

**Leidos  
2026 Plan Year Benefit Summary**

|                        |                                              |
|------------------------|----------------------------------------------|
| PLAN NAME              | <b>VSP</b>                                   |
| PRODUCT NAME           | <b>VSP Choice - Base Plan</b>                |
| LEIDOS SYSTEMS CODE    | VSP                                          |
| PLAN STATES            | Nationwide                                   |
| CUSTOMER SERVICE PHONE | 1-800-877-7195                               |
| WEB ADDRESS            | <a href="http://www.vsp.com">www.vsp.com</a> |

| Benefit                                                                  | 2026 Plan Year - In Network * - Employee Pays                                                                                                                                                                                     | 2026 Plan Year - Out of Network - Plan Reimburses                                                                                           |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Frequency - Exams</b>                                                 | Every calendar year                                                                                                                                                                                                               | Every calendar year                                                                                                                         |
| <b>Frequency - Lenses</b>                                                | Every calendar year                                                                                                                                                                                                               | Every calendar year                                                                                                                         |
| <b>Frequency - Frames</b>                                                | Every calendar year                                                                                                                                                                                                               | Every calendar year                                                                                                                         |
| <b>Copay</b>                                                             | \$20                                                                                                                                                                                                                              |                                                                                                                                             |
| <b>Vision Exam</b>                                                       | Covered in full after copay                                                                                                                                                                                                       | Up to \$45 for exam services                                                                                                                |
| <b>Routine Retinal Screening</b>                                         | \$10                                                                                                                                                                                                                              |                                                                                                                                             |
| <b>Lenses</b>                                                            | Plan pays 100% for single vision, standard progressive, lined bifocal, lined trifocal and lenticular lenses. Lens options that enhance appearance, durability and functions of glasses are available with an average 30% discount | Plan reimburses up to:<br>\$30 for single vision;<br>\$50 for lined bifocal;<br>\$65 for lined trifocal;<br><del>\$100 for lenticular</del> |
| <b>Frames</b>                                                            | Plan covers frames up to \$150 (featured brands covered up to \$200); participants may upgrade frames by paying the difference in cost: <del>20% discount on any out-of-pocket costs</del>                                        | Plan reimburses up to \$70                                                                                                                  |
| <b>Contacts (in lieu of lenses and frames)</b>                           | Plan pays up to \$150 allowance for contact lenses. Contact lens exam (fitting and evaluation) covered in full after a copay not to exceed \$60; 15% discount on contact lens exam                                                | Plan reimburses up to \$105 for both contact lens fitting and evaluation and contacts                                                       |
| <b>Medically necessary contact lenses (in lieu of lenses and frames)</b> | Plan pays 100% if contact lenses are required for certain medical conditions that prevent a participant from wearing eyeglasses. Medically necessary contact lenses must be approved by VSP                                       | Plan reimburses up to \$210                                                                                                                 |
| <b>Laser Vision Correction</b>                                           | Plan pays \$100 per eye up to a \$200 lifetime maximum, plus plan provides discounts averaging 15% on charges not to exceed:<br>Custom LASIK: \$2,300 per eye;<br>LASIK \$1,800 per eye;<br>PRK: \$1,500 per eye                  | Plan pays \$100 per eye up to a \$200 lifetime maximum, no discounts available                                                              |
| <b>LightCare</b>                                                         | \$20 Copay<br>\$150 allowance                                                                                                                                                                                                     | Plan reimburses up to \$70                                                                                                                  |

\*\*Not available at Walmart Optical or Sam's Club Optical

**\*VSP doctors offer additional savings including a 20% discount on non-covered pairs of prescription glasses (lenses and frames). Services must be received within 12 months from the same VSP doctor who provided your last covered eye exam.**

**You can also save 15% off the cost of your contact lens exam when you receive contact lens services from VSP.**

**\*\*Coverage with a retail chain affiliate may be different. Once your benefit is effective, visit [vsp.com](http://vsp.com) for details.**

***This benefit summary has been prepared by Mercer based on documents provided by the applicable licensed insurance carrier. Please refer to the Certificate of Coverage (COC) for terms and conditions of all benefits. Benefits may require pre-certification in order to avoid a reduction in benefits or denial of coverage. The insured should contact the carrier at the phone number indicated on this summary or refer to the COC for further details prior to seeking treatment. If there is any conflict between this benefit summary and the Plan Document/Certificate, the Plan Document/Certificate governs. Contact Plan for limitations, exclusions, and additional costs.***