-installed supplemental restraint system (airbag) that inflates on impact.

Verification of the proper inflation of the supplemental restraint system at the time of impact must be part of the official accident report or be certified, in writing, by the investigating officers.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels

that is of a type both designed and required to be licensed for use on the highway of any state or country. Automobiles include but are not limited to sedans, station wagons, sport utility vehicles, Jeep, pickups, vans, campers or motor homes. Automobiles do not include mobile homes or motor vehicles used for mass or public transportation.

No benefit will be paid if the accident causing the covered person's death occurred as a result of participation in a race, or a speed or endurance test.

- **Secure Travel** - New York Life Group Benefit Solutions Secure Travel is a comprehensive worldwide travel assistance program including pre-trip planning, assistance while traveling and emergency assistance. All of the program services are available when the covered person is traveling 100 miles or more from home. Services for medically necessary transport, return of dependent children, return of a traveling companion, visit of a family member/friend and repatriation of remains are covered by the program. Expenses for local ambulance or medical care are not covered under the program.

- **Special Education Benefit** — If a covered person elects family coverage, VAD&D Insurance will pay an additional benefit for education assistance, as follows:
  - For a covered spouse or registered domestic partner: The plan will pay an additional 10% of the employee's principal sum, to a maximum of $10,000, for up to three years when the spouse or registered domestic partner enrolls in any accredited school within one year of the employee's death. Enrolling in school must be for the purpose of retraining or refreshing skills needed for employment. The spouse or registered domestic partner must incur expenses that must be paid directly to, or approved and certified by, the same school.
  - For covered dependent children: The plan will pay an additional 10% of the employee's principal sum, to a maximum of $10,000, for up to four consecutive years when the child enrolls as a full-time student before age 26. The school must be a college, university, or other institute of higher education. The expenses of higher education should be related to tuition, fees, books, room and board, and transportation, and must be paid directly to, or approved and certified by, the same school.

  If the employee does not have a qualifying dependent for the Education and Training Benefit, $1,000 will be paid to the employee's beneficiary.

- **Terrorism Benefits** — If a covered person suffers a covered loss caused directly and independently of all other causes while the victim of a Terrorist Act the amount payable is the Principal Sum multiplied by the percentage applicable to the covered loss.

"Act of terrorism" refers to a hostile or violent act carried out by a group of persons having political, military or territorial goals, but who are not operating on behalf of a sovereign state. Their purpose is to compel an act or omission by any other person or any government entity.

Limitations and Exclusions

VAD&D Insurance will not pay benefits if a loss results, directly or indirectly, from or is caused by:

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface as follows:
    a. being flown by the covered person or in which the covered person is a member of the crew;
    b. being used for crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, racing, stunt or acrobatic flying; or
    c. an ultra-light or glider;
    d. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. Travel in any aircraft owned, leased or controlled by Leidos, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Leidos if the Aircraft may be used as Leidos wishes for more than 10 straight days, or more than 15 days in any year;
8. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. A covered accident that occurs while engaged in the activities of active-duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Business Travel Accident (BTA) Insurance

Business Travel Accident Insurance provides additional coverage for eligible employees traveling on Leidos-related business. Any benefits paid are in addition to Basic Term Life Insurance and Basic AD&D Insurance benefits.

How Business Travel Accident Insurance Works

Eligible employees automatically receive BTA Insurance coverage.

Class	Business Travel Accident Coverage
Class 1 – All active regular full-time benefit eligible Employees of Leidos Inc. working a minimum of 30 hours per week or a regular part-time benefit eligible Employee scheduled to work between 12 and 30 hours per week for the Employer.	Employees receive coverage, or a principal sum, equal to three times their annual compensation, to a maximum of $500,000. Coverage is rounded to the next higher $1,000 if not already a multiple of $1,000.
Class 4 - All Employees of Leidos, Inc. classified as a Consultant. A Consultant is an Employee who performs the duties of a salaried employee; works on an on-call, sporadic basis; and does not meet the Internal Revenue Service (IRS) standards for independent contractor/consultant status. Working hours must total at least 180 and not exceed 1,860 in any 12-month period.	Employees receive coverage, or a principal sum, equal to $300,000.

Leidos pays the full cost of coverage.

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the worked performed as of the date of loss. It does not include earnings received as bonuses, overtime pay and other extra compensation. ***Commissions*** will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Employees Ages 70+

Class	Business Travel Accident Age Reduction Schedule
Class 1 – All active regular full-time benefit eligible Employees of Leidos Inc. working a minimum of 30 hours per week or a regular part-time benefit eligible Employee scheduled to work between 12 and 30 hours per week for the Employer.	Age reduction does not apply.
Class 4 - All Employees of Leidos, Inc. classified as a Consultant. A Consultant is an Employee who performs the duties of a salaried employee; works on an on-call, sporadic basis; and does not meet the Internal Revenue Service (IRS) standards for independent contractor/consultant status. Working hours must total at least 180 and not exceed 1,860 in any 12-month period.	Age reduction does not apply.

Schedule of Benefits

In the event of an employee's death while traveling on Leidos-related business, benefits will be paid to the designated beneficiary. If an employee accidentally suffers dismemberment, the benefits will be paid directly to the employee. The chart below shows the benefit payments under the Business Travel Accident Insurance plan:

Business Travel Accident Insurance Schedule of Benefits	
Covered Loss*:	**Benefit Received:**
• Life • Two or more members • One hand or one foot and sight in one eye • Both upper and lower limbs (quadriplegia)** • Speech and hearing in both ears	100% of the principal sum
• One member • Both lower limbs (paraplegia)** • Upper and lower limbs on one side of the body (hemiplegia)** • Speech • Hearing in both ears	50% of the principal sum
• Thumb and index finger of the same hand • All four fingers of the same hand • All toes of the same foot	25% of the principal sum

*An employee's loss must occur within 365 days of the date of the accident. "Member" means hand, foot or eye. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total, permanent and irrevocable loss by natural, surgical or artificial means. "Loss of speech" means total, permanent and irrevocable loss of audible communication. "Loss of hearing" means total and permanent loss of hearing in both ears which cannot be corrected by any means. "Loss of a thumb and index finger" means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

**These injuries — or paralyses — mean the loss of use, without severance, of a limb. Such a loss must be determined by a doctor to be complete and not reversible.

If more than one loss is sustained by an Insured Person as a result of the same accident, only one amount, the largest will be paid.

Defining Leidos-Related Travel

"Leidos-related travel" means that the employee is traveling on a required business trip away from where he or she is permanently assigned to work. Coverage will begin from the start of a planned trip. The employee may leave from his or her place of work, home or another location. Coverage ends upon the employee's return to his or her place of work or home, whichever occurs first. These benefits are subject to the conditions, limitations and exclusions of the policy.

Business-related travel does not include any commuting travel or time the employee is regularly commuting directly from his or her place of work to home, or vice versa.

Additional Benefits

Business Travel Accident Insurance also pays additional benefits, including:

- **Accidental Burn and Disfigurement Benefit –** If a covered person suffers a covered injury that leaves him/her disfigured, and that covered injury resulted directly and independently of all

  other causes from a covered accident, and the disfigurement satisfies the following conditions, then an accidental burn and disfigurement benefit will be paid.
  1. reconstructive or cosmetic surgery is required to restore the employee's physical abilities or correct Disfigurement, and must be performed within twelve months of the covered accident;
  2. a Physician must determine that the burn satisfies all of the following:
     a. involves the minimum percentage shown below;
     b. be classified as shown below; and
     c. results in disfigurement or loss of physical abilities.
        - 75-100% Body Disfigurement 100% of the Principal Sum
        - 50-74% Body Disfigurement 50% of the Principal Sum
        - 25-49% Body Disfigurement 10% of the Principal Sum
        - Burn Classification Third Degree

  For purposes of this benefit: **Disfigurement or Disfigured** means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- **Brain Damage** — If a covered person becomes brain damaged within 30 days and as a result of a covered accident, the plan will pay 100% of the principal sum. The covered person must be hospitalized for treatment of the brain damage at least 7 of the first 30 days of the injury, and the brain damage must continue for at least 12 months.

  If, after 12 months of continuous brain damage, a physician determines that the covered person is permanently and totally disabled due to the brain damage, benefits will be paid in a lump sum at the beginning of the 13th month following the original date of the injury.

- **Carjacking Benefit –** If the covered employee suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a carjacking of an automobile that the employee was operating, getting into or out of, or riding in as a passenger. A carjacking benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of $25,000.

Verification of the Carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

- **Exposure and Disappearance Coverage** - If a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident benefits for Accidental Death and Dismemberment will be payable.

  If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the covered person was riding in the course of a trip which would otherwise be covered, it will be presumed that the covered person's death resulted directly and independently of all other causes from a covered accident.

- **Felonious Assault and Violent Crime Benefit –** If a covered employee suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The covered accident must occur while the covered employee is on the business or premises of the Employer.

  To qualify for benefit payment, the covered accident must occur during any of the following:
  1. actual or attempted robbery or holdup;
  2. actual or attempted kidnapping;
  3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

  The insurance company will pay a hospital stay benefit, subject to the following conditions and exclusions, when the covered employee suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault if all of the following conditions are met:
  1. the covered employee is covered for hospital stay benefits under this Policy;
  2. the hospital stay begins within 30 days of the violent crime/felonious assault;
  3. the hospital stay is at the direction and under the care of a Physician;
  4. the covered employee provides proof satisfactory to New York Life Group Benefit Solutions that his/her hospital stay was necessitated to treat covered injuries sustained in a covered accident caused solely by a violent crime or felonious assault;
  5. the Hospital Stay begins while the covered employee's insurance is in effect.

A felonious assault/violent crime benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of $25,000 as well as a hospital stay benefit of $100 per day to a maximum benefit period of 365 days per hospital stay, per covered accident.

- **Home Alterations and Vehicle Modifications** — If a covered person suffers a covered loss, other than a loss of life, due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of $10,000, for home alterations and vehicle modifications to accommodate the participant's injury.

- **Monthly Coma Benefit** — If an employee is in a coma for at least 31 consecutive days as a result of an accident, a monthly coma benefit of 1% of the principal sum will be paid. This benefit will be paid until the employee's recovery, the 11th month of payment, or theemployee's death, whichever is earliest.

  If the employee dies while in a coma or remains comatose after 11 months of benefit payments, the plan will pay a lump sum to the employee's beneficiary equal to the principal sum.

- **Owned Aircraft Coverage** – If the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs during travel or flight in, including getting in or out of, any Aircraft that is owned, leased, operated or controlled by Leidos, Inc. or any of its subsidiaries or affiliates benefits will be payable.

- **Personal Deviation** — If an employee suffers a loss of life or dismemberment due to an accident while outside the employee's city of permanent assignment which occurs seven days before or seven days after a scheduled business trip, and such loss occurs within 365 days of the covered accident, benefits are payable. For more information about these benefits andany provisions, refer to the plan's certificate of coverage.

- **Pilot Coverage** – If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs while the covered person is flying as a licensed pilot or member of the crew of an aircraft the accidental death and dismemberment benefit will be payable if the covered person meets the following requirements:

  1. has submitted a completed Pilot Data History form and been accepted for Pilot Coverage by New York Life Group Benefit Solutions;
  2. maintains the same level of qualification stated on the Pilot Data History form submitted to and approved by New York Life Group Benefit Solutions;

3. is flying as a pilot or member of the crew of an Aircraft travelling on or transacting business for the Policyholder. All trips must have been authorized in advance by the Policyholder;
4. is flying as a pilot or member of the crew of an Aircraft on a list of eligible Aircraft maintained by the Policyholder;
5. is not giving or receiving flight instruction.

- **Rehabilitation** — If a covered person suffers a covered loss due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of $10,000, for covered rehabilitative expenses. Rehabilitative expenses must be incurred within two years of the covered accident.

- **Seat Belt(s) and Airbag Benefit** — If an employee dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile and he or she was wearing a seat belt, New York Life Group Benefit Solutions will pay a seat belt benefit to the designated beneficiary.

  The benefit will be at least $1,000, to a maximum of 25% of the covered person's benefit or $25,000, whichever is less. An employee's beneficiary will receive the seat belt benefit if:
  a. The automobile the employee was driving/riding in was equipped with seat belts;
  b. The seat belt(s) was in actual use and properly fastened at the time of the covered accident; and
  c. The position of the seat belt(s) was certified in the official report of the covered accident or by the investigating officer. A copy of the police accident report must be submitted with the claim. If certification is not available but it is clear that the employee was properly wearing a seat belt, New York Life Group Benefit Solutions will pay the additional benefit. If, however, certification is not available and it is not certain that the employee was wearing a seat belt, then the benefit will be fixed at $1,000.

  Additionally, New York Life Group Benefit Solutions will pay an additional 10% of the employee's benefit, to a maximum of $12,500, if a seat belt benefit is payable to him or her, and he or she was positioned in a seat that was protected by a properly functioning, original, factory-installed supplemental restraint system (airbag) that inflates on impact.

  Verification of the proper inflation of the supplemental restraint system at the time of impact must be part of the official accident report or be certified, in writing, by the investigating officers.

  "Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highway of

any state or country. Automobiles include but are not limited to sedans, station wagons, sport utility vehicles, Jeeps, pickups, vans, campers or motor homes. Automobiles do not include mobile homes or motor vehicles used for mass or public transportation.

No benefit will be paid if the accident causing the employee's death occurred as a result of participation in a race, or a speed or endurance test.

- **Secure Travel** —New York Life Group Benefit Solutions Secure Travel is a comprehensive worldwide travel assistance program including pre-trip planning, assistance while traveling and emergency assistance. All of the program services are available when the covered person is traveling 100 miles or more from home. Services for medically necessary transport, return of dependent children, return of a traveling companion, visit of a family member/friend and repatriation of remains are covered by the program. Expenses for local ambulance or medical care are not covered under the program.

- **War Risk Benefits** — If an employee suffers a loss of life or dismemberment due to war or an act of war, whether declared or undeclared, and such loss occurs within 365 days of the covered accident, benefits are payable. For more information about these benefits and any provisions, refer to the plan's certificate of coverage.

  War risk coverage does not apply if the loss occurs in the United States or in any nation in which the covered employee is a citizen.

Limitations and Exclusions

Business Travel Accident Insurance will not pay benefits resulting from:

1. Intentionally self-inflicted Injury, suicide or any attempt while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface as follows:
   a. being flown by the covered person or in which the covered person is a member of the crew;
   b. being used for crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, racing, stunt or acrobatic flying; or
   c. an ultra-light or glider;
   d. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical

treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;

7. Travel in any aircraft owned, leased or controlled by Leidos, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Leidos if the Aircraft may be used as Leidos wishes for more than 10 straight days, or more than 15 days in any year;
8. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. A covered accident that occurs while engaged in the activities of active-duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Only one amount, the largest to which the employee is entitled, will be payable for all losses resulting from one covered accident.

The total amount the plan will pay as the result of any one accident is $20 million. If multiple employees are involved in a single accident and their claims for benefits total more than $20 million, the employee's benefit will be determined using the following formula: $20 million divided by the total amount claimed by all employees. The result of applying this formula will be a percentage, and the employee's benefit will be this percentage of the amount he or she originally claimed.

Naming a Beneficiary for Life and Accident Insurance

An employee can name any person or persons* as beneficiary(ies) for his or her Basic Term Life Insurance, Group Universal Life (GUL) Insurance, Basic AD&D Insurance, Voluntary AD&D Insurance and Business Travel Accident (BTA) Insurance by accessing the Leidos Human Resources System, Workday. If the employee wishes to name a minor (under age 18 in most states) or a trust as beneficiary, the employee should obtain legal advice, as special rules may apply.

The beneficiary the employee designates for these coverages may be different for each plan for which Leidos offers. The employee may change his or her beneficiary(ies) at any time via Workday.

If you fail to designate your beneficiaries with Leidos, your benefits will be paid based on the preferential beneficiary designation clause at the time of a claim. This means that any amount of insurance for

which there is no beneficiary at your death will be payable to the first of the following:

- Your surviving spouse;
- Your surviving child(ren), in equal shares or if none;
- Your surviving parents, in equal shares or if none;
- Your surviving siblings, in equal shares or if none;
- Your estate

The employee is automatically the beneficiary for any covered dependents.

**Community Property Laws – If you are married and reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin) and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.*

Continuing Life and Accident Insurance After Coverage Ends

When an employee leaves Leidos or transfers to an ineligible class, he or she may be able to continue his or her life and/or AD&D coverage through individual policies.

Basic Term Life Insurance

An employee may port or convert his or her Basic Term Life Insurance coverage to an individual life insurance policy issued by Prudential Insurance Company of America*. The employee must make this election within 31 days of losing coverage under the Leidos group plan. No medical examination or other EOI will be required for conversion. However, EOI is required for portability. The employee pays the cost of coverage directly to the insurer.

**Portability is not available if coverage ends due to retirement or disability or for Basic Dependent Life coverage.*

Group Universal Life (GUL) Insurance

An employee may continue his or her GUL coverage by making an election within 31 days after his or her last day of employment with Leidos. No medical examination or other EOI is required for continuation of GUL.

Optional Dependent Life Insurance

An employee may port or convert his or her spouse's or registered domestic partner's coverage, as well as any child life coverage, to individual policies. An employee must port his or her life insurance in order for any dependents to be eligible to port. The exceptions to this rule are death of employee or divorce.

In the event of the employee's death, both the spouse life and child life can be ported. In the event of divorce, the spouse life can be ported.

Spouses or Registered Domestic Partners may continue Spouse Life coverage up to the amount the individual was eligible for prior to losing coverage.

In addition, a dependent age 26 years or older who loses eligibility for Child Life Insurance may continue all or a portion of their coverage. To continue Dependent Life Insurance, you must complete an application and apply within 31 days of your coverage termination. To obtain an application, please contact Prudential at 1-800-778-3827. Please provide the contract number 52844 when calling. If you are using a telecommunications device for the hearing impaired (TDD), please call 1–800-496-1214. Representatives are available to assist you Monday through Friday between 8:00 a.m. and 8:00 p.m.

Separate certificates of insurance will be issued for an employee's spouse or registered domestic partner and/or dependents. The employee and/ or dependent pay the full cost of any continued coverage directly to The Prudential Insurance Company of America.

Basic AD&D Insurance and VAD&D Insurance

If an employee is age 69 or younger, their Basic AD&D Insurance and VAD&D Insurance, as well as the policies covering the employee's dependents, can be converted to an individual policy through New York Life Group Benefit Solutions. The employee pays the full cost of coverage directly to New York Life Group Benefit Solutions.

Life and Accident Insurance Continuation, Portability, and/or Conversion

The information on this page will help you determine which life insurance plans you can continue (port), and which ones are eligible for conversion only. On the matrix below select the scenario that most closely describes your situation and read the options that are available to you.

Continuation/Conversion Matrix

Life and Accident Insurance Continuation/Conversion Matrix					
Reason Coverage Ends	**Group Term Life**	**Group Universal Life**	**Optional Dependent Life**	**Basic AD&D**	**Voluntary AD&D**
	Portability*	Continuation**	Portability	Conversion	Conversion
Employee Terminates Employment	Yes, to age 80^	Yes, to age 100	Yes, to age 80	Yes, to age 70	Yes, to age 70
Employee loses eligibility and is no longer in an eligible class under the group policy	Yes, to age 80^	Yes, to age 100	Yes, to age 80	Yes, to age 70	Yes, to age 70
Spouse no longer eligible due to divorce/legal separation	N/A	N/A	Yes, to age 80	N/A	N/A
Spouse loses coverage due to employee reaching age 70	N/A	N/A	N/A	N/A	Yes, to age 70
Child loses coverage due to ineligibility (No longer a dependent child of the employee)	No	N/A	Yes, able to convert policy	N/A	Yes
Employee loses a portion of coverage and still in an eligible class under the group policy due to:					
• **Reduction in hours**	No	No	No	No	No
• **Age Reduction Schedule (35% at age 70)**	No	No	No	No	No

* If you are losing coverage due to retirement or disability, you will be offered the option to convert your basic life coverage.
^ Coverage is limited to age 80

** Conversion option is also available for GUL plan. For more information, contact Prudential at 1-877-889-2070

Important Information for Basic and Dependent Life Insurance Portability

1. The cost to port the life insurance products is based on the insurance company's standard group rates and will differ from the rate employees currently pay.
2. An insured will remit premiums directly to The Prudential Insurance Company of America.
3. Ported insurance is a group term policy issued by The Prudential Insurance Company of America.
4. Age Restrictions: Ported life insurance terminates at the age of 80.
5. Portability application must be submitted in writing within 31 days of the date coverage ends.
    a. Employee portion of application should be completed and submitted to the address indicated on the form by the individual seeking coverage.
    b. The insurance company will contact Leidos for the employer data.
    c. The insurance company will issue new policy(ies), which becomes effective 31 days after active coverage ends.
    d. EOI is not required if life insurance is continued within the specified time period.

Important Information for Group Universal Life Insurance Continuation

1. The cost to continue the GUL insurance for retirees and employees on a leave of absence is the same as active employee rates. For terminated employees, the cost is based on the insurance company's standard group rates and will differ from the rate employees currently pay.
2. An insured will remit premiums directly to Mercer Health & Benefits Administration, LLC.
3. Continued insurance is a whole life policy issued by The Prudential Insurance Company of America.
4. Continued GUL insurance terminates at the age of 100.
5. An application for Continuation must be submitted in writing within 31 days of the date coverage ends.
    a. The Continuation portion of application should be completed and submitted to the address indicated on the form by the individual seeking coverage.
    b. Mercer Health & Benefits Administration LLC will obtain the employer data from Leidos.
    c. The insurance company will issue new policy(ies), which becomes effective 31 days after active coverage ends.
    d. EOI is not required if life insurance is continued within the specified time period.

Important Information for Accident Insurance Conversion

An employee can convert group accident insurance to an individual policy without medical certification for themselves and their eligible family members. To convert a policy, an employee must be under age 70 and apply for conversion within that later of 62 days of the group insurance coverage end date or 31 days of the date of the conversion notification. In no event will an application be accepted beyond 105 days of the group insurance coverage end date. The converted policy will be effective on the day following the date

coverage ended under the group insurance policy or the date of the application, if later. The converted policy terminates at age 70.

Conversion/Continuation Forms

- **Group Term Life Conversion Form**
  This form should be completed if an employee would like to convert all or a portion of the terminating coverage to an individual policy (subject to conversion amount limitations).
- **Group Term Life Portability Form**
  This form should be completed if an employee would like to convert all or a portion of the terminating coverage to an individual policy (subject to conversion amount limitations).
- **Accidental Death and Dismemberment (AD&D) Conversion Form**
  This form should be completed if employee would like to convert all or a portion of the terminating coverage to an individual policy (subject to conversion amount limitations).

Filing Claims

If an employee or a covered dependent dies or is seriously injured, the appropriate insurance company should be notified immediately. Please contact Leidos Employee Services at AskHR@leidos.com or by phone at 855-553-4367, option 3 for assistance with filing a claim.

Basic Term Life, Dependent Life and GUL Insurance claims:
The Prudential Insurance Company of America
P.O. Box 8517
Philadelphia, PA 19176
1-888-257-0412 (phone)
1-888-227-6764 (fax)

AD&D claims:
New York Life Group Benefit Solutions - Life Claims
P.O. Box 223268
Pittsburg, PA 15222-0328
1-800-238-2125 (phone)
1-412-402-3506 (fax)

After receiving notification, the insurer will process the claim for payment of benefits. All claims for benefits must be made by filing a properly completed form. If the claim is for a death benefit, a death certificate must be furnished along with the claim form.

If a covered person has concerns about how a claim has been administered or wishes to appeal a claims decision, information on relevant procedures is available in the Claims Appeal and Review Procedures Under ERISA in the Plan Information section.

The Leidos Disability Program is designed to provide income in the event a participant becomes ill or disabled and is unable to work for an extended period of time. There are two components of the Disability Program:

- **Short-Term Disability** (STD)
- **Long-Term Disability** (LTD)

Important: This document provides only a summary of general plan provisions. Separate Plan Documents and Insurance Certificates are available from the Plan Administrators, which serve as the legal documents that govern these plans.

Short-Term Disability (STD)

If a participant is sick or injured and unable to work, he may receive benefits through Short -Term Disability (STD). Visit the *How Short-Term Disability Works (STD)* section to learn more.

- Disability Sick Leave (DSL)
- Voluntary Short-Term Disability Insurance (VSDI)
- Leidos California Voluntary Disability Plan (Leidos CA VDP)
- Other State-Mandated Short-Term Disability Plans and Medical Leave Programs:
  - California State Disability Insurance (CA SDI)*
  - Connecticut Paid Family and Medical Leave (CT PFML)
  - District of Columbia Universal Paid Family Leave (DC PFL)
  - Hawaii Temporary Disability Insurance (HI TDI)
  - Massachusetts Paid Family and Medical Leave (MA PFML)
  - New Jersey Temporary Disability Insurance (NJ TDI)
  - New York Disability Benefit Law (NY DBL)
  - Oregon Paid Family Leave Insurance (benefits begin 9/3/2023)
  - Puerto Rico Temporary Disability Insurance
  - Rhode Island State Temporary Disability Insurance (RI TDI)
  - Washington State Paid Family and Medical Leave (WA PFML)

* All Leidos, Inc. employees living in California are automatically covered by the Leidos California Voluntary Disability Plan (Leidos CA VDP). Employees working at Varec, Leidos Security Detection and Automation, Leidos Engineering, 1901 Group and Gibbs & Cox are covered by the State of California SDI program. If you are unsure which plan you participate in, contact Employee Services at 855-553-4367, option3 or email LeaveAdmin@leidos.com.

STD benefits may be paid for up to 180 days of continuous disability. The benefit amount is determined by the length of the disability, the participant's elected disability coverage and any state disability and medical leave benefits.

Below are some important terms used in describing how a participant is eligible to receive benefits through the disability plans:

- **Active Pay Status** — Employee receives pay for a normal scheduled day of work, including regular pay, comprehensive leave, bereavement, or jury duty benefits. Active pay status does not include employees who are on leave of absence, on whole-week voluntary or involuntary LWOP, or receiving disability benefits (DSL, CA VDP, VSDI, or LTD).

- **Claims Administrator** — The organization that is accountable for receiving the participant's application, determining which benefits are payable and ensuring that payments are made:
    - For DSL, VSDI and Leidos CAVDP, Sedgwick administers the plans.
    - For the Hawaii state disability plan, Life Insurance Company of North America (LINA), a New York Life company, administers the plan.

- For the California SDI, Connecticut, District of Columbia, Hawaii, Massachusetts, New Jersey, New York, Oregon, Puerto Rico, Rhode Island, and Washington state, the respective states administer the state disability and medical leave programs.

- **Hospital Confinement** — any 24-hour period of time, or any part thereof, for which a claimant is properly charged a full day's rate for room and board as a registered bed patient in a hospital, or in a nursing home as defined in Section 1395X of Title 42 of the United States Code. This includes hospital admission under inpatient status or observation status. Emergency Room Visit and Outpatient Surgery are excluded.

- **Physician** – Includes physicians and surgeons holding an M.D. or D.O. degree, physician's assistants (PA's), nurse practitioner's (NP's), psychologists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by state law and acting within the scope of their practice as defined by state law. For disability related to normal pregnancy or childbirth, medical certification may be provided by a midwife or nurse practitioner.

- **Psychologist** – a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure under applicable state law and acting within the scope of practice as defined by state law.

  Qualified Disability — A disability that has been certified by a physician or other health care provider, based on objective medical evidence, and subsequently reviewed and approved by the claims administrator. Each plan may have different definitions as to what

types of conditions are disabling (for example, some state plans differ from the private insurance plans). Keep in mind that not all disabilities will be approved.

In general, under most short-term disability plans, a participant is considered disabled when the participant:

- Is physically or mentally ill, or is injured and the condition prevents him or her from performing his or her regular work;
- Is under the regular and continuous care of a physician or other health care provider; and
- Is not performing work for any other employer, including self-employment.

Regardless of the plan, the participant maybe required to provide objective medical evidence to qualify for benefits. The claims administrator will determine the types of medical documentation needed and how frequently the documentation must be updated.

- **Recurring Disability—**Recurring Disability shall mean two or more intervals of disability, due to the same cause or condition, separated by less than31 days of continuous active work with the Company and shall be considered the same disability. Anew waiting period will not be required. The period of time worked between disabilities will not count against the maximum benefit leave duration. For purposes of calculating the claimant's amount of benefits under the Plan, regular wages as of the date of the original onset of disability shall be used.
- **Regular Wages**
  - With respect to Regular, Full-time Employees, regular wages shall mean the scheduled base salary amount of compensation prior to any voluntary salary reduction, excluding overtime, shift differential pay, bonuses, commissions, stock transactions, expense reimbursements and moving expenses in effect during the last completed payroll period immediately prior to the date of commencement of the employee's disability.
  - With respect to all Part-time Employees, regular wages shall mean the average weekly compensation paid by the Company excluding overtime, shift differential pay, bonuses, commissions, and stock transactions during the previously completed 12-weekperiod prior to the date of commencement of the employee's disability.

Important: This document provides only a summary of general plan provisions. Separate documents are available from the plan administrators, which serve as the legal documents that govern these plans.

Overview of the Short-Term Disability (STD) Plans

Leidos' Short-Term Disability (STD) Program is made up of four components:

- **Disability Sick Leave (**DSL) hours, which are provided by Leidos at no cost to eligible employees;
- **Voluntary Short-Term Disability Insurance(VSDI)**, which is elected and paid for by the participant;
- **Leidos California Voluntary Disability Plan (Leidos CAVDP),** which is paid for by the participant; and
- **Other state-mandated disability or medical leave programs** in California, Hawaii, New Jersey, Washington, Massachusetts, New York, Puerto Rico, Rhode Island, Washington, DC, Connecticut and Oregon (beginning 9/3/2023). This is paid by either the employee, employer or a combination of employee and employer.

If a participant becomes disabled, these STD benefits are designed to work together to replace a percentage of a participant's regular wages prior to the disability. After a participant is certified as having a qualified disability, STD benefits are generally payable for up to 180 days, based on the length of disability and the program components available.

Under some circumstances, separate absences might be defined as the same disability if there were two consecutive periods of qualified disability due to the same or a related cause or condition that are separated by less than 31 consecutive days.

STD Program Components				
PLAN	**WHO IS COVERED?**	**WHO PAYS FOR COVERAGE?**	**WHEN DOES IT BEGIN?**	**HOW LONG DOES IT LAST?**
DSL	Those in benefit-eligible fringe packages	Leidos	On the 8th calendar day, except when hospitalized	For a maximum of 180 days or upon exhaustion of benefits in accordance with plan limits
VSDI	Only those who enroll	The participant	On the 8th calendar day, except when hospitalized	Until the end of the qualified disability, to a maximum of 180 days
Leidos CAVDP	Leidos, Inc. employees in California who are eligible and automatically enrolled in this plan	The participant	On the 8th calendar day of disability	Until the end of the 52nd week of a qualified disability; or after the participant has exhausted his or her 52-week benefit amount, if part-time
OTHER STATE LAWS	Employees in California who are not eligible for the Leidos CA VDP; all employees in Connecticut, District of Columbia, Hawaii, Massachusetts, New Jersey, New York, Oregon, Puerto Rico, Rhode Island, Washington State and Oregon	Varies by state; usually both the participant and the employer	Varies by state	Varies by state

How Short-Term Disability Works

How to File a Claim

If a participant becomes disabled, as defined by the Disability Program, the participant must take the following steps to apply for benefits:

- Notify supervisor and HR POC.
- If enrolled in the **DSL**, **VSDI** or Leidos **CAVDP**, the participant should call Sedgwick, Leidos' disability claims administrator, at 1-877-399-6443. Participants can contact Sedgwick to file a claim 7 days a week/24 hours a day. Participants may also file a claim via www.mysedgwick.com. Sedgwick will need the following information:
  - The participant's personal information (including name, address, phone number and employee number);
  - The participant's healthcare provider's name, mailing address, phone number and fax number; and
  - The participant's anticipated length of time away from work due to the qualified disability.
- Under DSL and VSDI:
  - Supporting medical documentation from the physician must be provided to Sedgwick within thirty (30) days of the date on the initial packet letter or thirty (30) days from the first date of absence, if a claim is future dated. Medical documentation for disability extensions must be submitted within twenty (20) days of the date the employee requests the extension or the claim may be denied.
  - Sedgwick will make a decision on the disability claim within two (2) business days of receiving medical documentation.
- Under the CA VDP:
  - Supporting medical documentation from the physician must be provided to Sedgwick within sixty (60) days of the first day of disability.
  - Sedgwick will make a decision on the disability claim within two (2) business days of receiving medical documentation.
- If the participant lives in Connecticut, District of Columbia, Hawaii, Massachusetts, New Jersey, New York, Oregon, Puerto Rico, Rhode Island, Washington state, or if the participant lives in California and is not eligible to enroll in the Leidos CAVDP, the participant will also need to file for state disability or medical leave benefits. See the *Other State-Mandated Short-Term Disability Plans* section for more information.

The payment of a disability claim is not automatic - the participant must take the appropriate steps or disability benefits may be delayed or denied. Under most circumstances, if the participant is not able to contact the claims administrator(s), a family member or other designee can initiate the appropriate steps on the participant's behalf. The claims administrator will begin evaluating the participant’s condition afterreceiving notification of the disability.

How STD Benefits Are Paid

After certification of qualified disability, the participant receives STD benefits based on the length of disability, elected coverage (VSDI), DSL balance and any state benefits.

Under DSL and VSDI, a participant will receive disability benefits, not to exceed 180 days, based on the following schedule: *

- **Week 1:** 7 calendar day waiting period unless hospitalized as defined;
- **Weeks 2 — 10:** Up to 100% of weekly wages to a maximum plan benefit;
- **Weeks 11 — 19:** Up to 80% of weekly wages to a maximum plan benefit;
- **Weeks 20 — 26:** Up to 66 2/3% of weekly wages to a maximum plan benefit.

*If hospitalized as defined, the participant will receive:

- **Weeks 1-9:** Up to 100% of weekly wages to a maximum plan benefit
- **Weeks 10-18:** Up to 80% of weekly wages to a maximum plan benefit
- **Weeks 19-26:** Up to 66 2/3 of weekly wages to a maximum plan benefit

If the participant is receiving benefits from the DSL, VSDI and/or Leidos CAVDP plans:

- Disability benefits will be paid through the Leidos payroll system;
- The benefit amount will be reduced proportionately if a benefit is payable for less than a full week;
- Benefits are paid through the participant’s paychecks, through direct deposit, if applicable, as long as the check is processed as part of the regular payroll cycle;
- DSL and VSDI payments are taxable income. The Leidos CAVDP benefit payments are not taxable.
- Payroll deductions will continue to be made for elected benefits such as medical, dental, vision, VSDI, the Group Universal Life (GUL) Insurance Plan, and the Voluntary AD&D Insurance Plan.
- Participants on part-time disability will have one pay period delay in receiving their benefit payment.

If the participant is receiving benefits from a state-mandated STD plan:

- Benefit payment schedules and taxability vary by state plan;
- The state plan determines eligibility for benefits;
- The employee will receive a separate check directly from the state plan;
- Contact the state agency for specific information.

Each STD claims administrator determines eligibility for the plan it administers and makes a determination of benefits eligibility.

Each STD plan may require, at the Plan's expense, an independent medical evaluation. The participant may be required to go to a doctor of the plan's choice to be examined or to have medical records sent to a third party for review.

In each plan, there is a formal appeal process if the participant disagrees with the determination of the claims administrator.

- For the DSL and VSDI plans, refer to "Claims Appeal and Review Procedures Under ERISA" in the Plan Information section for more information on relevant procedures.
- For all other plans, contact the claims administrator for information on the appeal process.

Pregnancy

Pregnancy is treated as a disability. Participants who are considered to be disabled due to pregnancy must follow the same process that apply to all other disabilities. However, the 7-day waiting period for non- hospitalization will not apply to participants who give birth at home or at birthing centers.

Participants on Rotation

A participant on a rotational work schedule (e.g., 90 days on/90 days off) who has a qualifying disability, will be paid disability benefits even if the disability falls on a period the participant is scheduled to be off.

Home Confinement

Illnesses or disabilities that involve home confinement and that have been certified by a physician or other health care provider qualify employees for disability benefits as of the 8th calendar day, based on approval from the claims administrator.

Hospice

A disabled participant admitted to hospice care will not be required to complete the 7-day waiting period.

Public Health Emergencies and Pandemics

The Plan reserves the right to waive the 7-day waiting period in the event of a pandemic or public health emergencies (declared or undeclared), as determined in the reasonable discretion of the Plan.

Bereavement, Jury Duty, Voting Time or Holiday

A participant will receive disability pay if on approved disability on a day bereavement, jury duty, voting time or holiday occurs. The participant will not receive separate paid time off for bereavement, jury duty, voting time or holiday.

Intermittent Disability

A participant may be approved for intermittent disability if the physician provides medical documentation supporting medically accepted and necessary intermittent treatments (e.g., cancer treatments).

Confidentiality

All medical information that a participant and his or her physician or health care provider supply to the disability plans is kept confidential and will be protected from unauthorized use. Certain claims may require the use of a special, written authorization form. The participant will need to sign and return the form as soon as possible so there is no delay in processing the claims.

STD Claims Management

All STD Plans require that the participant cooperates in collecting the medical information necessary to review the claims and make a benefit determination. The most common reason that claim payments are delayed is the failure of the participant's health care provider to return calls, return forms or otherwise provide requested medical documentation.

A participant can help the claims administrators make more timely decisions by:

- Explaining to the healthcare provider that the administrator will be contacting them;
- Following up with the health care provider's office after a request for information has been made to ensure that the information is being collected and sent to the administrator; and
- Notifying the claims administrator immediately if the participant's return-to-work plans change, or if the health condition significantly changes (for example, if a surgery is needed). This will allow the plan administrator to help the employee file for an extension of benefits, if appropriate.

Some state plans insist that the documentation be provided only on specific forms. The healthcare provider should be aware of these requirements. However, a participant who receives a letter

from the state indicating that the documentation was not provided in the appropriate format should contact his or her health care provider immediately.

For the DSL, VSDI and Leidos CAVDP, Sedgwick will contact the participant's physician or healthcare provider to request the appropriate documentation. In addition, Sedgwick will make a determination as to the expected return-to-work date based on objective medical evidence provided by the participant's physician or health care provider. If a participant's qualified disability extends beyond the original estimated return-to-work date, the participant should have his or her physician or health care provider complete the extension form provided by Sedgwick. Failure to provide disability extension documentation could result in delayed or denied benefits.

Coordination Among the STD Plans

The STD Program is designed to provide a certain degree of income protection if a participant is unable to work. The individual STD plans coordinate with each other so that participants do not receive duplicate benefits. In addition, some offsets or deductions may be made for other plans for which the participant might be eligible. In general, STD benefits will be offset by:

- Social Security benefits (except family Social Security benefits) for any period of time during which disability benefits are paid. Once disability benefits begin, however, they will not be further reduced by any statutory increase in Social Security benefits. If the receipt of Social Security retirement benefits commenced prior to the Participant's disability such benefits will not be offset;
- Any benefits based on wages payable to the participant under any worker's compensation law;
- Disability benefits payable to the participant under any employer-sponsored group policy other than the Leidos disability plans;
- Disability/medical leave benefits for employee's own serious health condition payable under any federal or state law;
- Any salary (excluding vacation pay), income or sick pay from any employer or from self-employment;
- Any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any Compulsory Benefit Act or law of any government;
- Any government retirement or disability plan that is initiated or increased as a result of a participant's disability;
- Any income or wages earned during rehabilitation employment;
- Any financial settlement, award, benefit or other monetary recovery the participant receives — through litigation or otherwise — attributable in whole or in part to the negligence, the wrongful act or any other civil or criminal incident that resulted, in whole or in part, in the

disease, illness, incapacity or injury that substantiates the disability claim. (This offset can be made for the entire amount of the third-party recovery, regardless of whether it is attributable to lost wages, incurred medical expenses or punitive damages.);

- Benefits payable under any Unemployment Compensation Act of the United States or of any state during any period of disability leave.

Although the coordination of benefits may reduce the amount received from the STD plans, all benefits together will still equal the total amount under the STD plan(s) that the employee is eligible for and enrolled in.

Medical Record Fees

The participant is responsible for any fees associated with obtaining medical records and medical certification forms related to the disability claim. However, the Plan will pay for document translation services if necessary.

Acts of Third Parties

In the event that a participant is injured through the acts of a third party (e.g., auto accidents), the Plan will provide benefits only under the condition that the participant agrees in writing that the Plan will be subrogated to all rights of recovery that the participant may have as a result of the injury. The participant must sign the Reimbursement Agreement prior to receiving claim payments from the Plan. If the participant is incapacitated and unable to sign the agreement, the Plan will pay the claim and pursue reimbursement at a later time. The Plan will pursue reimbursement regardless of whether a signed reimbursement agreement is in place.

The Plan reserves the right to reduce the amount of its recoverable subrogation interest if, in the discretion of the Plan, a reduction is in the best interest of the Plan and its participants and warranted by the circumstances. The Plan is not responsible for the expenses or attorney fees incurred by the participant in connection with any recovery.

STD Participation and Benefit Payment Duration

When Participation in the STD Plan Ends

Participation in the STD Plans generally ends on the earliest of the following:

- On the end date of the pay period which marks the termination of employment
- On the end date of the pay period in which an approved leave of absence without pay commences, except as required by law
- At 12:00 midnight when a protected leave ends, if the participant fails to return to work
- On the end date of the pay period in which an employee ceases to be eligible
- On the end date of the pay period in which a strike occurs (if the participant is a member of the bargaining unit engaged in the strike)
- On the date of a qualified life event
- On the date of termination of the Plan

When STD Benefit Payments End

STD benefits generally end when the participant:

- Returns to work as cleared by the participant's physician
- Is no longer disabled as defined by the particular disability plan
- Reaches the maximum duration payable under that plan
- Refuses to submit to an independent medical examination (arranged and paid for by the claims administrator) or fails to comply with any request, by the claims administrator, to help substantiate that the participant is disabled
- Is no longer under the regular and continuous care and treatment of a qualified Physician
- Dies

If a participant's disability started prior to termination of employment, disability benefits will continue to be paid up to the maximum duration approved under the plan.

For collectively bargained participants, disability benefits will continue to be paid if a strike occurs and the disability started prior to the strike. Benefits will be paid up to the maximum duration approved under the plan.

For more information on when participation or benefit payments end for all disability plans, refer to the Plan Document or Certificate of Insurance for each plan.

Returning to Work

Leidos requires that all participants returning from a disability leave provide a “fitness for duty" or “doctor's release" clearly stating the date he is no longer considered to be disabled, as well as the date he is able to return to work. This document is usually a note from the health care provider stating that the participant may return to full duty. If the healthcare provider is requesting modified

duty or limited hours, this should be discussed with the claims administrator and the workplace in advance of the participant's return to work. A participant who does not present a release may not be allowed to work until the release is presented.

If the Participant Becomes Disabled Again

If a participant recovers from an illness or injury and returns to full active employment with Leidos (other than in rehabilitation employment), the participant may again be eligible for disability benefits if, within 31 days, the participant suffers another period of disability caused by, related to, and based on the same diagnosis as the prior period of disability. If these conditions are met, the participant will not be required to satisfy another waiting period. The period of time worked will not count against the maximum benefit leave duration.

Successive disability benefits will begin on the most recent date the participant was unable to work. The participant must notify Sedgwick within five days of the successive disability. Participants in a state-mandated plan must also notify the appropriate state claims administrator.

For more information about what happens when a participant becomes disabled again, refer to the Plan Document or Certificate of Insurance for each Plan.

Important: State-mandated plans have different maximum benefit durations.

STD Limitations and Exclusions

In general, benefits may be limited if:

- The participant is referred or recommended by competent medical authority to participate as a resident in either an approved alcoholism recovery program or an approved drug-free residential program. Benefits for alcoholism recovery treatment will be paid for a period not to exceed thirty (30) days for a period of disability. Benefits for drug-free residential facility participation will be paid for a period not to exceed forty-five (45) days for a period of disability. If the referring physician certifies the need for continuing resident services, benefits will be payable for up to sixty (60) additional days for alcoholism recovery treatment and up to forty-five (45) additional days for drug-free residential facility participation.
- The participant receives wages from Leidos (excluding Paid Time Off pay) for any day. Benefits will be paid for any seven-day week or partial week, in an amount that does not

exceed the participant's maximum weekly benefit amount and which, when added to the wages received, does not exceed the participant's weekly wages, exclusive of the wages paid for overtime immediately prior to the commencement of the participant's qualified disability.

- The participant, for any day of unemployment or disability, receives or is entitled to receive benefits or cash payments for temporary or permanent disability under a workers' compensation or employer liability law of the federal government or any state (in which case, if the cash payments for temporary or permanent disability are less than the amount of disability benefit the participant would have received, the participant, if otherwise eligible, will be entitled to receive disability benefits, reduced by the amount of such cash payments).
- The employer can provide alternative employment that is within the capabilities of the employee, and that has status and compensation comparable to the employee's regular occupation as determined solely by the employer.

In general, benefits may not be available, if:

- The participant is not in an employment status that is eligible for disability benefits;
- The disability leave is not supported by objective medical evidence from a treating physician or other health care provider and approved by the claims administrator;
- The participant has reached the maximum benefits or duration allowed under the plan
- The participant's illness or injury is caused by participation in a violent disorder, assault or illegal occupation;
- The participant:
  - Is incarcerated in any federal, state, or municipal penal institution, jail, medical facility, public or private hospital, or in any other place because of a criminal conviction of a federal, state or municipal law or ordinance; or
  - Commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction
- The participant has willfully, for the purpose of obtaining benefits, either made a false statement or representation, with actual knowledge of the falsity thereof, or withheld a material fact, in order to obtain any benefits from the Plan;
- The disability is:
  - Not disabling (i.e., do not prevent the employee from doing his or her job)
  - Incurred during, or as a result of, engaging in a criminal act
  - Incurred while on layoff or leave of absence, severance, military leave of absence, or any other status where the participant was not engaged in active employment with Leidos
  - Incurred while on full-time or part-time long-term disability

- Incurred while the employee was on unauthorized absence, or was not an employee
- Incurred as a result of service in any armed forces, except as required by law
- Intentionally self-inflicted
- Incurred because the participant was not receiving care or following the prescribed treatment plan that is:
  - From a healthcare provider whose training and clinical experience are suitable for treating the disease, illness, incapacity or injury
  - Consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research, and health coverage organizations and governmental agencies
  - Consistent with the diagnosis of the condition
  - For the purpose of maximizing medical improvement

- The participant is not under the continuous care and treatment of a duly qualified physician
- The illness or injury is caused by any act of war, declared or undeclared, or insurrection, except while traveling overseas on company business
- The disability is filed more than 60 days after the qualified disability began. The Plan Administrator may extend this period for good cause (for example, physician's delay in providing the requested medical information)

State-mandated plans may have different limitations and exclusions. Refer to each respective state's disability program for more information. See the *Leidos California Voluntary Disability Plan (CA VDP)* section for limitations and exclusions related to the CA VDP.

Disability Sick Leave (DSL)

Disability Sick Leave (DSL), which is company-provided and administered by Sedgwick, provides participants with paid time off for approved disabilities (maximum of180 days). If a participant becomes sick or injured, DSL can be used to replace income or augment other short- term disability payments to the maximum level of DSL benefits available, based on the length of disability leave.

A participant receives DSL hours on the first day of hire or transfer date into a benefit-eligible status. Thereafter, a participant receives DSL hours on each employment anniversary. A participant receives up to80 hours of DSL each year. Participants can accumulate up to 1,560 hours of DSL. Unused DSL hours are not payable upon termination. Eligible part-time employees will receive a prorated number of DSL hours based on their standard workweek schedule at the time of grant.

Newly eligible employees acquired as part of a merger, acquisition, or incumbent capture may

receive credit for prior service earned at the M&A target or incumbent company for purposes of calculating the initial DSL credit. Eligible employees granted prior service under this policy must be clearly defined and approved by the Chief Human Resources Officer (or delegate(s) of any such officer).

The commencement of DSL benefits depends on the circumstances of the participant's disability. DSL is payable:

- On the first day of a qualified disability if the participant is hospitalized as **defined**;
- On the eighth calendar day of a qualified disability.

Should it be medically necessary for the participant to reduce work hours by 25% or more, but not cease work entirely, the reduced workday will be applied to serve the waiting period consecutively for seven (7) calendar days.

DSL benefits are payable for up to 180 days for any one period of disability. DSL may not be used to supplement Long-Term Disability (LTD) benefits, even if the participant has DSL available.

Any DSL benefits participants receive are taxable, and payroll deductions for elected benefits will continue to be made while a participant receives DSL benefits.

Based on the length of disability and the DSL hours available:

- A participant who is unable to work due to a qualified disability may receive a weekly benefit of up to 100% of his regular wages after satisfying the waiting period. These benefits are available for weeks two (2) through ten (10) of disability.
- If the participant remains eligible after the 10th week of disability, the participant may receive up to a maximum of 80% of his regular wages. These benefits are available through the 19th week of disability.
- If the participant remains eligible after the 19th week of disability, he may receive up to 66 2/3% of his regular wages. These benefits are available through the 26th week of disability not to exceed 180 days.

Voluntary Short-Term Disability Insurance (VSDI)

Eligible employees can purchase additional STD coverage through Voluntary Short-Term Disability Insurance (VSDI). This plan is intended to integrate with other Leidos plans such as DSL, Leidos CAVDP and state-mandated programs. Contributions are made on a pre-tax basis. VSDI is administered by Sedgwick.

VSDI benefits begin:

- On the first day of a qualified disability if the participant is hospitalized as defined; or
- On the eighth calendar day of a qualified disability.

Should it be medically necessary for the participant to reduce his or her hours by 25% (minimum two hours for an eight-hour workday) or more, but not cease work entirely, the reduced workday will be applied to serve the waiting period consecutively for seven calendar days.

A participant who elects VSDI will be eligible to receive up to 80% of his total disability benefit (not to exceed plan maximums) from the VSDI plan.

The VSDI schedule below illustrates the integration of VSDI with other disability plans such as DSL and other state plans for periods of up to 26 weeks, not to exceed 180 days.

VSDI Schedule			
PERIOD OF DISABILITY	**TOTAL PAY (From all sources)**	**VSDI (Integrated with state plan, if applicable)**	**DSL PORTION**
WEEK 1	0 (7-day waiting period)	0 (7-day waiting period)	0 (7-day waiting period)
WEEKS 2 – 10	100% of regular weekly wages	80% (maximum weekly benefit of $4,808)	20%, as available
WEEKS 11 – 19	80% of regular weekly wages	80% (maximum weekly benefit of $3,846)	20%, as available
WEEKS 20 – 26*	66 2/3% of regular weekly wages	80% (maximum weekly benefit of $3,202)	20%, as available

* Not to exceed 180 days

Example: Fora participant who does not live in a state with a mandated plan, has enrolled in VSDI and is making $1,000 per week, the participant would be eligible for the following disability benefits:

Example VSDI Payment Schedule			
LENGTH OF DISABILITY	**TOTAL BENEFIT (From all sources)**	**VSDI (Integrated with state plan, if applicable)**	**DSL BENEFIT**
WEEK 1	0	0	0
WEEKS 2 – 10	$1,000	$800	$200**
WEEKS 11 – 19	$800	$640	$160**
WEEKS 20 – 26*	$667	$534	$133**

* Not to exceed 180days
** Based on DSL balance

If hospitalized as defined, the participant will receive:

- **Weeks 1-9:** Up to 100% of weekly wages to a maximum plan benefit
- **Weeks 10-18:** Up to 80% of weekly wages to a maximum plan benefit
- **Weeks 19-26:** Up to 66 2/3 of weekly wages to a maximum plan benefit

For the same participant who has elected not to enroll in VSDI, all benefits would be paid from the DSL plan and state plan where applicable.

Any VSDI benefits participants receive are taxable, and payroll deductions for elected benefits will continue to be made while a participant receives VSDI benefits.

Leidos California Voluntary Disability Plan (Leidos CA VDP)

Eligible employees in Leidos, Inc. are automatically enrolled in a special short- term disability insurance plan, the Leidos California Voluntary Disability Plan (Leidos CAVDP). This excludes employees working for subsidiaries who are covered by the State of California Short-Term Disability Insurance (CA SDI) program.

The Leidos CA VDP is administered by Sedgwick and meets or exceeds the requirements of the state of California.

Participants pay for coverage through contributions that are no higher than the contribution rate for the California SDI Plan. These rates are established each year by the California Employment Development Department. For the 2023 plan year, the contribution rate has been set at 0.9 percent of taxable wages. The maximum salary subject to this contribution is $153,164. The maximum contribution is $1,378.48 in 2023.

If a participant is enrolled in the Leidos CA VDP and is unable to work due to a qualified disability, the plan pays benefits equal to 60% to 70% of a participant's regular base wages. The current weekly maximum is $1,620 per week (as of January 1, 2023). The weekly benefit maximum is set each year by the State of California. This is a calendar-day plan, so each day's benefit during a qualified disability is one-seventh of a participant’s weekly benefit.

The Leidos CAVDP will pay benefits after a mandatory seven-calendar-day waiting period, but for no more than 52 weeks (or 52 times the weekly amount). A partial day of disability will be counted as a full day for purposes of fulfilling the waiting period requirement.

Participants who also work for employers other than Leidos are entitled to receive a prorated benefit

from those employers' disability plans in addition to any Leidos CA VDP benefit payments. Payments from each plan depend on the number of plans involved. The total amount a participant can receive from each disability plan will equal the portion payable under the California State Disability Insurance Plan. If the participant's employer has a private disability plan (as Leidos does) additional benefits may be payable.

Leidos CAVDP benefit payments are non-taxable, and certain payroll deductions will continue to be made while a participant is receiving Leidos CA VDP benefits.

If you have any questions about this Voluntary Plan or wish to withdraw from the Leidos CA VDP, contact Employee Services at 855-553-4367, option 3 or email LeaveAdmin@leidos.com.

To report a claim, contact Sedgwick, Leidos' disability claims administrator, at 1-877-399-6443.

Leidos CA VDP Limitations and Exclusions

Leidos CA VDP benefits may be limited, if:

- The participant is receiving wages or regular wages from any employer, except that benefits will be paid for any week or partial week not to exceed the maximum weekly benefit amount which, when added to the wages or regular wages, does not exceed the participant's weekly regular wages prior to the beginning of the disability;
- The participant is referred or recommended by competent medical authority to participate as a resident in either an approved alcoholism recovery program or an approved drug-free residential program. Benefits for alcoholism recovery treatment will be paid for a period not to exceed thirty (30) days for a period of disability. Benefits for drug-free residential facility participation will be paid for a period not to exceed forty-five (45) days for a period of disability. If the referring physician certifies the need for continuing resident services, benefits will be payable for up to sixty (60) additional days for alcoholism recovery treatment and up to forty-five (45) additional days for drug-free residential facility participation;
- The participant is receiving or is entitled to receive benefits or cash payments for temporary disability, vocational rehabilitation maintenance allowance or permanent disability benefits under workers' compensation law. However, if these benefits are less than the amount the participant would otherwise receive as benefits under this plan, he or she will be entitled to receive disability benefits reduced by the amount of these workers' compensation payments. Benefits will be limited to the state plan rate for disabilities occurring during the extended coverage period following the beginning of a layoff without pay or a leave of absence without pay.

Leidos CA VDP benefits may not be available, if:

- The participant is not an employee as defined in the plan;
- The participant did not meet the seven-day consecutive waiting period;
- The participant does not work for a Leidos organization that participates in this program;
- The disability is not supported by a certificate from a physician or health care provider stating a diagnosis, the medical facts within his or her knowledge, a conclusion with respect to the disability and an opinion with respect to the probable duration of the disability:
  - Physicians or other health care providers are required to submit an ICD diagnostic code or a detailed description of symptoms. The physician's or other healthcare provider's certificate must be based on a physical examination;
  - If the participant has been referred or recommended by a competent medical authority to participate as a resident in an alcoholism recovery program or drug residential program, the participant need not show actual disability;
  - Certification of disability may also be accepted from any duly authorized medical officer of any medical facility of the United States government; the registrar of a county hospital in this state; the duly authorized or accredited practitioner of any bona fide church sect, denomination, or organization, which depends on healing entirely upon prayer and spiritual means;
  - Certification is not required if the participant submits evidence of receipts of temporary or permanent benefits under a workers' compensation law for any day for which he or she is entitled to receive disability benefits reduced by such temporary or permanent worker's compensation benefits;
- The participant has knowingly made a false statement or representation in order to receive any benefits under this plan;
- The participant is incarcerated because of a criminal conviction, or he or she commits a crime and becomes disabled due to an illness or injury in any way caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.

Other State-Mandated Short-Term Disability Plans and Medical Leave Programs

In certain states, other short-term disability plans or medical leave programs will pay benefits. These plans include:

- California State Disability Insurance*
- Connecticut Paid Family & Medical Leave
- District of Columbia Universal Paid Leave
- Hawaii Temporary Disability Insurance
- Massachusetts Paid Family and Medical Leave
- New Jersey Temporary Disability Insurance
- New York Disability Benefit
- Oregon Paid Family Leave Insurance (benefits begin 9/3/2023)
- Puerto Rico Temporary Disability Insurance
- Rhode Island State Temporary Disability Insurance
- Washington State Paid Family and Medical Leave

* All Leidos, Inc. employees living in California are automatically covered by the Leidos California Voluntary Disability Plan(Leidos CA VDP). Employees working at Varec, Leidos Security Detection and Automation, Leidos Engineering, 1901 Group and Gibbs & Cox are covered by the State of California SDI program. If you are unsure which plan you participate in, contact Employee Services at 855-553-4367, option 3 or email LeaveAdmin@leidos.com.

The state-mandated plans are administered by the participant's respective states. These plans are required by state law.

DSL and VSDI are supplements to these plans, which means that the state plans pay first and DSL/VSDI will make up the difference, up to the benefit level that the plans would normally pay.

Contact Information for State-Mandated Plans

For more detailed information about these state-mandated plans, contact the following:

Contact Information for State-Mandated Plans	
State Mandated Short-Term Disability	**Contact Information**
California State Disability Insurance	Employment Development Department 800 Capitol Mall Sacramento, CA 95814 1-800-480-3287 If you are covered under the Leidos California Voluntary Disability Plan (CA VDP), contact Sedgwick at 1-877-399-6443.
Connecticut Paid Family & Medical Leave	Connecticut Department of Labor www.ctpaidleave.org For claims, call 1-877-499-8606

Contact Information for State-Mandated Plans	
State Mandated Short-Term Disability	**Contact Information**
District of Columbia Universal Paid Leave	Office of Human Rights District of Columbia 441 4th Street NW, Suite 570 Washington, DC 20001 202-899-3700
Hawaii Temporary Disability Insurance	**For claims:** ESIS P.O. Box 1639 Honolulu, HI 96806 ESIS Phone: 1-800-779-6249 **State Plan General Contact Information:** Disability Compensation Division 830 Punchbowl Street, Room 209 Honolulu, HI 96813 808-586-9188
Massachusetts Paid Family and Medical Leave	**Department of Family & Medical Leave** 833-344-7365
New Jersey Temporary Disability Insurance	**Division of Disability Insurance Service** Department of Labor P.O. Box 387 Trenton, New Jersey 08625 609-292-7060
New York Voluntary Disability Insurance	**For claims:** New York State Insurance Fund Disability Benefits P.O. Box 66698 Albany, NY 12206 866-697-4332 **State Plan General Contact:** Disability Benefits Bureau Workers Compensation Board P.O. Box 9029 Endicott, NY 13761-9029 800-353-3092
Oregon Paid Family Leave Insurance	For questions email: mailto:Paidleave@oregon.gov or call 833-854-0166. **Applying for benefits**: When you are ready to apply for benefits, you will use Frances Online. Employees can begin creating an account on Frances Online in August 2023. Make sure to: • Apply no earlier than 30 days before you need to take leave, or Apply no later than 30 days after you take your leave

Contact Information for State-Mandated Plans	
State Mandated Short-Term Disability	**Contact Information**
Puerto Rico Temporary Disability Insurance	Bureau of Employment Security Disability Insurance Program 505 Ave Munoz Rivera San Juan, Puerto Rico 00918-3514 787-625-7900 or 787-754-5353
Rhode Island State Temporary Disability Insurance	Dept. of Labor and Training Temporary Disability Insurance 1511 Pontiac Avenue Cranston, Rhode Island 02920-4407 401-462-8420
Washington State Paid Family & Medical Leave	Employment Security Department Washington State 833-717-2273

Voluntary Long-Term Disability (LTD)

After 180 days of disability, a participant may be eligible to receive benefits through Long-Term Disability (LTD) insurance if elected. LTD benefits are designed to provide you with income if you are absent from work for six consecutive months or longer due to an eligible illness or injury.

In some states, LTD benefits may be paid at the same time as STD benefits. When this occurs, benefits will be integrated with other sources (refer to your LTD evidence of coverage for more information).

Below are some important terms used in describing how a participant is eligible to receive benefits through the LTD Plan:

- **Qualified Disability** —One where a participant cannot perform his or her own occupation in the first two years of disability. After two years of disability, a qualified disability is one where a participant is unable to perform any occupation that he or she is reasonably qualified to hold. Refer to the LTD evidence of coverage, issued by Life Insurance Company of North America (LINA), a New York Life company, for more information on criteria for "own occupation" versus" any occupation."
  The participant will be required to provide objective medical evidence to LINA, the claims administrator, to qualify for benefits. The plan administrator will determine the types of medical documentation needed and how frequently the documentation must be updated.
- **Claims Administrator—Life Insurance Company of North America** (LINA), a New York Life company.
- **Claims Fiduciary—Life Insurance Company of North America** (LINA), a New York Life company.

The plan administrator has appointed **Life Insurance Company of North America** (LINA), a New York Life company, as the claims fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

Important: This document provides only a summary of general plan provisions. A separate evidence of coverage is available from LINA, which serves as the legal document that governs the plan.

Overview of LTD Benefits

If a participant is unable to work after 180 days of continuous disability, the participant may be eligible to receive LTD benefits if elected. LTD provides a monthly benefit equal to 60 percent of an employee's base monthly salary not to exceed $14,500 per month.

Employees enrolled in LTD pay 100 percent of the cost on an after-tax basis thereby providing a tax-free benefit when received.

LTD is underwritten by LINA (a New York Life company), and a participant must meet the Plan's criteria for disability to qualify for income replacement under this program. Refer to the Plan's evidence of coverage for more information about qualifying for income replacement.

The following maximum benefit periods apply:

Duration of LTD Benefit	
AGE WHEN PARTICIPANT'S DISABILITY BEGINS:	**MAXIMUM BENEFIT PERIOD:**
AGE 62 OR UNDER	The employee's 65th birthday or the date the 42nd Monthly Benefit is payable, whichever is later
AGE 63	The date the 36th Monthly Benefit is payable
AGE 64	The date the 30th Monthly Benefit is payable
AGE 65	The date the 24th Monthly Benefit is payable
AGE 66	The date the 21st Monthly Benefit is payable
AGE 67	The date the 18th Monthly Benefit is payable
AGE 68	The date the 15th Monthly Benefit is payable
AGE 69 OR OLDER	The date the 12th Monthly Benefit is payable

How LTD Works

What to Do in Case of a Long-Term Disability

To assist the employee in transitioning from short-term to long-term disability claim with LINA, the following will occur at week 17 of an employee's disability:

1. For participants who elected LTD, Sedgwick will send all open STD claims to LINA via an

electronic file. LINA plan administrators will also have access to the Sedgwick system to view pertinent claims information.

2. Sedgwick will send a letter notifying the claimant that the claim was referred to LINA for evaluation of LTD Benefits.
3. LINA will acknowledge receipt of claim by sending out a confirmation letter to the employee once the online submission is completed.
4. Within 10 days, a dedicated claim manager will contact the employee via telephone to introduce themselves and notify the employee of the process. A follow-up letter will be sent following this conversation to notify the claimant of any outstanding information and all applicable policy provisions.

Definition of Disability / Disabled

A participant is disabled if, because of injury or illness:

- The participant is unable to perform all the duties of his or her regular occupation, or unable to earn more than 80% of indexed covered earnings.
- The participant has been paid disability benefits for 24 months and unable to perform all the duties of any occupation for which he or she may reasonably become qualified based on education, training or experience, or unable to earn more than 80% of his or her indexed covered earnings. Refer to the evidence of coverage for more information about indexed covered earnings.

How LTD Benefits Are Paid

If the participant is receiving benefits from the LTD plan:

- Disability benefits are paid once a month;
- Benefits can be sent through the mail, or electronically deposited;
- If not directed otherwise, a check will be mailed to the participant's home or address of record from the insurance company; and
- There are no deductions other than applicable taxes and offsets (seethe evidence of coverage for more details).

Pre-Existing Conditions

LTD benefits will not be paid for any disability caused by, contributed to or resulting from a pre- existing condition that is diagnosed or treated within a three-month time period before the

LTD coverage effective date. For this policy, a "pre-existing condition" means any injury or illness for which the participant:

- Received medical treatment, care or services including diagnostic measures; or
- Took prescribed drugs or medicines; or
- Incurred expenses

The pre-existing condition limitation will apply to any added benefits or increases in benefits. It will not apply to a period of disability that begins after you are in active service for at least 12 months after your most recent effective date of insurance or the effective date of any added or increased benefits.

The pre-existing condition limitation will not apply to a participant covered under a prior plan who satisfied that plan's pre-existing condition limitation, if any. It will still apply to any benefit amount greater than that of the prior plan. If the participant did not completely satisfy the pre-existing condition limitation of the prior plan, the participant will receive credit for any time that was satisfied. For any person who becomes an employee of the employer as a part of an acquisition, the pre- existing condition limitation will not apply.

Time will not be credited for any day a participant is not actively at work due to his or her injury or illness. The pre-existing condition limitation will be extended by the number of days the participant is not actively at work due to injury or illness.

Benefit Maximums for Certain Conditions

LTD benefits will be paid on a limited basis during a participant's lifetime for a disability caused by, or contributed to by, any of the following conditions. Once 24 monthly disability benefits have been paid, no further benefits will be paid for any of the following conditions:

- Alcoholism
- Anxiety disorders
- Delusional(paranoid) disorders
- Depressive disorders
- Drug addiction or abuse
- Eating disorders
- Mental illness
- Somatoform disorders (psychosomatic illness)

If before reaching the lifetime maximum of 24 monthly benefits, a participant is confined in a hospital for more than14 consecutive days for the appropriate care of any of the conditions listed above, that period will not count against the lifetime limit.

For a complete list of the LTD plan's limitations and exclusions, refer to the plan's evidence of coverage.

The Plan Determines Eligibility and Certifies Disability

The plan's claims administrator, LINA, determines eligibility and makes a determination of disability.

LINA, at its expense, has the right to examine, as often as reasonably required, any participant with a pending claim. LINA may also require an autopsy, at its expense, unless prohibited by law.

There is a formal appeal process if the participant disagrees with the determination of the claims administrator. For more information on the appeal process, refer to the plan's evidence of coverage.

Evidence of Insurability (EOI)

Employees who choose to waive LTD coverage when first eligible, and later choose to elect coverage will be required to complete EOI.

LTD Actively-at-Work Provision

If the employee is on STD or not actively at work at the time of enrollment, LTD coverage will not be effective until the employee returns from leave. Premiums will not be charged until the coverage is active.

Confidentiality

All medical information that a participant or the physician supply to the LTD plan is kept confidential and will be protected from unauthorized use. Certain claims for non-occupational disability benefits may require the use of a special, written authorization form. The participant must sign and return the form as soon as possible so there is no delay in processing the claim.

LTD Claims Management

The LTD plan will require that the participant cooperate in collecting the medical information

necessary to review the claim and make a benefit determination. The most common reason that claim payments are delayed is the failure of the participant's healthcare provider to return calls, return forms or otherwise provide medical documentation. A participant can help the plan administrators make more timely decisions by:

- Explaining to the healthcare provider that the administrator will be contacting them;
- Following up with the health care provider's office after a request for information has been made to ensure that the information is being collected and sent to the administrator; and
- Notifying LINA immediately if the participant's return-to-work plans change, or if the health condition significantly changes (for example, if a surgery is needed). This will allow the plan administrator to help the employee file for an extension of benefits, if appropriate.

Continuation of Insurance

Disability insurance continues if a participant's active service ends because of a disability for which covered benefits are or may become payable. Premiums for the participant will be waived while disability benefits are payable. If the participant does not return to active service, this insurance ends when the disability ends or when benefits are no longer payable, whichever occurs first.

If a participant's active service ends due to an employer-approved unpaid leave of absence, insurance for that participant will continue for up to 24 months if the required premium is paid.

If a participant's active service ends due to family medical leave of absence, insurance for that participant will continue for up to 12 weeks if the required premium is paid.

Rehabilitation During a Period of Disability

If the plan determines that a disabled participant is a suitable candidate for rehabilitation, a rehabilitation plan may be put in place. The terms and conditions of the rehabilitation plan must be mutually agreed upon by the participant and the plan.

The plan may require a participant to participate in a rehabilitation assessment or a rehabilitation plan at its expense. The plan will work with the participant, the employer and the participant's physician and others, as appropriate, to develop a rehabilitation plan. Disability benefits will not be paid if the participant refuses to participate in the rehabilitation efforts.

The rehabilitation plan may, at the plan's discretion, allow payment of the participant's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

A "rehabilitation plan" is a written agreement between the participant and the plan in which the plan agrees to provide, arrange or authorize vocational or physical rehabilitation services.

Work Incentive Benefits

For the first 12 months the participant is eligible for a disability benefit, the disability benefit is determined based on the minimum and maximum disability benefit. If for any month during this period, the sum of the participant's disability benefit, current earnings and any additional other income benefits exceeds 100% of his or her indexed covered earnings, the disability benefit will be reduced by the excess amount.

After the first12months, the disability benefit is determined based on the minimum and maximum disability benefit, reduced by 50% of current earnings received during any month the participant returns to work. If the sum of the current earnings and any additional other income benefits exceeds 80% of the participant's monthly indexed covered earnings, the disability benefit will be reduced by the excess amount figured above. No benefits will be paid if the plan determines the participant is able to work and refuses to do so under a transitional work arrangement or other modified work arrangement.

Current earnings include any wage or salary for work performed while disability benefits are payable. If participant is working for another employer on a regular basis when disability begins, current earnings will include any increase in the amount the participant earns from this work during the period for which disability benefits are payable.

Survivor Benefits

The plan will pay a survivor benefit if a participant dies while monthly benefits are payable. The benefit will equal 100% of the sum of the last full disability benefit payable to the participant plus any current earnings by which the disability benefit was reduced for that month. A single lump sum payment equal to 6 monthly survivor benefits will be payable.

Benefits will be paid to the participant's spouse or registered domestic partner. If there is no spouse or registered domestic partner, benefits will be paid in equal shares to the participant's surviving children. If there is not a spouse/registered domestic partner and no children, no benefits will be paid.

"Spouse" means a participant’s lawful spouse. **“Registered Domestic Partner**" is defined in the Eligibility section. "Children" means a participant's unmarried children under age 26 who are primarily dependent upon the participant for support and maintenance. The term includes a stepchild living with the participant at the time of his or her death.

Coordination with Other Benefits

Social Security Disability Benefits

When a participant is unable to work for an extended period of time, the participant may be eligible for Social Security Disability Income (SSDI). SSDI allows an employee to receive income.

A participant who is disabled should apply for SSDI as soon as it is clear that the duration of the disability will be longer than six months. When the participant applies for LTD benefits, LINA will require that the participant apply for SSDI benefits and will offer assistance throughout the SSDI application process.

If the participant is eligible for Social Security disability benefits, any such payment will be subtracted from disability benefits the participant receives from the disability plans.

It is not uncommon for the SSDI application and approval process to take several months, and for benefits paid to be retroactive back to a certain date of disability. A participant receiving LTD benefits will be asked by LINA to sign an Overpayment Reimbursement Agreement stating that the participant will reimburse LINA for any Social Security benefits received for the same period of time the participant was receiving disability benefits.

Other LTD Benefits

The LTD plan is designed to provide a certain degree of income protection if a participant is unable to work for long periods of time. However, the plan may reduce the disability benefit paid if, while a participant is disabled, he or she may be eligible for benefits from other income sources. If so, benefits may be reduced by the amount of these other income benefits, including:

- Any amounts which the participant or any dependents receive (or are assumed to receive) under:
    - the Canada and Quebec Pension Plans;
    - the Railroad Retirement Act;
    - any local, state, provincial or federal government disability or retirement plan or law as it relates to the participant;

  - any employer sick leave plan;
  - any work loss provision in mandatory "No-Fault" auto insurance;
  - any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted;

- Any Social Security disability benefits the participant or any third-party receives (or are assumed to receive) on the participant's behalf or for his or her dependents; or, which his or her dependents receive (or are assumed to receive) because of the participant's entitlement to such benefits;
- Any employer-funded retirement plan benefits. "Retirement plan "means any defined benefit or defined contribution plan sponsored or funded by a participant's employer. It does not include:
  - an individual deferred compensation agreement;
  - a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan;
  - any participant savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan;
- Any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same disability claim, and which contains the same or a similar provision for reduction because of other insurance, the plan will pay a pro rata share of the total claim. “Pro rata share” means the proportion of the total benefit that the amount payable under one policy, without other insurance, bears to the total benefits under all such policies;
- Any amounts paid because of lost earnings or loss of earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined;
- Any wage or salary for work performed. If a participant is covered for Work Incentive Benefits, the plan will only reduce disability benefits to the extent provided under the Work Incentive Benefit in the Schedule of Benefits.

Although this coordination of benefits may reduce the amount received from the LTD plan, all benefits together will still equal the total amount the participant is eligible for under the LTD plan.

When LTD Benefits End

Returning to Work

Leidos requires that all participants returning from LTD provide a "fitness for duty" or "doctor's release" prior to returning to work. This document is usually a note from the health care provider clearly stating that the participant is not considered to be disabled, as well as the date the participant is able to return. If the healthcare provider is requesting modified duty or limited hours, this should be discussed with LINA and the workplace in advance of the participant's return to work. A participant who does not present a release may not be allowed to work until the release is presented.

When LTD Coverage Ends

LTD coverage ends:

- When the participant is eligible for coverage under a plan intended to replace this coverage;
- When the insurance policy is terminated;
- At the end of the pay period in which the participant is no longer in an eligible class;
- At the end of the last pay period for which premiums are paid; or
- When the participant dies.

When LTD Benefit Payments End

LTD benefit payments end on the earliest of the following dates:

- The date the participant earns more than the percentage of indexed covered earnings which is used to determine if the participant is disabled;
- The date the claims administrator determines the participant is no longer disabled;
- The date the maximum benefit period ends;
- The date the participant dies;
- The date the participant refuses to participate in rehabilitation efforts;
- The date the participant is no longer receiving appropriate care.

If a participant's disability started prior to termination of employment, disability benefits will continue to be paid up to the maximum duration approved under the Plan.

For collectively bargained participants, disability benefits will continue to be paid if a strike occurs and the disability started prior to the strike. Benefits will be paid up to the maximum duration approved under the Plan.

For more information about when LTD benefits end, refer to the plan's evidence of coverage.

If a Participant Becomes Disabled Again

Once a participant is eligible to receive LTD benefits, separate periods of disability resulting from the same or related causes are considered a continuous period of disability unless the participant returns to active service with Leidos for more than six consecutive months. A period of disability is not continuous if separate periods of disability result from unrelated causes or the later disability occurs after coverage ends.

If a participant is eligible for coverage under a plan that replaces this disability plan, the successive periods of disability provision will not apply.

For more information about what happens when a participant becomes disabled again, refer to the plan's evidence of coverage.

What the LTD Plan Does Not Cover

LTD benefits will not be paid for a disability that results, directly or indirectly, from:

- Suicide, attempted suicide, or whenever a participant injures himself or herself on purpose;
- War or any act of war, whether or not declared (For Class 1 employees only);
- Serving on full-time active duty in any armed forces. If the participant sends proof of military service, the plan will refund the portion of the premium paid to cover the participant during a period of such service;
- Active participation in a riot;
- Commission of a felony; or
- Revocation, restriction or non-renewal of a participant's license, permit or certification necessary to perform the duties of his or her occupation unless that is due only to covered injuries or illnesses.

LTD benefits will not be paid for any period of disability during which the participant:

- Is incarcerated in a penal or corrections institution;
- Is not receiving appropriate care under a licensed physician;
- Fails to cooperate with the plan in the administration of the claim, such as providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;

- Refuses to participate in rehabilitation efforts as required by the plan; or
- Refuses to participate in a Transitional Work Arrangement or other modified work arrangement.

"Transitional Work Arrangement" means any work offered to the participant by Leidos or an affiliated company while the participant is disabled, and which may be his or her own or any occupation. The term includes but is not limited to reassigned duties, work site modification, flexible work arrangements, job adaptation or special equipment.

For more information about what the LTD Plan does not cover, refer to the plan's certificate of coverage.

Conversion Privilege

If a participant's coverage ends because employment with Leidos ends, or a participant is laid off or on an uninsured leave of absence, the participant may be eligible for long-term disability conversion insurance. To be eligible, a participant must have been insured for disability benefits and actively at work for at least 12 months. A participant must apply for conversion insurance within 62 days after coverage ends. The benefits of the conversion plan will be those benefits offered at the time a participant applies. The premium will be based on the rates in effect for conversion plans at that time.

Conversion insurance is not available if any of the following conditions apply:

- A participant is retired or age 70 or older;
- A participant is not in active service because of disability; or
- The insurance policy is canceled for any reason.

Leidos offers eligible participants the opportunity to save money by paying for eligible health care and/or dependent daycare expenses on a pre-tax basis through the **Health Care Flexible Spending Account** and the **Dependent (Day) Care Flexible Spending Account.** A participant may make contributions to one or both Flexible Spending Accounts, which can reduce his or her tax liability. Participation in a Flexible Spending Account program is voluntary.

The Leidos Flexible Spending Accounts are administered by HealthEquity. Participants may log on to HealthEquity to submit verification, order additional health care debit cards, file a claim, check claim status or account balance information.

Health Care Flexible Spending Account

Leidos offers two types of Health Care FSAs:

- Limited Purpose Health Care FSA (HSA Compatible)
- HealthCare FSA

Limited Purpose Health Care FSA (HSA-Compatible)	Health Care FSA
• Use it when you have an HSA	• Use it when you are not enrolled in a Healthy Focus plan with an HSA and are not enrolled in any other High Deductible Medical Plan with an HSA
• For eligible dental and vision expenses	• For eligible medical, prescription drug, dental and vision expenses
• For medical and prescription drug expenses after you meet the annual deductible (Contact HealthEquity if you meet the deductible to find out what you will need to provide to begin using your account for eligible medical and prescription drug expenses)	

A participant can set aside between $100 and $3,050 for the 2023 Plan Year—on a pre-tax basis—to pay for eligible medical, dental, and vision care expenses, including:

- Eligible services not covered by a medical, dental or vision plan (except for cosmetic procedures);
- Annual deductibles;
- Copayments; and
- Out-of-pocket expenses.

See list of **eligible** and **ineligible** health care expenses later in this document.

Once enrolled in the Health Care Flexible Spending Account, a participant may not change the amount he or she contributes to the account, unless the participant experiences a qualified status change. See "**Changing Coverage (Qualified Status Changes)**"in the Participating in the Plans section for more information about qualified status changes.

Important: Participants must make an annual election each year. Health Care Flexible Spending Account elections cannot automatically roll over into the next plan year.

Carry-Over Feature

For the 2023 Plan Year, employees are able to carry-over up to $610 of unused Limited Purpose Health Care FSA or Health Care FSA balance remaining at the end of the year into the next Plan Year. These funds will be added to the Participant's Health Care FSA or Limited Purpose Health Care FSA balance in the subsequent Plan Year.

Participants who elect to contribute to a Health Savings Account (HSA) for the next Plan Year, may carry over up to $610 of unused FSA funds to a Limited Purpose Health Care FSA balance in the subsequent Plan Year. Any remaining balances in excess of the $610 carry-over feature at the end of the year will be forfeited.

Eligible Health Care Expenses

Generally, any health care expense that the IRS allows as a deduction on income tax returns is eligible for reimbursement, provided it is not reimbursed from any other source. This includes expenses incurred for anyone a participant is entitled to claim as a dependent on his or her tax return, regardless of whether that dependent is covered under Leidos' medical, dental or vision plans. **Please note that neither participant insurance premiums nor expenses for registered domestic partners are eligible for reimbursement under the Healthcare Flexible Spending Account.**

You may be reimbursed for your own expenses as well as those for your qualified dependents. A dependent is an individual who qualifies as a dependent under a Company-sponsored health plan. This generally includes your spouse and your children up to age 26. For this purpose, "children" means your natural children, your stepchildren, your legally adopted children, and children placed with you for adoption. (Expenses for a domestic partner or children of a domestic partner are generally not

eligible for reimbursement unless the person qualifies as your dependent for federal tax purposes). Your dependents do not need to be enrolled in a Company-sponsored health plan for you to receive reimbursement of their eligible health-related expenses. Only expenses incurred while you are participating in the Health Care FSA are eligible for reimbursement.

Health-related expenses that qualify for reimbursement are defined by the IRS (details can be found in IRS Publication 502, which provides general guidance as to whether expenses qualify as medical care under Section 213). Keep in mind that eligible expenses may change if the tax laws are revised. The health care expenses below are examples of covered expenses when not reimbursed by another plan, insurance policy or Medicare. This list is meant to provide only a summary of eligible expenses. For a more comprehensive list, visit the HealthEquity website:

- Acupuncture;
- Alcohol/substance abuse treatments or rehab;
- Ambulance services;
- Artificial limbs;
- Artificial teeth;
- Assisted Living
- Baby Formula
- Birth control pills and devices prescribed by a physician;
- Contact lenses/eyeglasses;
- Braces
- Breast Pump
- Copayments & Coinsurance (under insurance plan);
- Crutches and canes(prescribed);
- Deductibles (under insurance plan);
- Dental treatments
- Dentures
- Fees for physical and mental health services provided by:
    - Chiropodists;
    - Chiropractors;
    - Christian Science practitioners;
    - Dentists;
    - Ophthalmologists;
    - Optometrists;
    - Osteopaths;
    - Podiatrists;

  - Psychiatrists;
  - Psychologists;
  - Surgeons
- Feminine Hygiene Treatment
- Fertility Treatment
- Fitness Tracker
- Flu Shot
- Glucose Monitor
- Health institute—treatment that is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness;
- Hearing aids and diagnostic services;
- Hospital services;
- In Vitro Fertilization
- Laboratory fees;
- Laser eye surgery;
- Learning disability treatment;
- Long-term care expenses
- Medical equipment (prescribed);
- Nicotine Patches
- Nursing home
- Nursing services;
- Operations/surgery, including abortions;
- Orthodontia
- Orthopedic shoes (excess cost of regular shoes);
- Over-the-counter medications
- Oxygen Equipment;
- Physical Therapy
- Pregnancy Tests
- Prenatal Vitamins
- Prescription drugs;
- Routine physical exams and immunizations;
- Smoking cessation programs;
- Special schools for the mentally and/or physically handicapped;
- Speech Therapy
- Sterilization/vasectomy;

- Telephone and television equipment for the deaf;
- Therapy (physical, psychiatric, occupational);
- Transplants;
- Vasectomy
- Viagra
- Weight-loss programs (only for treatment of a medical condition, not for general well- being);
- Wheelchair; and
- X-rays.

Ineligible Health Care Expenses

Some expenses are not eligible for reimbursement from the Health Care Flexible Spending Account. Below are examples of ineligible health care expenses. This list is meant to provide only a summary of ineligible expenses:

- Bottled water;
- Care of a normal and healthy baby by a nurse;
- Cosmetic dentistry, including teeth bleaching or whitening;
- Dance lessons;
- Elective cosmetic medical procedures;
- Electric toothbrushes, even if recommended by a dentist;
- Electrolysis or hair removal;
- Funeral and burial expenses;
- Hair transplants;
- Health club dues;
- Household help;
- Insurance premiums other than those explicitly included;
- International medicines;
- Medical coverage premiums;
- Maternity clothes;
- Special foods, even if required for allergies;
- Swimming lessons;
- Toothpaste and other sundries;
- Trips or vacations for general health improvement;
- Vitamins, supplements or tonics (unless specifically directed to use by a medical provider to treat a specific medical condition)

Flexible Spending Account Reimbursement

Participants have three options in which to receive reimbursement from their **flexible spending account:**

- **Health Care Debit Card (not available for dependent daycare)**—Participants can use their HealthEquity health care debit card at select pharmacies, healthcare providers and general merchandise stores that have an IRS-approved inventory and checkout system. In most instances, the card transaction will be automatically verified at checkout. With this verification, participants may have to submit a receipt to HealthEquity after the transaction. Participant is required to keep each receipt for tax purposes and in the event it is needed for verification.
- **Request Reimbursement** — Participants will be able to claim funds from their flexible spending account by requesting reimbursement on the HealthEquity website. As part of the online process, they can upload the backup documentation and associate them directly to the claim. Most claims are processed within a few days after they are received, and payments are sent shortly thereafter. Participants will receive a check in the mail if they do not set up their direct deposit information with HealthEquity.

  The participant can fax or mail their claim form, by downloading the Health Care Flexible Spending Account claim form to 1-801-999-7829 or mailing it to:

  HealthEquity
  Attn: HealthEquity Claims
  15 W. Scenic Pointe Dr.
  Suite 100
  Draper, UT 84020

- **Pay Provider Online**— Participants can pay many of their eligible healthcare expenses directly from their flexible spending account without filling out paper claims forms. Just enter the provider's name and other requested information with the backup documentation and payment will be sent directly to the provider.

Participants in the Health Care Flexible Spending Account can be reimbursed for the full amount they contribute during the year at any time during the year, even if they do not currently have that much money in their account.

If participants have concerns about how a claim has been administered, or wish to appeal a claims decision, information on relevant procedures is available in the Plan Information section.

If You Leave Leidos

If you leave the Company during the year, any contributions you are making will stop and you have until April 30 of the following plan year to submit claims for reimbursement for any remaining balance. You will not be reimbursed for any eligible expenses incurred after your date of termination (or end of plan participation, if later). However, you may be able to continue your Health Care Flexible Spending Account coverage under COBRA on an after-tax basis.

Electing COBRA Coverage

When your participation in your Health Care Flexible Spending Account ends due to one of the qualifying events listed below, you may have limited rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your account until the end of the calendar year in which your participation ends.

- You leave the Company (for reasons other than gross misconduct);
- Your coverage stops because you no longer meet the eligibility requirements;
- You die;
- You fail to return to work at the end of your leave under FMLA

If you have funds remaining in your Health Care Flexible Spending Account, the COBRA administrator will provide you with a COBRA election form for continued coverage. To elect COBRA continuation coverage, you must complete and return the form to the COBRA administrator within 60 days after your coverage ends or within 60 days after you receive the form (whichever is later). If you elect COBRA coverage, the effective date of the coverage is the date of the qualifying event. You will have an additional 45 days following your election of COBRA coverage to pay any outstanding premiums.

You can continue the coverage until the end of the calendar year, as long as:

- You continue to make contributions for coverage within 30 days of the due date, and
- The Company is still offering the Plan to its employees.

You will have to pay 100% of the monthly contribution plus a 2% administrative charge for coverage under COBRA. Your contributions will be made on an after-tax basis.

Dependent (Day) Care Flexible Spending Account

A participant can set aside money on a pre-tax basis to pay for eligible dependent day care expenses for qualified dependents. These expenses must be necessary in order for a participant (and spouse, if married) to work. The amount that can be set aside each year is a minimum of $100 up to:

- $5,000* if the participant is single, or married and filing tax returns jointly;
- A total amount of $5,000* together if the participant's spouse has a dependent care Flexible Spending Account through his or her company; or
- $2,500* if the participant is married but files separate tax returns

* These are the maximum contributions allowed for dependent care expenses under current IRS rules.

Important: Participants must make an annual election each year. Dependent (Day) Care Flexible Spending Account elections cannot automatically roll over into the next plan year.

If a participant or spouse earns less than $5,000, the combined amount that the participant and spouse can contribute may not exceed the amount of the lower salary.

Under the Dependent (Day) Care Flexible Spending Account, a qualified dependent is:

- A child under age 13 whom the participant claims as a dependent on his or her federal income tax return;
- A participant's spouse who is physically or mentally incapable of self-care; or
- Any other dependent that is physically or mentally incapable of self-care, whom the participant claims as a dependent on his or her federal income tax return, and who normally spends at least eight hours in the participant's home each day.

Once enrolled in the Dependent (Day) Care Flexible Spending Account, a participant generally may not change the amount he or she contributes to the account, unless the participant experiences a qualified status change. See "**Changing Coverage (Qualified Status Changes)**"in the Participating in the Plan section for more information about qualified status changes.

However, a participant may change the amount he or she contributes when there is a change in providers, a change in childcare or adult care costs or a general change in his or her care situation.

Eligible Dependent (Day) Care Expenses

Generally, any dependent care expense that the IRS allows as a deduction on income tax returns is eligible for reimbursement, provided it is not reimbursed from any other source. This includes

expenses incurred for anyone a participant is entitled to claim as a dependent on his or her tax return, regardless of whether that dependent is covered under Leidos' medical, dental or vision plans. **Please note that expenses for registered domestic partners and dependent children of registered domestic partners are <u>not</u> eligible for reimbursement under the Dependent (Day) Care Flexible Spending Account.**

Below are examples of eligible dependent care expenses. This list is meant to **provide only a summary of eligible expenses**:

- Care at a licensed nursery school, day camp, or day care center;
- Services from individuals who provide dependent care in or outside a participant's home, unless the provider is the participant's spouse, own child under age 19, or any other dependent;
- After-school care for children under age13;
- Household services related to the care of an elderly or disabled adult who lives with a participant; and
- Any other services that qualify as dependent care expenses under IRS regulations.

Important: For a detailed list of eligible dependent care expenses, please refer to IRS publication 503, (called" Child and Dependent Care Expenses") available from your local IRS office or go to the **IRS web site**(www.irs.gov).

Ineligible Dependent (Day) Care Expenses

Below are examples of ineligible dependent care expenses. This list is meant to **provide only a summary of eligible expenses**:

- Expenses for food, clothing or education (unless incidental to the care);
- Registrations fees;
- Expenses for overnight camp;
- Expenses for transportation between a participant's house and the place that provides day care services, or the cost of transportation for a care provider;
- Expenses for dependent care when either the participant or his or her spouse is not working or is not looking for work;
- Charges for convalescent or nursing home care for a parent or a disabled spouse;
- Expenses paid to the spouse, a participant's own children under age 19, or any other dependents; and
- Expenses for which a federal child-care tax credit would be taken.

Important: For a detailed list of eligible dependent care expenses, please refer to IRS publication 503, (called "Child and Dependent Care Expenses") available from your local IRS office or go to the **IRSweb site**(www.irs.gov).

Child Care Credit

Another way to reduce dependent care expenses is to take a tax credit when filing an income tax return. However, a participant may not contribute to a Dependent (Day) Care Flexible Spending Account and take the tax credit for any expenses reimbursed through the Dependent (Day) Care Flexible Spending Account.

With the tax credit, a participant can claim a deduction for a percentage of eligible dependent care expenses (the same expenses as defined for the Dependent (Day) Care Flexible Spending Account). The tax credit may be taken only on expenses up to $3,000 for one dependent and up to $6,000 for two or more dependents.

The tax credit percentage applied to eligible expenses decreases as a participant's adjusted gross income rises. Generally, if a participant's family income is greater than$24,000 per year, the Dependent (Day) Care Flexible Spending Account will save more in taxes than the childcare income tax credit. However, the advantages of the Flexible Spending Account or the tax credit depend on a participant's overall tax situation and should be discussed with a tax adviser.

Dependent (Day) Care Flexible Spending Account Reimbursement

Participants must pay for eligible dependent day care expenses, save the receipts, and then file a claim for reimbursement from their accounts.

- **Request Reimbursement** — Participants will be able to claim funds from their flexible spending account by requesting reimbursement on the HealthEquity website. As part of the online process, they can upload the backup documentation and associate them directly to the claim. Most claims are processed within a few days after they are received, and payments are sent shortly thereafter. Participant will receive a check in the mail if they do not set up their direct deposit information with HealthEquity.

  The participant can fax or mail their claim form, by downloading the Dependent Care Flexible Spending claim form and faxing the completed form to 1-801-999-7829or mailing it to:

  HealthEquity
  Attn: HealthEquity Claims
  15 W. Scenic Pointe Dr.
  Suite 100
  Draper, UT 84020

- **Pay Provider Online** — Participants can pay many of their eligible dependent daycare expenses directly from their flexible spending account without filling out paper claims forms. Just enter the provider's name and other requested information with the backup documentation and payment will be sent directly to the provider.

Unlike with the Health Care Flexible Spending Account, a participant may receive reimbursement only up to the balance available in his or her account at the time the claim is filed.

If participants have concerns about how a claim has been administered, or wish to appeal a claims decision, information on relevant procedures is available in the Plan Information section of the complete SPD.

If You Leave the Company

If you leave the Company during the year, any contributions you are making will stop and you have until April 30 of the following plan year to submit claims for reimbursement for any remaining balance. You will not be reimbursed for any eligible expenses incurred after your date of termination.

Important Rules About Flexible Spending Accounts

- **Must enroll annually** — Participants must enroll during each Open Enrollment period in order to participate each calendar year.
- **Use it or lose it** — Estimate annual dependent (day) care expenses carefully! Any money put aside in a Dependent (Day) Care Flexible Spending Account must be used for eligible dependent care expenses incurred between January1 and December 31 (or during the period of plan participation). The deadline to submit claims for the previous year's expenses is April 30th of the following year. Any money left in the account after April 30th may be forfeited.
- **Carry-Over Provision –** IRS regulations specify that an employer may choose to allow a carry-over of unused healthcare FSA funds to the next plan year. For the 2023 Plan Year, Leidos allows active participants to carry-over up to $610 of unused funds to be reimbursed for qualified medical expenses incurred in the following Plan Year (2024). Any unused funds in excess of the carryover will be forfeited after the April 30th deadline to submit claims for the previous Plan Year.
- **No double dipping**— Healthcare expenses reimbursed through the HealthCare Flexible Spending Account and dependent care expenses reimbursed through the Dependent (Day) Care Flexible Spending Account cannot also be deducted on federal income tax returns.

- **No transferring of funds** — Transfers of funds from the HealthCare Flexible Spending Account to the Dependent (Day) Care Flexible Spending Account and vice versa are not permitted per the IRS.
- **Credit Balance at End of Coverage Period –** Claims received by the Plan Administrator on or after the earlier of (a) 90 days after termination of employment, or (b) April 30 following the end of the Plan Year for expenses incurred during the prior Plan Year, will be considered untimely and not eligible for reimbursement under the Plan. If any balance remains credited to the Participant's Health Care FSA after all reimbursements are made for that Plan Year, such balance is not carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during the subsequent Plan Year and is not available to the Participant in any other form or manner. Instead, such balance remains the property of Leidos, and the Participant forfeits all rights with respect to such balance.
- **Continuation of Coverage** —Participants who would lose coverage under the Health Care FSA as a result of a qualifying life event can elect, within a stated election period, continuation of coverage of benefits previously received under the Health Care FSA. If a participant timely elects continuation of coverage under COBRA, the benefits elected will be available for the time period prescribed by law (i.e., the end of the Plan Year).

Leidos provides a variety of voluntary well-being benefits to support employees long-term health and well-being.

- Virgin Pulse Well-Being Platform
- Headspace Mindfulness App
- meQuilibrium Digital Resiliency Program

Virgin Pulse Well-Being Platform

Leidos has partnered with Virgin Pulse to help support employees on their journey to health and well-being. The Virgin Pulse program is available to all benefit eligible employees and their spouse/domestic partner, if enrolled in the well-being benefit. The program supports participants on their journey to their best health and well-being. By checking in on your health and completing engaging activities and healthy habits, you will earn points toward great rewards.

Note: Incentive rewards are paid out as soon as administratively possible. The participant must be an active Leidos employee or spouse/domestic partner of an active Leidos employee on the date of the incentive payment in order to be eligible to receive such payment.

Equal Employment Opportunity Commission (EEOC) Notice for Employer-Sponsored Well-being Programs

The Virgin Pulse well-being program is a voluntary well-being program and is administered according to federal rules permitting employer-sponsored well-being programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Protections from Disclosure of Medical Information

Leidos is required by law to maintain the privacy and security of your personally identifiable health information. Although Virgin Pulse and Leidos may use aggregate information it collects to design a program based on identified health risks in the workplace, Virgin Pulse will never disclose any of your

personal information either publicly or to Leidos, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the well-being program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the well-being program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the well-being program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the well-being program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the well-being program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the well-being program will be maintained by Virgin Pulse. Information stored electronically will be encrypted, and no information you provide as part of the well-being program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the well-being program, we will notify you immediately.

Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the well-being program, nor may you be subjected to retaliation if you choose not to participate.

Headspace Mindfulness App

Leidos is pleased to partner with Headspace and announce that all global employees can subscribe to Headspace for Work at **no cost**.

Headspace is meditation made simple, teaching members life-changing mindfulness skills in just a few minutes a day. Headspace can make your everyday just a little bit better by helping you get happy, stress less, and sleep soundly. You can learn the life-changing skills of meditation and mindfulness through simple exercises and expert guidance.

If you choose to subscribe to Headspace, your use of their application and website is subject to Headspace's **Terms and Conditions** and **Privacy Policy**. You are encouraged to review these documents before providing your information to Headspace.

meQuilibrium Digital Resilience Program

Leidos has partnered with meQuilibrium (meQ), a digital resilience training program that makes is easy to prioritize mental well-being and helps participants learn ways to reduce stress and have more energy, focus, and control. This benefit is available to all global Leidos employees at no cost.

meQ is a personalized and confidential resilience building platform designed to help participants build the mental and emotional strength to face each day with confidence. meQ helps people understand the thinking patterns and lifestyle habits that cause them to feel overwhelmed, anxious, or at risk of burnout. The personalized program delivers a guided step-by-step approach to help build resilience and manage challenging situations.

If you choose to enroll in meQ, your use of their platform is subject to their **Terms and Conditions** and **Privacy Policy**. You are encouraged to review these documents before providing your information to meQ.

Leidos employees and their eligible dependents have access to the ComPsych Employee Assistance Plan (EAP), which offers confidential, personal assessment and referral services. The full cost of the program is paid for by Leidos.

Covered Benefits

Employees and their dependents are each eligible for up to eight (8) visits per presenting problem, per calendar year at no charge.

EAP defines a "dependent" as any natural person (other than an employee) eligible to receive benefits under the Plan. In addition, with respect to EAP services, "dependent" shall also include any person residing with an employee on a full-time basis.

ComPsych EAP counselors can help you with the following:

- Relationship counseling (marital discord, parent-child issues, etc.)
- Emotional counseling (depression, anxiety, moodiness, etc.)
- Financial and legal service referral assistance
- Help in dealing with work-related stress
- Counseling on providing care for elderly parents
- Addiction counseling (alcohol, substance abuse, gambling, etc.)
- Work/Life resources and referral programs for childcare, education, eldercare, legal assistance and multitude of other community services

Confidentiality

It's important that you and your household have access to confidential counseling and that your right to privacy is maintained. That's why your contact with ComPsych, including counseling records and services, will be kept confidential in accordance with federal and state laws.

ComPsych will not share information about your counseling with Leidos or anyone else without your written permission. The only exception is when the life or safety of an individual is seriously threatened, or if disclosure is required by law.

For more information regarding your privacy, refer to the ComPsych Privacy Notice, or contact ComPsych directly at 866-365-0853.

Accessing ComPsych

ComPsych EAP is available 24 hours a day, seven days a week.

- **Telephone Access**: Call ComPsych at 866-365-0853 anytime, day or night, to speak with a professional counselor about any issue of concern in your life. TDD and language translation services are available.
- **Website**: Access ComPsych resources on the internet at www.guidanceresources.com and enter the WebID: Leidos. Log on to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.
- **Email**: Visit www.guidanceresources.com and select “Send a Question” to request secure email contact with a counselor.
- **App**: Download the ComPsych GuidanceNow app for quick, convenient access to ComPsych services. To log into the app, use the Leidos WebID: Leidos.

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 theorder 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