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 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 the Classic Network Plan, Health Maintenance Organizations (HMOs), Triple S, 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.

Dependents

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

- The participant's legal spouse or domestic partner (See "Domestic Partners")
- Each child of the participant or 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 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, 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 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.

Domestic Partners

The participant may enroll his or her domestic partner and the 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 domestic partnership is a committed same-sex or opposite- sex relationship, in which 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 domestic partner and have not signed a 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 and proof of joint ownership 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.

Domestic partner coverage is different from spouse coverage. For instance:

- Participant contributions for domestic partner coverage and their eligible children must be paid on an after-tax basis;
- The value of benefits provided to a 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, Alight. Throughout the year, Alight 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.

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 Alight 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 Alight at 1-866-851-0731, or Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

Employee Contributions

Leidos and participants share the cost of coverage. Each pay period, a participant who enrolls in a Leidos medical plan 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.

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.

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 prostate-specific antigen/digital rectal examination (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/maximum allowed amount (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/maximum allowed amount.

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/maximum allowed amounts; 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 $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/maximum allowed amount. The participant pays the remaining percentage (coinsurance) plus any amount above the recognized charge/maximum allowed amount.

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/Maximum Allowed Amount – Voluntary Services

The recognized charge or maximum allowed amount 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/maximum allowed amount 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. The Plan Administrator 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 the administrator.

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.

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 prostate-specific antigen/digital rectal examination (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 plan begins paying100% of eligible expenses up to the negotiated rate (for in-network providers) or recognized charge/maximum allowed amount (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/maximum allowed amounts.

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/maximum allowed amounts; 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 $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/maximum allowed amount. The participant pays the remaining percentage (coinsurance) plus any amount above the recognized charge/maximum allowed amount.

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/Maximum Allowed Amount – Voluntary Services

The recognized charge/maximum allowed amount 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/maximum allowed amount 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. The Plan Administrator 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 the Plan Administrator.

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.

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 $1,800; the family deductible is $3,600.

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 prostate-specific antigen/digital rectal examination (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/maximum allowed amount (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/maximum allowed amounts.

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/maximum allowed amounts; 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 $3,600; the family annual out-of- pocket maximum is $7,200. 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/maximum allowed amount. The participant pays the remaining percentage (coinsurance) plus any amount above

the recognized charge limit/maximum allowed amount.

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/Maximum Allowed Amount – Voluntary Services

The recognized charge/maximum allowed amount 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/maximum allowed amount 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. The Plan Administrator 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 the Plan Administrator.

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.

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 $1,800; the family deductible is $3,600.

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 prostate-specific antigen/digital rectal examination (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/maximum allowed amount (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/maximum allowed amounts.

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/maximum allowed amounts; 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 $1,800; the family annual out- of- pocket maximum is $3,600. 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.

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/maximum allowed amount. The participant pays the remaining percentage (coinsurance) plus any amount above the recognized charge/maximum allowed amount.

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/Maximum Allowed Amount – Voluntary Services

The recognized charge/maximum allowed amount 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/maximum allowed amount 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.

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. The Plan Administrator 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 the Plan Administrator.

Comparing the Healthy Focus Medical Plans

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

Self-Insured Medical Plans (Healthy Focus)								
	Healthy Focus Basic Plan		**Healthy Focus Essential Plan**		**Healthy Focus Advantage Plan**		**Healthy Focus Premier Plan**	
	In-Network*	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****	**In-Network***	**Out-of-Network****
Annual Deductible								
• **Employee Only**	$4,000	$8,000	$2,000	$4,000	$1,800	$3,600	$1,800	$3,600
• **Family**	$8,000	$16,000	$4,000	$8,000	$3,600	$7,200	$3,600	$7,200
Annual Out-of-Pocket (OOP) Maximum (includes deductible)								
• **Employee Only**	$6,750	$13,000	$5,000	$10,000	$3,600	$7,200	$1,800	$7,200
• **Family**	$13,500	$27,000	$10,000	$20,000	$7,200	$14,400	$3,600	$14,400
• **Embedded OOP**	$8,550 individual within family	N/A	$8,550 individual within family	N/A	N/A	N/A	N/A	N/A
Office Visits – Preventive Care	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% after deductible	Covered at 100% (deductible does not apply)	You pay 50% 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 50% 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)	You pay 50% after deductible
Emergency Room	You pay 50% after deductible	You pay 50% after deductible	You pay 35% after deductible [3]	You pay 35% after deductible [3]	You pay 20% after deductible [3]	You pay 20% after deductible [3]	You pay 0% after deductible[3]	You pay 0% after deductible [3]

	Healthy Focus Basic Plan		Healthy Focus Essential Plan		Healthy Focus Advantage Plan		Healthy Focus Premier Plan	
	In-Network[1]	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**	**In-Network[1]**	**Out-of-Network[2]**
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 50% 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 50% 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 50% after deductible
Routine Mammogram[4]	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% after deductible
Prostate Screening[4]	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% 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 50% 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 50% 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 50% after deductible
Outpatient Rehabilitation – Physical, Occupational 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 50% after deductible

	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****
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 50% after deductible
Hearing Aid Exam (1 every 24 months)	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 50% after deductible
Hearing Aids ($2,500 max every 3 years)	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 50% after deductible
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 50% 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 50% 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 50% 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 50% after deductible
Transplant Services[5]	Aetna IOE or Anthem BDCT/CME: You pay 50% after deductible Non-Aetna IOE or Non-Anthem BDCT/CME: You pay 50% after deductible	You pay 50% after deductible	Aetna IOE or Anthem BDCT/CME: You pay 35% after deductible Non-Aetna IOE or Non-Anthem BDCT/CME: You pay 50% after deductible	You pay 50% after deductible	Aetna IOE or Anthem BDCT/CME: You pay 20% after deductible Non-Aetna IOE or Non-Anthem BDCT/CME: You pay 50% after deductible	You pay 50% after deductible	Aetna IOE or Anthem BDCT/CME: You pay 0% after deductible Non-Aetna IOE or Non-Anthem BDCT/CME: You pay 50% after deductible	You pay 50% after deductible

[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 the recognized charge/maximum allowed amount.
[3]For non-emergent use of the emergency room, employee pays 50% after deductible.
[4]Subject to age and visit limits under Aetna.
[5]Transplants must be performed at an Aetna Institute of Excellence (IOE) or at an Anthem Blue Distinction Center for Transplants (BDCT) or Center of Medical Excellence (CME) to be covered at the in-network level.

How the Healthy Focus 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.

Classic Network Medical Plan

The Classic Network Medical Plan provides comprehensive medical benefits and quality care. This plan provides in-network coverage only, which means all services must be obtained from in-network providers to be eligible for coverage. Out-of-network services will not be covered except in cases of emergency or network deficiency. Be sure to review the provider directory to ensure your preferred providers are in-network.

Coverage is provided under Aetna's Select Open Access network and Anthem's Bluecard PPO network. Both networks provide an extensive selection of physicians, hospitals and specialists. Please note that Anthem is available only to employees of Dynetics, Dynetics Technical Solutions, Inc. (DTS), and certain Leidos, Inc. employees.

Classic Network Medical Plan				
	Aetna		Anthem	
	In- Network You pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Annual Deductible • Employee Only • Family	 $1,500 $3,000	 N/A	 $1,500 $3,000	 N/A
Annual Out- of-Pocket (OOP) Maximum (includes deductible) • Employee Only • Family • Embedded OOP	 $3,000 $6,000 $3,000	 N/A	 $3,000 $6,000 $3,000	 N/A

Classic Network Medical Plan				
	Aetna		**Anthem**	
	In- Network **You pay**	**Out-of-Network** **You Pay**	**In-Network** **You Pay**	**Out-of-Network** **You Pay**
Preventive Care	0%; no deductible	N/A	0%; no deductible	N/A
Office Visits (PCP)	$30 copay, no deductible	N/A	$30 copay, no deductible	N/A
Office Visits (Specialist)	$50 copay, no deductible	N/A	$50 copay, no deductible	N/A
Emergency Room • Emergent Visit (no deductible) • Non-emergent Visit	• $250 copay • Deductible, then 50%	• $250 copay • Not covered	• $250 copay • Deductible, then 50%	• $250 copay • Not covered
Hospital Admission	Deductible, then 20%	N/A	Deductible, then 20%	N/A
Outpatient Lab and X-ray (non-routine)	Deductible, then 20%	N/A	Deductible, then 20%	N/A
Outpatient Surgery	Deductible, then 20%	N/A	Deductible, then 20%	N/A
Skilled Nursing Facility	Deductible, then 20% 60 days per confinement	N/A	Deductible, then 20% 60 days per confinement	N/A
Home Health Care (maximum visits combined with Private Duty Nursing)	Deductible, then 20% (each Home Health Aide visit up to 4 hours = 1 visit; 100 visits per year)	N/A	Deductible, then 20% (4 hours = 1 visit; 3 visits per day; 100 visits per year)	N/A
Hospice Care (includes part-time or infrequent nursing care by an RN or LPN up to 8 hours a day. Also includes part-time or infrequent home health aide services up to 8 hours per day)	Deductible, 20%	N/A	Deductible, 20%	N/A
Outpatient Rehabilitation – Physical, Occupational and Speech Therapy (as medically necessary) Limited to 60 combined visits per year	$50 copay, no deductible	N/A	Outpatient Institutional: deductible, then 20% PCP Office: $30 copay, no deductible Specialist Office: $50 copay, no Deductible	N/A
Durable Medical Equipment	Deductible, then 20%	N/A	Deductible, then 20%	N/A
Hearing Aid Exam	Covered based on type of service and where it is received (1 visit every 24 months)	N/A	Covered based on type of service and where it is received (1 visit every 24 months)	N/A
Hearing Aids	Deductible, then 20% ($2,500 per pair every 3 years)	N/A	Deductible, then 20% ($2,500 per pair every 3 years)	N/A
Mental Health and Substance Abuse – Inpatient	Deductible, then 20%	N/A	Deductible, then 20%	N/A

Classic Network Medical Plan				
	Aetna		Anthem	
	In- Network You pay	Out-of-Network You Pay	In-Network You Pay	Out-of-Network You Pay
Mental Health and Substance Abuse – Outpatient	Office visit - $30 copay, no deductible Outpatient-All Other (habilitative treatment, partial hospitalization): 0%, no deductible	N/A	Outpatient – Deductible, then 20% Office visit - $30 copay, no deductible	N/A
Autism Spectrum Disorder Treatment	Covered based on type of service and where it is received	N/A	Covered at the benefit level of the services billed	N/A
Applied Behavioral Analysis	Covered based on type of service and where it is received	N/A	Covered at the benefit level of the services billed	N/A
Transplant Services[1]	IOE: Deductible, then 20% Non-IOE: Deductible, then 50%	N/A	BDCT/CME: Deductible, then 20% Non-BDCT/CME: Deductible, then 50%	N/A

[1] Transplants must be performed at an Aetna Institute of Excellence (IOE) or at an Anthem Blue Distinction Center for Transplants (BDCT) or Center of Medical Excellence (CME) to be covered at the in-network level (20% member coinsurance)

Precertification

If a participant is enrolled in a Healthy Focus Medical Plan or the Classic Network Medical 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.

The Plan Administrator will certify the medical necessity and length of any applicable hospital confinement for inpatient care. Under Aetna, inpatient precertification must be requested at least 14 days before admission. Under Anthem, pre-service review must be requested at least the day prior to the admission. The Plan Administrator 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 the Plan Administrator of all inpatient treatment within 48 hours of the admission. The participant or provider must contact the Plan Administrator regarding an emergency admission, regardless of whether the facility is in-network or out-of-network.

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 and Classic Network Medical Plan Cover

Services or supplies must be considered medically necessary by the Plan 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.

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 member from the place where the member 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 for a person confined as a full-time inpatient;
    - Outpatient hospital expenses: Charges for hospital services and supplies for a person who is not confined as a full-time inpatient; and
- 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 (preventive) physical exams (subject to age and visit limitations under Aetna);
- 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 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 proven that it is needed due to a change in the person's physical condition;
- Maternity;
- Mammograms;
- Routine pap smears (subject to age and frequency guidelines under Aetna);
- Chiropractic care, if medically necessary;
- Prostate specific antigen (PSA) (subject to age and frequency guidelines under Aetna);
- Infertility treatment for a female employee, the wife or 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;
- Spinal disorders;
- Treatment of the mouth, jaws and teeth due to a congenital birth defect or injury due to an accident. When provided by a physician, dentist and hospital, the plan covers the below. These procedures cannot be associated with the removal, replacement or repair of teeth unless due to an accident or congenital birth defect:
    - Cutting out cysts, tumors or other diseased tissues
    - Cutting into gums and tissues of the mouth;
- 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
- Under Aetna, transplants are covered at the in-network level only if performed by the Administrator's contracted Institutes (or Centers) of Excellence facilities. This includes heart transplant, lung transplant, liver transplant, bone marrow transplant, heart/lung transplant, kidney transplant, pancreas transplant, kidney/pancreas transplant.
- Under Anthem, transplants are covered at the in-network level only if performed at an Anthem Blue Distinction Center for Transplants (BDCT) or Center of Medical Excellence (CME).
- 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.
- 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
    - To be eligible for travel and lodging reimbursement, you must first confirm with the plan administrator that a network provider is not available within 100 miles of your home by calling the toll-free number on your ID card. Prior authorization may be required.
    - Under Aetna, this travel and lodging benefit is covered separately for:
        - Services coordinated through the Institutes of Excellence™, Institutes of Quality, National Medical Excellence® or Gene-based, Cellular and other Innovative Therapies (GCIT) programs
    - Under Anthem, travel and lodging benefits are covered separately for transplants at a Blue Distinction Center for Transplant (BDCT)
    - Under Aetna, the claim form must be submitted within 6 months of the date of service
- Under Aetna: 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.
- Under Anthem, the plan will pay for travel and lodging expenses to a Blue Distinction Center for

Transplant (BDCT) facility if the patient lives more than 100 miles from the transplant facility. The maximum lodging allowance is $50 per person for the patient and one companion, up to a total of $100 per night, The maximum travel and lodging benefit is $10,000 per transplant.

What the Healthy Focus Medical Plans and Classic Network Medical Plan Do Not Cover

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

- Except in cases of congenital birth defects or injury due to an accident, treatment for the mouth, jaws and teeth are excluded, 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;
- 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 domestic partner while the participant has dependent coverage under the plan;
- Charges above the recognized charge limits/maximum allowed amount as determined by the applicable Plan 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 an 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;
    - 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). Under Aetna, blood and blood products are covered when purchased by a facility/provider;
- 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

Mental Health and Drug or Alcohol Treatment

The Healthy Focus and Classic Network 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:

- Outpatient care:
    - Under the Healthy Focus Plans, a participant must meet the deductible and pay the applicable coinsurance.
    - Under the Classic Network Plan, a participant must meet the deductible and pay the applicable coinsurance. For office visits, the participant is responsible for the copay which is not subject to the deductible. Other outpatient services (habilitative treatment, partial hospitalization) are covered at 100% with no deductible.
- For inpatient care under the Healthy Focus and Classic Network Plan, a participant must meet the deductible and pay the applicable coinsurance.

Participants should call the plan administrator to receive information and guidance on how to locate a network provider or participants can search for a provider on the plan administrator's 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 under the Healthy Focus plans, 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 the Plan Administrator count toward the annual out-of-pocket maximums for the Healthy Focus plans.

Under the Classic Network Plan, you pay as follows:

- Inpatient: 20% after deductible
- Outpatient under Aetna: Office visits - $30 copay, no deductible; Other outpatient services (habilitative treatment, partial hospitalization) are covered at 100% with no deductible.
- Outpatient under Anthem: 20% after deductible; Office visits: $30 copay, no deductible

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/maximum allowed amount after deductible
- Healthy Focus Essential Plan: 50% of recognized charge/maximum allowed amount after deductible
- Healthy Focus Advantage Plan: 50% of recognized charge/maximum allowed amount after deductible
- Healthy Focus Premier Plan: 50% of recognized charge/maximum allowed amount after deductible

Under the Classic Network Plan, there is no coverage for out-of-network visits unless there is a network deficiency. You must call Aetna or Anthem to establish network deficiency.

Note: Deductibles and coinsurance for mental health and substance abuse services 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.

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 the Plan Administrator 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 the Plan Administrator's 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 the Plan Administrator as medically necessary;
- Psychological testing, except when considered medically necessary by the Plan Administrator;
- Private duty nursing, except when pre-certified by the Plan Administrator 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 the Plan Administrator with a lien against such claim for damages or relief in a form and manner satisfactory to the Plan Administrator;
- 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;

Network Deficiency Accommodation

If there is no in-network provider available near the member's home (within 45 miles for Aetna or 30 miles for Anthem), the Plan will cover an out-of-network provider at the in-network level. Member must call Aetna or Anthem to arrange the network deficiency accommodation.

Hearing Aids

Aetna

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
- Click on *Health & Wellness*
- Under *Health & Wellness Discounts*, click on *Hearing*

Anthem

If you reside in one of the states served by Anthem, you will have access to prescription and over-the-

counter (OTC) hearing aids through TruHearing, Anthem's hearing aid preferred provider partner. These states include California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, New York, Ohio, Virginia and Wisconsin. TruHearing will submit claims directly to Anthem on behalf of members. TruHearing is searchable on the provider search feature on the member portal, www.anthem.com. Members may also call the dedicated TruHearing phone number for Anthem members: 877-653-9397.

Members in non-Anthem states may purchase OTC hearing aids from any provider. The member must pay for the hearing aids upfront. The member may then submit a claim form along with the receipt and doctor's prescription for reimbursement.

Members also have access to prescription hearing aid discounts through NationsHearing, Hearing Care Solutions and Amplifon. Members may access these discounts by logging into www.anthem.com, clicking on **Care** and then selecting **Discounts**.

Coordination of Benefits

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

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

- Healthy Focus Basic Plan;
- Healthy Focus Essential Plan;
- Healthy Focus Advantage Plan;
- Healthy Focus Premier Plan
- Classic Network 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 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 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 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 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 Plans and Classic Network Plan Administrators

Aetna Inc. administers the Leidos Healthy Focus Consumer Directed Healthcare Plans (CDHP) and the Classic Network Plan:

- **Product Names:**
  - Aetna Open Access Plans– Aetna Choice POSII network
  - Open Access Aetna Select Health Plan – Select Open Access network

- **Leidos Group Number:** 698685
- **Aetna Customer Service (Aetna One Advisor) Phone:** 800-843-9126
- **Web site: Aetna** (www.aetna.com)

For Dynetics, Dynetics Technical Solutions (DTS), and a small subset of the Leidos population, the plan administrator is Anthem.

- **Product Name:** Anthem BlueCard PPO Network
- **Leidos Group Number:** 201108
- **Anthem Customer Service Phone:** 833-549-1179
- **Web site:** Anthem (www.anthem.com)

Filing Claims

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

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.

Aetna

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

Anthem

Participants may submit out-of-network claims online at www.anthem.com or through the Anthem Sydney Health app. Click on ***Claims***, then ***Submit a Claim***. Participants must attach receipts including provider name and address, National Provider Identifier (NPI), date of service, diagnosis code and CPT code with description.

Alternatively, participants may submit completed claim forms with documentation to:

P.O. Box 105187
Atlanta, GA 30348-5187

Healthy Focus Medical Plans and Classic Network Plan Prescription Drug Program

Prescription drug coverage under the Healthy Focus Medical Plans and the Classic Network Plan 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 30 days) 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.

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

Healthy Focus Medical Plans 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.

	Healthy Focus Basic Plan		Healthy Focus Essential Plan		Healthy Focus Advantage Plan		Healthy Focus Premier Plan	
	Network	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**	**Network**	**Out-of-Network**
Generic	50%	Not Covered	$5	Not Covered	$5	Not Covered	0%	Not Covered
Preferred Brand	50%		30%		30%		0%	
Non-Preferred Brand	50%		50%		50%		0%	

- **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.

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.** However, you must meet the annual medical plan deductible before the plan begins sharing the cost for non-preventive prescription drugs.

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.

Classic Network Medical Plan Prescription Drug Coverage

If you are enrolled in the Classic Network medical plan, you have access to prescription drug coverage through Express Scripts (ESI). You are not required to meet the deductible before the Plan begins covering your prescriptions, making it predictable to budget for your medications.

Below is the plan design for the prescription drug program.

	Classic Network Plan	
	Network	**Out-of- Network**
Generic	$10 Copay (Retail) $20 Copay (Mail Order)	Not Covered
Preferred Brand	$50 Copay (Retail) $100 Copay (Mail Order)	
Non- Preferred Brand	$100 Copay (Retail) $200 Copay (Mail Order)	
Specialty Drug	$250 Copay (Retail) $250 Copay (Mail Order)	

- **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.

Classic Network Plan copays do not count towards meeting your deductible. For the formulary, refer to the 2025 National Preferred Formulary.

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.

Healthy Focus Medical Plans and Classic Network Medical Plan 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.

Step Therapy

Step Therapy is an approach intended to control the costs of certain prescription drugs when lower cost drugs are available, such as a generic or lower-cost brand name. These drugs are proven to be safe and effective, as well as affordable. It begins by trying the most cost-effective drug therapy for a medical condition first. When patients don't respond to the first-line medications, more costly drug therapies, typically brand name drugs, can be requested for coverage approval.

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, penalties will be imposed after a covered member has met their out-of-pocket maximum.

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. 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 Health Benefits: 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 their Country of Citizenship (for U.S. citizens and their covered dependents, a Member working outside their Home Country or outside the United States for at least 180 days in a rolling 12-month period that overlaps with the plan year).

How the Cigna Plan Works

Participants in the Cigna Health Benefits 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 Health Benefits medical plan.

For more information about how a Cigna Health Benefits 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.

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.

HMSA Hawaii

The HMSA medical plan is a Preferred Provider Organization (PPO) available to employees who reside in Hawaii. With HMSA, members have access to quality care from their choice of doctors and specialists and Hawaii's top hospitals. This plan offers flexibility in the way a member gets medical benefits (e.g. office visits, inpatient facility services, outpatient services, etc.). In general, to get the best benefits possible, a member should seek services from HMSA participating providers. If a member chooses to visit a non-participating provider, the out-of-pocket costs may be higher.

Medical Plan Benefit Charts

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

Self-Insured CDHP Medical Plans				
Plan Name	**Benefit Summary - Aetna**	**Benefit Summary - Anthem**	**Detailed Plan Information - Aetna**	**Detailed Plan Information - Anthem**
Healthy Focus Basic Plan	2025 Benefit Summary	2025 Benefit Summary	2025 Evidence of Coverage	2025 Evidence of Coverage
Healthy Focus Essential Plan	2025 Benefit Summary	2025 Benefit Summary	2025 Evidence of Coverage	2025 Evidence of Coverage
Healthy Focus Advantage Plan	2025 Benefit Summary	2025 Benefit Summary	2025 Evidence of Coverage	2025 Evidence of Coverage
Healthy Focus Premier Plan	2025 Benefit Summary	2025 Benefit Summary	2025 Evidence of Coverage	2025 Evidence of Coverage

Self-Insured Network-Only Medical Plan		
Plan Name	**Benefit Summary**	**Detailed Plan Information**
Classic Network Plan	2025 Benefit Summary	2025 Evidence of Coverage

Fully-Insured Medical Plans		
Plan Name	**Benefit Summary**	**Detailed Plan Information**
Cigna Global Plan	2025 Benefit Summary	2025 Evidence of Coverage
HMSA Hawaii Plan	2025 Benefit Summary	2025 Evidence of Coverage
Kaiser Permanente Hawaii Plan	2025 Benefit Summary	2025 Evidence of Coverage
Kaiser Permanente California Plan	2025 Benefit Summary	2025 Evidence of Coverage
Kaiser Permanente Mid-Atlantic Plan	2025 Benefit Summary	2025 Evidence of Coverage
Kaiser Permanente Colorado Plan	2025 Benefit Summary	2025 Evidence of Coverage
Tricare Supplement Plan	2025 Benefit Summary	N/A
Triple S (Puerto Rico)	2025 Benefit Summary	2025 Evidence of Coverage

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 2025. (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.

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

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.
- Call 1-800-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).

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).