Leidos Benefits Summary Plan Description

Participating in the Plans

Leidos' benefit programs are intended to provide a competitive and comprehensive level of protection for our employees and their families. The benefits described in this document are not applicable to employees of Leidos Biomedical Research, Inc. or Leidos QTC Health Services.

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

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

Eligibility

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

- Employees
- Dependents (including Spouse)
- Domestic Partner and Children of Domestic Partner

Employees

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

Employee Eligibility	
Type of Coverage	**Eligibility Requirements**
Medical, Dental, Vision, Employee Assistance Program, Flexible Spending Accounts, Health Savings Account, Well-being, Disability Insurance, Life and Accidental Death and Dismemberment Insurance Programs, Supplemental Health Benefits, and Voluntary Benefits	• Must be an active, regular full-time employee working at least 30 hours per week; or • Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week. • Consulting Employees (CEs) are eligible for Leidos-sponsored medical coverage only • If applicable, must live in the geographic area served by a particular plan. • For salary-based plans (i.e., Disability, Life Insurance, and Accidental Death & Dismemberment Insurance) the benefit is pro-rated for part-time employees working at least 12 hours per week
Cigna Global Health Benefits: Medical and Dental Plans	Available to expatriate employees scheduled to be overseas for at least a minimum of ninety consecutive days in a rolling twelve-month period.

Dependents

Participants may also enroll their eligible dependents in some Leidos benefit programs. 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 began before age 26;
    - The child is primarily dependent on the participant for support; and
    - The participant provides periodic evidence of incapacity.

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

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

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

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

"Double coverage" is not permitted under Leidos' benefit programs. Therefore, participants may not cover a spouse, domestic partner, or dependent child if that individual 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. In addition, if the participant has children, only the participant or spouse/domestic partner can choose coverage for 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.

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

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 financial partnership must be provided. Alternatively, a *Declaration of Domestic Partnership* form can be completed, notarized and submitted along with required proof of financial partnership in order to enroll a domestic partner. Contact Employee Services for additional information on enrolling a domestic partner.

Domestic partner coverage is different from spouse coverage. Differences include:

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

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

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

If an employee receives a request from 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 program may be directed to Alight at 866-851-0731, or Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

When Coverage Begins

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

New Employees

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

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

Current Employees

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

Cost of Coverage

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

How Pre-Tax Premium Contributions Affect Take-Home Pay

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

To provide the tax advantage of reduced taxable income, the IRS restricts the ability to change coverage during the year unless the participant or dependent experiences a qualified life event or changes coverage during an Open Enrollment period.

Enrolling In Coverage

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

Participants will select from a number of plan options prior to enrolling for coverage. The plan the participant chooses during enrollment will apply to the participant and any covered dependents and will remain in effect for the entire plan year. In the case of a qualified life event, under most circumstances, the participant will be able to change only the level of coverage (e.g., Employee Only to Family Coverage) but not change coverage options (switch from one plan to another). However, a change in residence that affects available benefit programs may allow a participant to change only the impacted plan(s) . The participant may also choose to drop coverage.

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

be covered for benefits:

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

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

Open Enrollment

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

Important: **Annual election required during Open Enrollment period for Health Savings Accounts, Flexible Spending Accounts and the GUL Cash Accumulation Fund.**

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

Changing Coverage (Qualified Life Event Changes)

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

Any changes made outside of the Open Enrollment period must be consistent with the qualified life event and occur within 31 days of the event. The participant may add a spouse as a dependent, for example, after a marriage, but may not change from one plan to another. A qualified life event does not occur when a participant's provider leaves a plan or network.

Qualified status changes include, but are not limited to:

- *Adding a dependent* through marriage, registration or establishment of domestic partnership, birth, adoption or legal guardianship;
- *Losing a dependent* through legal separation, annulment, divorce, dissolving of a domestic partnership or death;
- *Dependent's loss of eligibility* by attaining age 26;
- *Loss of other health insurance* coverage through the employer of a spouse or domestic partner (for example, because of layoff, termination, disability, severance, substantial reduction in benefits or reduction in work hours);
- *Gaining eligibility for other coverage* through the Health Insurance Marketplace, a spouse's or domestic partner's plan, COBRA or Medicare (or MediCal in California);
- *Receiving a court order — a **Qualified Medical Child Support Order (QMCSO)*** — requiring the addition of medical coverage for children;
- *Changing residence* and thereby affecting access to a plan service area; and

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

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

When Coverage Ends

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

- Termination of employment;[1]
- Failure to pay required premiums;
- Commencement of a leave of absence;
- Loss of eligibility status
- Strikes[2]

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

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

Coverage for a permanently disabled child continues as long as the child qualifies as a disabled dependent as determined by the plan. Periodic proof of continued disability (generally every three (3) years) will be required.

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

Family and Medical Leave

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

Disability

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

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

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

Military Leave

Participants on military leave of absence are eligible to elect COBRA continuation coverage.

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

Reinstatement of Benefits

Termination and Rehire Within 30 Days

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

Leave of Absence

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

Continuing Coverage

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

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

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

Eligibility for COBRA

Who is eligible for COBRA:

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

Continuing Coverage Through COBRA

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

COBRA End Date

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

- 18 months in the case of termination of employment, layoff, or work force reduction;
- 24 months in the case of military leave of absence;
- 29 months in the event of a disability, according to Social Security;
- 36 months in the event of legal separation, divorce; dissolution of domestic partnership or death of the employee;
- 36 months in the event of all other qualifying events;
- Failure to pay any required premium when due;
- The date a covered participant, under the continuation program, becomes covered under another group plan or Medicare — one that does not impose any pre-existing condition limitations on the coverage; or
- The date that Leidos no longer provides a group medical plan to any of its employees

If a participant wants to continue coverage, they can elect COBRA online or mail their election directly to the COBRA administrator. Information to enroll will be included in the COBRA Notice mailed to that

participant’s home address on file. If a participant has any questions, they should contact the COBRA administrator's Member Support Team at the number indicated on the notification letter.

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

Disability

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

Second Qualifying Life Events

If a current COBRA covered participant experiences a second qualifying life event during the initial 18- or 29-month COBRA coverage period, the covered spouse/domestic partner and/or dependent children may receive up to a maximum of 36 months of coverage from the initial qualifying event date. A participant will only be entitled to an extension if the initial qualifying event was the covered employee’s termination of employment or reduction in hours, and the same event would have caused a loss of coverage under the Plan if it were the original event.

The extension may be available to the covered spouse/domestic partner and /or dependent children for one of the following reasons:

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

You must notify the COBRA administrator of the second qualifying event within 60 days of the event and before the applicable 18 or 29 month period of continued coverage end. You will not be entitled to the extension if you fail to provide timely notice.