Plan Information

This section describes plan provisions and/or regulations that are applicable to most or all of the Leidos employee benefit plans. These provisions and/or regulations include:

- **Employee Retirement Income Security Act of 1974 (ERISA)**
- **Qualified Medical Child Support Orders (QMCSOs)**
- **Children's Health Insurance Program (CHIP)**
- **Claims Appeal and Review Procedures Under ERISA**
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**
- **Health Plan Regulations**
- **Uniformed Services Employment and Reemployment Rights Act of 1994**
- **Additional Information Regarding Coordination of Benefits**
- In addition, this section includes important **administrative information** for each Leidos benefit plan.

Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act (ERISA) requires plans to include in their summary plan descriptions a notice outlining participants' and beneficiaries' rights. Leidos has developed its own notice, based on the model language provided by the Department of Labor, which includes the appropriate information but is written in more understandable language.

ERISA Rights Statement

Participants in the plans are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description(s). The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuation of Group Health Plan Coverage

ERISA also provides that all plan participants shall be entitled to:

- Continuation of health care coverage for the participant, participant's spouse and/or participant's dependents if there is a loss of coverage under the plan as a result of a qualifying event. Participants and their dependents may have to pay for such coverage. Review this summary plan description and the rules governing **COBRA continuation coverage rights**.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including the participant's employer, or any other person, may fire the participant or otherwise discriminate against him or her in any way to prevent his or her obtaining a welfare benefit or exercising rights under ERISA.

Enforcement of Participants' Rights

If a **claim** for a welfare benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps the participant can take to enforce the above rights. For instance, if the participant requests a copy of plan documents or the latest annual report from the plan and does not receive it within 30 days, the participant may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the administrator's control.

If the participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in a state or federal court. In addition, if the participant disagrees with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if the participant is discriminated against for asserting his or her rights, the participant may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person the participant has sued to pay these costs and fees. If the participant loses, the court may order the participant to pay these costs and fees — for example, if it finds that the participant's claim is frivolous.

No one, including a participant's employer, union or any other person, may fire or otherwise discriminate against a participant in any way to prevent him or her from obtaining a benefit or exercising his or her rights under ERISA.

Assistance with Questions

If the participant has questions about the plan, the participant should contact the **plan administrator**. If the participant has any questions about this statement or about rights under ERISA, or if the participant needs assistance in obtaining documents from the plan administrator, the participant should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The participant may also obtain certain publications about rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

Qualified Medical Child Support Orders (QMCSOs)

A QMCSO is a judgment, decree or order issued either by a court of competent jurisdiction or through an administrative process established under state law which has the force and effect of law in that state. It directs the plan administrator to cover the participant's child for benefits under the medical, dental, and/or vision plans, if available. Federal law provides that a Medical Child Support Order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order. Coverage under the plan pursuant to a QMCSO won't become effective until the plan administrator determines that the order is a QMCSO.

Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility:

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507

ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

For more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA(3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Claims Appeal and Review Procedures Under ERISA

This section provides general information about the claims appeal procedures applicable to the plan under ERISA:

- **Disability Plan Claims**
- **Non-Disability Welfare Plan Claims**

Please note: Participants enrolled in an **HMO** or a **CIGNA International Medical Plan** should also review the applicable medical plan documentation.

Disability Plan Claims

Claim Review

When a participant (or the participant's beneficiary, where applicable) files a claim with the insurance carrier, the participant's claim will be promptly evaluated. Within 45 days after the participant's claim has been received, the participant will be provided with:

- A written decision on the participant's claim; or
- A notice that the period to decide the participant's claim is being extended for 30 days.

Before the end of this extension period, the participant will be sent:

- A written decision on the participant's claim; or
- A notice that the period to decide the participant's claim is being extended for an additional 30 days

If an extension is due to the participant's failure to provide information necessary to decide the claim, the extended time period for deciding the participant's claim will not begin until the participant provides the necessary information.

If the period to decide the participant's claim is extended, the participant will be notified of the following:

- The reasons for the extension;
- When it is expected that the decision on the participant's claim will be made;
- An explanation of the standards on which entitlement to benefits is based;
- Any unresolved issues preventing a decision; and
- Any additional information needed to resolve those issues

If additional information is requested, the participant will have 45 days to provide the information. If the participant does not provide the requested information within 45 days, the participant's claim may be decided based on the information that has been received.

If a Claim Is Denied

If all or part of the participant's claim is denied, the participant will receive a written notice of denial containing:

- The specific reasons for the decision;
- Reference to the specific provisions of the plan documents on which the decision is based;
- A description of any additional information needed to support the participant's claim and an explanation of why it is needed;
- Information describing procedures and time limits to appeal the decision;
- Information concerning the participant's right to receive, free of charge upon request, copies of non-privileged documents and records relevant to the participant's claim;
- Any internal rule, guidelines, protocol or similar criterion relied on in making the decision; and
- A statement of the participant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination following an appeal

The notice of determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Claims Appeal Procedure If a Claim Is Denied

If all or part of the participant's claim is denied, the participant may request an appeal. The participant must request a review of the denied claim in writing within 180 days after receiving notice of the denial. The participant's request should be sent to the address specified in the claims denial.

The participant may also send written comments or other items to support his or her claim. The participant may review and receive copies, free of charge, of any non-privileged information that is relevant to his or her request for an appeal. The participant may also request the names of medical or vocational experts who provided advice about his or her claim.

The person conducting the review will be someone other than the person who denied the claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based on a medical judgment, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original medical judgment and will not be subordinate to that person.

The appeal will include any written comments or other items the participant submits to support his or her claim.

The participant's claim will be promptly reviewed following receipt of all necessary information. Within 45 days after receipt of the participant's request for an appeal, the participant will be sent:

- A written decision on the appeal; or
- A notice that the review period is being extended for 45 days.

If the extension is due to the participant's failure to provide information necessary to decide the appeal, the extended time period for review of the participant's claim will not begin until the participant provides the necessary information.

If the review period is extended, the participant will be notified of the following:

- The reasons for the extension;
- When a decision on the participant's appeal is expected; and
- Any additional information needed to decide the participant's claim

If additional information is requested, the participant will have 45 days to provide the information. If the participant does not provide the requested information within 45 days, a decision on the review of the participant's claim may be based on the information that has been received.

Following the re-review, if all or part of the participant's claim is denied, he or she will receive a written notice of denial containing:

- The specific reasons for the decision;
- Reference to the specific provisions of the plan documents on which the decision is based;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the decision;
- Information concerning the participant's right to receive, free of charge, copies of non-privileged documents and records relevant to the participant's claim upon request;
- A statement of the participant's right to bring a civil action under Section 502(a) of ERISA; and
- A statement that "The participant or the plan administrator may have other voluntary alternative dispute resolution options, such as mediation. One way for the participant to find out what may be available is to contact his or her local U.S. Department of Labor Office or state insurance regulatory agency."

The notice of determination may be provided in written or electronic form. Electronic notes will be provided in a form that complies with any applicable legal requirements.

Non-Disability Welfare Plan Claims

Definitions

- **Claim:** Any request for plan benefits made in accordance with the plan's claims filing procedures, including any request for a service that must be pre-approved.
- **Urgent Care Claim:** Any claim for medical care or treatment that has to be decided more quickly because the normal timeframes for decision-making could seriously jeopardize the participant's life or health or the participant's ability to regain maximum function, or in the opinion of a physician with knowledge of the participant's condition, could subject the participant to severe pain that cannot be adequately managed without the care or treatment addressed in the claim.
- **Pre-service Claim:** Any claim for a benefit — other than an urgent care claim — that must be approved in advance of receiving medical care (for example, requests to pre-certify a hospital stay or for pre-approval under a utilization review program).
- **Post-service Claim:** Any other type of claim.
- **Concurrent Care Decision:** Any decision in which the plan — after having previously approved an ongoing course of treatment provided over a period of time or a specific number of treatments — subsequently reduces or terminates coverage for the treatments (other than by plan amendment or termination).
- **Adverse Decision or Adverse Decision on Appeal:** A denial, reduction, or termination of, or a failure to provide or make, payment (in whole or in part) for a benefit. An adverse decision includes a decision to deny benefits based on:
    - An individual's being ineligible to participate in the plan;
    - Utilization review;
    - A service's being characterized as experimental or investigational or not medically necessary or appropriate; and
    - A concurrent care decision.
- **Authorized Representative:** An individual authorized to act on the participant's behalf in pursuing a claim or appeal in accordance with procedures established by the plan. For urgent care claims, a health care professional with knowledge of the participant's medical condition may act as an authorized representative. (A health care professional is a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law.) For information about appointing an authorized representative, contact Human Resources.

Filing an Initial Claim

The participant must file a claim for benefits within the time specified by the benefit plan and in accordance with the plan's established claim procedures.

Insufficient Claims

Improperly Filed Pre-service Claims

If a pre-service claim is incorrectly filed according to the plan's claim procedures, the participant will be notified as soon as possible, but no later than five days after the claim is received by the plan. If the claim is an urgent care case, the participant will be notified within 24 hours. Notice of an improperly filed pre-service claim may be provided orally — or in writing, if the participant requests so. The notice will identify the proper procedures to be followed in filing the claim.

In order to receive notice of an improperly filed pre-service claim, the participant or an authorized representative must have provided a communication regarding the claim to the person or organizational unit that customarily handles benefit matters for the plan. The communication must include:

- The identity of the claimant;
- A specific medical condition or symptom; and
- A request for approval for a specific treatment, service or product

Incomplete Urgent Care Claims

If a properly filed urgent care claim is missing information needed for a coverage decision, the participant will be notified by the plan as soon as possible, but no later than 24 hours after the claim has been received by the plan. The participant will be notified of the specific information necessary to complete the claim. The participant will have a reasonable amount of time considering the circumstances (but not less than 48 hours) to provide the specific information. The plan will then provide notice of the claim decision as soon as possible, but no later than 48 hours after whichever is earlier:

- The date the plan receives the specified information; or
- The end of the additional time period given for providing the information

Notice of Benefit Determination

After the participant's claim is reviewed by the plan, the participant will receive a notice of benefit determination within the timeframes specified below. For urgent care and pre-service claims, the participant will receive a notice of benefit determination whether or not the plan makes an adverse decision on the participant's claim. For post-service and concurrent care claims, the participant is entitled to receive a notice of benefit determination if the plan makes an adverse decision on, or denies, the participant's claim.

The timeframes for providing notice of a benefit determination generally start when a written claim for benefits is received by the plan. Notice of a benefit determination may be provided in writing by in-hand, mail, or electronic delivery. However, in some urgent cases, the participant may first be provided notice orally, which will be followed by written or electronic notice within three days. Note, "days" means calendar (not business) days. The timeframes for providing a notice of benefit determination are as follows:

- **Urgent Care Claims:** As soon as possible considering the medical urgency, but no later than 72 hours after the plan receives the participant's claim.
- **Pre-service Claims:** Within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after the plan receives the participant's claim. This timeframe may be extended for up to 15 days for matters beyond the plan's control.
- **Post-service Claims:** In the case of an adverse decision, within a reasonable period of time, but no later than 30 days after the plan receives participant's claim. This timeframe may be extended for up to 15 days for matters beyond the plan's control.
- **Concurrent Care Decisions:** If an ongoing course of treatment will be reduced or terminated, the participant will be notified sufficiently in advance to provide an opportunity to appeal and obtain a decision on appeal before a benefit is reduced or terminated

If the participant requests an extension of ongoing treatment in an urgent circumstance, the participant will be notified as soon as possible given the medical urgency, but no later than 24 hours after the plan receives the claim — provided the claim is submitted to the plan at least 24 hours before the expiration of the prescribed time period or number of treatments.

If the participant requests an extension of ongoing treatment in a non-urgent circumstance, the request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

For pre-service and post-service claims, the plan may extend the timeframe for making a decision on the participant's claim in certain cases. If an extension is necessary, the participant will be notified before the end of the initial timeframe (15 days for pre-service claims; 30 days for post- service claims) of the reasons for the delay and when the plan expects to make a decision. Further, if an extension is necessary because certain information was not submitted with the claim, the notice will describe the required information that is missing, and the participant will be given an additional period of at least 45 days after receiving the notice to furnish the information.

The plan's extension period will begin when the participant responds to the request for additional information. The plan will then notify the participant of the benefit determination within 15 days after a response is received.

Appeal of Adverse Decision

If the participant disagrees with the decision on a claim, the participant (or an authorized representative) may file a written appeal with the plan within 180 days after receipt of the notice of adverse decision. If the participant does not appeal on time, the participant may lose the right to file suit in a state or federal court, as the participant will not have exhausted internal administrative appeal rights (which is generally a requirement before suing in state or federal court).

The participant should include the reasons he or she believes the claim was improperly denied, and all additional facts and documents the participant considers relevant in support of the appeal. The decision on the participant's appeal will consider all comments, documents, records, and other information submitted, even if they were not submitted or considered during the initial claim decision.

A new decision-maker will review the denied claim — the appeal will not be conducted by the individual who denied the initial claim or by that person's subordinate. The new decision-maker will not give deference to the original decision on the participant's claim. That is, the reviewer will give the claim a "fresh look" and make an independent decision about the claim.

If the participant's claim was denied based on medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the claim. The health care professional will not be the same person (and will not be a subordinate of the person) who was consulted on the initial decision. (A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) The plan will also identify any medical or other experts whose advice was obtained in considering the original decision on the claim, whether or not the plan relied on their advice.

For appeals of adverse benefit decisions involving urgent care claims, the plan will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between the plan and the participant or health plan providers by telephone, fax or other available expeditious methods.

Important: Second Level of Appeal

If a participant is dissatisfied with an appeal decision on a claim, he or she may:

- **For urgent care claims, file a second level of appeal, and receive notification of a decision not later than 36 hours after the appeal is received.**

- **For pre-service or post-service claims, file a second level of appeal within 60 days of receipt of the level one appeal decision, and receive notification of a decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.**

If a participant does not agree with the final determination on review, he or she has the right to bring a civil action under Section 501(a) of ERISA, if applicable.

Notice of Decision on Appeal

After the participant's appeal is reviewed by the plan, the participant will receive a notice of decision on appeal within the timeframes specified below. The participant will receive a notice of decision on appeal whether or not the plan makes an adverse decision on the appeal. The timeframes for providing a notice of decision on appeal generally start when a written appeal is received by the plan. Notice of decision on appeal may be provided in writing through in-hand, mail, or electronic delivery. Urgent care decisions may be delivered by telephone, fax, or other expeditious methods. Note, "days" means calendar (not business) days. The timeframes for providing a notice of decision on appeal are as follows:

- **Urgent Care Appeals:** As soon as possible considering the medical urgency, no later than 72 hours after the plan receives the participant's appeal.
- **Pre-service Appeals:** Within a reasonable period of time appropriate to the medical circumstances, no later than 30 days after the plan receives participant's appeal.
- **Post-service Appeals:** Within a reasonable period of time appropriate to the medical circumstances, no later than 60 days after the plan receives participant's appeal.

A Participant's Right to Information

Upon request and free of charge, the participant has a right to reasonable access to and copies of all documents, records, and other information relevant to the plan's denial of a claim. Information is "relevant" information if it:

- Was relied upon in making the decision on participant's claim;
- Was submitted to, considered by, or generated by the plan in considering participant's claim; or
- Demonstrates compliance with the plan's administrative processes for making claim decisions.

The participant is also entitled access to, and a copy of, any internal rule, guideline, protocol, or other similar criteria used as a basis for a decision on participant's denied claim upon request, free of charge. Similarly, if participant's claim is denied based on a determination involving a medical judgment, the participant is entitled to an explanation of the scientific or clinical reasons for that determination free of charge upon request. (A medical judgment includes whether a

treatment, drug or other item is experimental, investigational or not medically necessary or appropriate.) In addition, if voluntary appeals or alternative dispute resolution options are available under the plan, the participant is entitled to receive information about the procedures for using these alternatives.

The participant can read "ERISA Rights Statement" for information on actions to take if the participant feels his or her rights to a benefit have been improperly denied.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) is a federal regulation that focuses on the portability, privacy and security of the participant and participant's dependent's health information. HIPAA protects the participant and participant's dependents by:

- Limiting exclusions for pre-existing medical conditions;
- Providing credit against maximum pre-existing condition exclusion periods for prior health coverage and a process for providing certificates showing periods of prior coverage to a new group health plan or health insurance issuer;
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married, or add a new dependent;
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors; and
- Ensuring the privacy of the participant's protected health information

Certificates of Creditable Coverage

The participant will receive, free of charge, a certificate of creditable coverage when the participant and his or her dependents lose health care coverage, become eligible for **COBRA** continuation coverage or exhaust COBRA continuation coverage. A certificate must also be provided free of charge upon request while the participant has health coverage or anytime within 24 months after coverage ends.

Certificates of creditable coverage should contain information about the length of time the participant and his or her dependents had coverage as well as the length of any waiting period for coverage that applied to the participant and his or her dependents.

If a certificate is not received, or if the information on the certificate is wrong, the participant should contact the prior plan or issuer. The participant has a right to show prior creditable coverage with other evidence — such as pay stubs, explanations of benefits, letters from a doctor — if the participant cannot get a certificate.

Disclosure of Protected Information

The confidentiality of the participant's health information is important. Leidos is required to maintain the confidentiality of the participant's information and has policies and procedures and other safeguards to help protect the participant's information from improper use and disclosure.

Leidos is allowed by law to use and disclose certain information without the participant's written permission. For example, Leidos may share information with the participant's health care provider to determine whether he or she is enrolled in the plan or whether premiums have been paid on the participant's behalf. Leidos may also share the participant's information when legally required to do so — for example, in response to a subpoena or if the participant's medical safety may be at risk.

When the participant's authorization is required and the participant authorizes Leidos to use or disclose personal information for some purpose, the participant may revoke that authorization by notifying Leidos in writing at any time.

The participant's health care provider must have a Notice of Privacy Practices and provide the participant with a copy. For more information, contact Aetna Member Services.

Adding New Dependents

Under **HIPAA**, the participant has 31 days following marriage or the birth, adoption, or placement for adoption of a child to enroll a dependent in the health plans. The participant does not have to provide any medical or health information to enroll a dependent.

Continuing Health Care Coverage through COBRA

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

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

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

Who Is Eligible for COBRA

- A covered participant who loses coverage due to termination (other than termination for gross misconduct) or reduction in work hours. Termination includes voluntarily quitting, layoff, and lack of work due to a work location closure.
- The spouse, registered domestic partnership 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 domestic partnership of the covered employee from his or her spouse or registered 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.

  To continue coverage, it is the participant's (or a family member's) responsibility to notify Leidos Employee Services within 31 days of a divorce, legal separation, dissolution of domestic partnership, or child's losing dependent status.

When COBRA Coverage Will End

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

- 18 months in the case of termination of employment, layoff, or work force reduction;
- 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.

The participant must apply for this coverage continuation within 60 days from the date the participant's Leidos medical coverage terminates or the date of notification, whichever is later. The participant then has 45 days from the date he or she elected continued coverage 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 a continued coverage, plus an additional 2% administrative fee (102% of the premium). If the participant wants to continue coverage through COBRA, please contact the number indicated on the notification letter, or, if eligible due to divorce, legal separation, dissolution of domestic partnership, or loss of dependent status, contact **Leidos Employee Services** for information and forms.

*To be eligible for the additional 11 months coverage due to disability, the participant must provide the Plan Administrator with: a Social Security Disability Award (SSDI) 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 a continued coverage, plus an additional 50% administrative fee (150% of the premium).

Remember: Participants must apply for continuation of coverage under COBRA within 60 days after receiving COBRA notification and enrollment information.

The following table summarizes COBRA benefits under the Leidos health care plans:

COBRA Benefits

THE SITUATION:	OBTAINING INFORMATION:	WHO CAN BE COVERED:	HOW LONG COVERAGE CAN LAST:
The participant's employment with Leidos is terminated for reasons other than gross misconduct	It will be sent to the participant automatically by Leidos' COBRA administrator	The participant and the participant's dependents	18 months
There is a reduction in the participant's work hours to the point where the participant no longer qualifies for benefits coverage	It will be sent to the participant automatically by Leidos' COBRA administrator	The participant and the participant's dependents	18 months

The participant begins a military leave of absence	The participant must notify Leidos Employee Services; forms sent upon notice of ineligibility	The participant and the participant's dependents	24 months
The participant is disabled according to Social Security	The participant must notify by Leidos' COBRA administrator	The participant and the participant's dependents	29 months
The participant dies	It will be sent to the covered dependents automatically by Leidos' COBRA administrator	The participant's currently covered dependents	36 months
The participant becomes divorced, legally separated or dissolves a domestic partnership	The participant must notify Leidos Employee Services; forms sent upon notice of ineligibility by Leidos' COBRA administrator	The participant's former spouse or former registered domestic partner	36 months
The participant's dependent reaches age 26	The participant must notify Leidos Employee Services; forms sent upon notice of ineligibility	The participant's dependent	36 months

Participants that lose health coverage as a result of an Open Enrollment action will not receive COBRA information.

Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) impose numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Leidos Health & Welfare Benefits Plan ("Plan") — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of the following plans:

- Healthy Focus Advantage Plan
- Healthy Focus Essential Plan
- Leidos Dental PPO

The plans are administered by Aetna and Anthem. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's Duties With Respect to Health Information About You

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in a fully insured plan option (such as an HMO plan) you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Leidos as an employer — that's the way the HIPAA rules work. Different policies may apply to other Leidos programs or to data unrelated to the health plan.

How the Plan May Use or Disclose Your Health Information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share health information about you with physicians who are treating you.
- **Payment** includes activities by this Plan and its administrators, AETNA and ANTHEM, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan in order to coordinate payment of benefits.
- **Health care operations** include activities by this Plan (and in limited circumstances other plans or providers) such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include vendor evaluations, credentialing, training, accreditation activities, underwriting, premium rating, arranging for medical review and audit activities, and business planning and development. For example, the Plan may use information about your claims to review the effectiveness of wellness programs.

The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules. The Plan, or its administrators, may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

How the Plan May Share Your Health Information with Leidos

For plan administration purposes, the Plan, may disclose your health information without your written authorization to Leidos. Leidos may need your health information to administer benefits under the Plan. Leidos agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Benefits, Finance, and Human Resources staff are the only Leidos employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Leidos, as allowed under the HIPAA rules:

- The Plan, or its administrators, may disclose "summary health information" to Leidos if requested, for purposes of obtaining premium bids to provide coverage under the Plan, or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, but from which names and other identifying information has been removed.
- The Plan, or its administrators, may disclose to Leidos information on whether an individual is eligible and/or participating in the Plan. This eligibility and/or participation disclosure is limited to Benefits, other Human Resources groups as required. No individual private health information is required for these purposes.

In addition, you should know that Leidos cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Leidos from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other Allowable Uses or Disclosures of Your Health Information

In certain cases, your personal health information may be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made if you are not present or if you are incapacitated).

The Plan may also use or disclose your personal health information without your written authorization for the following activities:

Other Allowable Uses or Disclosures of Your Health Information

Activity	Description
Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with such laws.
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (including disclosures to the target of the threat); includes disclosures to assist law enforcement officials in identifying or apprehending an individual because the individual has made a statement admitting participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody.
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects.
Judicial and Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process. The Plan may be required to notify you of the request, or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information.
Law enforcement purposes	Disclosures to law enforcement officials required by law or pursuant to legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosure about a death that may have resulted from criminal conduct; and disclosure to provide evidence of criminal
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, and subject to certain assurances and representations by researchers regarding necessity of using your health information and treatment of the information during a research project.

Other Allowable Uses or Disclosures of Your Health Information

Activity	Description
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws.
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates.
HHS investigations	Disclosures of your health information to the Department of Health and Human Services (HHS) to investigate or determine the Plan's compliance with the HIPAA privacy rule.

Except as described in this notice, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your Individual Rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to Request Restrictions on Certain Uses and Disclosures of Your Health Information and the Plan's Right to Refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment, or Health Care Operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and

disclosure of health information to notify those persons of your location, general condition, or death - or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

Right to Receive Confidential Communications of Your Health Information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to Inspect and Copy Your Health Information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "Designated Record Set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing within 30 days of receipt of your request (60 days if the health information is not accessible onsite), the Plan will provide you with:

- The access or copies you requested;
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint; or
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan may also charge reasonable fees for copies or postage.

If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed of where to direct your request.

Right to Amend Your Health Information that Is Inaccurate or Incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will:

- Make the amendment as requested;
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint; or
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to Receive an Accounting of Disclosures of Your Health Information

You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information going back for six (6) years from the date of your request. You do not have a right to receive an accounting of any disclosures made:

- For treatment, payment, or health care operations;
- To you about your own health information;

- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to Obtain a Paper Copy of This Notice from the Plan Upon Request

You have the right to obtain a paper copy of this Privacy Notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the Information in this Notice

The Plan must abide by the terms of the Privacy Notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies as described in this notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be notified of the changes by electronic or U.S. Postal Service.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, submit a written request to:

Leidos
Attn: HIPAA Compliancy Department
11955 Freedom Dr.
Reston, VA 20190

Contact

For more information on the Plan, its administrator's privacy policies or your rights under HIPAA, contact the Corporate Benefits Department at 571-526-6516.

Health Plan Regulations

The following federally mandated regulations are required of all group health plans and health insurance issuers.

Breast Reconstruction Following a Mastectomy

Federal law requires that group health plans provide coverage for breast reconstruction in connection with mastectomy as follows:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

Hospitalization in Connection with Childbirth

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to:

- Less than 48 hours following a vaginal delivery; or
- Less than 96 hours following a Caesarean section; or
- Require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay that falls within that time period

The law does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours after delivery, as applicable.

Military Leave — Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If the participant is on a military leave of less than 31 days, health care coverage for the participant and the participant's eligible dependents continues as long as the participant continues paying the applicable portion of the cost of coverage. If the participant's leave is longer than 31 days, the participant may continue coverage under rules similar to those for **COBRA coverage**.

The participant may continue coverage for 24 months or the period of duty, whichever is less. (This period also counts toward COBRA coverage, if applicable.) The participant pays the full cost of coverage for him- or herself and his or her dependents plus a 2% administration fee (102% of the premium). When the participant's leave ends, he or she will not be subject to a waiting or pre-existing condition period except for illnesses or injuries incurred or aggravated during the participant's leave duties.

If the participant is a member of the ready reserve of the armed forces and is called to active duty as a result of Executive Order 13223, special provisions regarding the participant's leave and health care coverage may apply. For more information, contact **Leidos Employee Services**.

Additional Information Regarding Coordination of Benefits

The following information pertains to group health care plans that may be coordinating how benefits are paid between a Leidos health care plan and another plan:

- **Releasing and Obtaining Information**
- **Subrogation**
- **Recovery of Overpayment**

Releasing and Obtaining Information

The health care plans reserve the right to release to, or obtain from, any other insurance company or other organization or person any information that, in its opinion, it needs for the purpose of coordination of benefits.

Subrogation

If the participant or the participant's dependent suffers an injury or illness through the fault of a third party (such as in an automobile accident), he or she may use the benefits from a Leidos health care and disability plans. Then, the plan will contact the insurer of the person who was at fault in the accident and/or that person's insurance company to seek reimbursement for plan benefits that were attributable to the accident.

In most cases, the plan will not be reimbursed directly. Normally, the claim with the injured person (that is, the participant or the participant's dependent) will be settled. Therefore, if the participant's claims are paid by the plan and then he or she receives a settlement from the other party or the other party's insurer, the participant must reimburse the plan for the amount of claims paid by the Leidos plan. The Plan's right of subrogation and reimbursement is a first-priority right of reimbursement, to be satisfied before payment of any other claims, including attorney fees and costs.

This arrangement allows the participant to receive prompt payment of benefits and, at the same time, places the expense of medical coverage where it belongs — with the person who caused the injury. As a condition of receiving benefits under this plan, the participant or the participant's dependents are expected to cooperate with the plan manager or administrator in recovering any amounts for which the plan is entitled to be reimbursed, and to repay the plan any amounts that the participant may have received to which the plan has a right to reimbursement.

Recovery of Overpayment

If one of the Leidos health care or disability plans makes an overpayment, it will have the right at any time to recover that overpayment from the participant to whom or on whose behalf it was made, or to offset the amount of overpayment from a future claim payment.

Administrative Information

Important administrative information for each Leidos benefit plan is described in this section.

For a, comprehensive contact information list, go to **Contact Information**.

Medical Plans

Medical Plans Administrative Information	
Leidos Benefit Plan:	**Healthy Focus Advantage Plan** **Healthy Focus Essential Plan**
Type of Plan:	Group health plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Leidos – Frederick Varec Holdings, Inc
Plan Administrator:	**Leidos** Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Group Number:	**Aetna – 698685** **Anthem – 170105**
Plan Number:	**501**
Agent for Service of Legal Process:	**Legal process may be served on the Plan Administrator at the address specified above.**

Medical Plans Administrative Information	
Plan Year:	January 1 – December 31
Funding:	The plans are self-funded and self-administered by Leidos. Leidos and participants share the cost of coverage.
Claims Administrators: Employees who live in these states are administered under the Aetna Inc: Alabama, Arkansas, California, Delaware, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, Vermont, Virginia, West Virginia, Wisconsin, Wyoming	**Aetna Life Insurance Company** P.O. Box 14089 Lexington, KY 40512-4089 800-843-9126 **Express Scripts** P.O. Box 14711 Lexington, KY 40512 877-223-4721
Claims Administrators: Employees who live in these states are administered under Anthem BC Life and Health with claims administered by Anthem Blue Cross: Alaska, Arizona, Colorado, Connecticut, Florida, Georgia, Louisiana, Massachusetts, Mississippi, New Mexico, North Carolina, Rhode Island, South Carolina, Texas, Utah, Washington state, and Puerto Rico	**Anthem** P.O. Box 60007 Los Angeles, CA 90060 866-403-6183 **Express Scripts** P.O. Box 14711 Lexington, KY 40512 877-223-4721

Dental PPO Plan

Dental Plans	
Leidos Benefit Plan:	**Leidos Dental PPO Plan**
Type of Plan:	Group health plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos Leidos Commercial Health BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Varec Holdings, Inc.
Plan Administrator:	**Leidos** Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Group Number:	698685-50
Plan Number:	501
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	The plans are self-funded and self-administered by Leidos. Leidos and participants share the cost of coverage.
Claims Administrators:	Delta Dental of VA 4818 Starkey Road Roanoke, VA 24018

Vision Plans

Vision Plan	
Leidos Benefit Plan:	**Vision Plan**
Type of Plan:	Group health plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Dr. Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos Leidos Commercial Health BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Varec Holdings, Inc.
Plan Administrator:	Leidos Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Plan Manager:	Process Works, Inc. P.O. Box 1470 Brookfield, WI 53008-1470 800-599-7546 or 262-797-7010
Group Number:	12180678
Plan Number:	514
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Participants pay the full cost of coverage. To be covered by benefits, participants make pre-tax contributions.
Claims Administrators:	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800-852-7600

Life and AD&D Insurance Plans

Life and AD&D Insurance Plans	
Leidos Benefit Plan:	**Basic Term Life Insurance**, **Group Universal Life Insurance**, **Basic AD&D Insurance**, and **Voluntary AD&D Insurance**
Type of Plan:	Group term life insurance plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Varec Holdings, Inc.
Plan Administrator:	**Life Insurance:** Prudential Insurance Company of America P.O. Box 8517 Philadelphia, PA 19176 **Accidental Death & Dismemberment Insurance:** Life Insurance Company of North America 1601 Chestnut Philadelphia, PA 19192-2235
Policy Number:	**Life Ins: Control #52844** **AD&D: OK 819515**
Agent for Service of Legal Process:	**Legal process may be served on the Plan Administrator at the address specified above.**
Plan Year:	**January 1 – December 31**

Life and AD&D Insurance Plans	
Funding:	Leidos pays the full cost of Basic Term Life Insurance and Basic AD&D Insurance. Participants pay the full cost of coverage for Group Universal Life Insurance and Voluntary AD&D Insurance. The Leidos employer paid life and employee paid life plans are combined for rating purposes. At any time, the cost of one plan may subsidize the cost of the other plan.
Claims Administrators:	**Life Insurance:** Prudential Insurance Company of America P.O. Box 8517 Philadelphia, PA 19176 **Accidental Death & Dismemberment Insurance:** Life Insurance Company of North America 1601 Chestnut Philadelphia, PA 19192-2235
Claim Forms:	Claim forms are available from **Leidos Employee Services**. Completed claim forms, along with supporting documentation, should be submitted directly to: **Leidos Employee Services** P.O. Box 2502 Oak Ridge, TN 37831

Business Travel Accident Insurance

Business Travel Accident Insurance	
Leidos Benefit Plan:	**Business Travel Accident Insurance**
Type of Plan:	Group term life insurance plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Dr. Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Varec Holdings, Inc.
Plan Administrator:	**Life Insurance Company of North America** 1601 Chestnut Philadelphia, PA 19192-2235
Policy Number:	ABL-65 86 41
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Leidos pays the full cost of Business Travel Accident Insurance.
Claims Administrators:	CIGNA Life Insurance 1601 Chestnut Philadelphia, PA 19192-2235
Claim Forms:	Claim forms are available from Leidos Employee Services. Completed claim forms, along with supporting documentation, should be submitted directly to: **Leidos Employee Services** P.O. Box 2502 Oak Ridge, TN 37831

Short-Term Disability Plan

Short-Term Disability Plan	
Leidos Benefit Plan:	**Voluntary Short-Term Disability Insurance**
Type of Plan:	Disability plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Dr. Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Leidos – Frederick Varec Holdings, Inc.
Plan Administrator:	Leidos Attn: Corporate Benefits 11955 Freedom Drive Reston, VA 20190
Plan Manager:	Sedgwick CMS 3280 E. Foothill Blvd., Suite 250 Pasadena, CA 91107 800-939-4911
Plan Number:	515
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Employees pay the full cost of Voluntary Short-Term Disability Insurance.
Claims Administrators:	Sedgwick CMS 3280 E. Foothill Blvd., Suite 250 Pasadena, CA 91107

Long-Term Disability Plan

Long-Term Disability Plan	
Leidos Benefit Plan:	**Long-Term Disability Insurance**
Type of Plan:	Disability plan
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Dr. Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Varec Holdings, Inc.
Plan Administrator:	**Life Insurance Company of North America** 1601 Chestnut Philadelphia, PA 19192-2235
Plan Number:	LK-980003
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	If elected, employees pay the full cost of Long-Term Disability Insurance.
Claims Administrators:	Life Insurance Company of North America 1601 Chestnut Philadelphia, PA 19192-2235

Flexible Spending Accounts

Flexible Spending Accounts	
Leidos Benefit Plan:	**Health Care Flexible Spending Account** and **Dependent (Day) Care Flexible Spending Account**
Type of Plan:	Group health plans
Plan Sponsor:	**Leidos** Attn: Corporate Benefits 11955 Freedom Dr. Reston, VA 20190
Plan Sponsor Employer Identification Number:	95-3630868
Participating Employers:	Leidos BD Systems, Inc. The Benham Companies, LLC and Majority-Owned Subsidiaries Eagan, McAllister Associates, Inc. Hicks & Associates, Inc. MEDPROTECT LLC Varec Holdings, Inc.
Plan Administrator:	Leidos Attn: Corporate Benefits 11955 Freedom Dr. Reston, VA 22102
Plan Manager:	HealthEquity 15 W. Scenic Pointe Drive Suite 100 Draper, UT 84020 Customer Service: 1-844-373-6981 healthequity.com
Agent for Service of Legal Process:	Legal process may be served on the Plan Administrator at the address specified above.
Plan Year:	January 1 – December 31
Funding:	Benefits are funded with voluntary pre-tax contributions made by enrolled participants.
Claims Administrators:	HealthEquity 15 W. Scenic Pointe Drive Suite 100 Draper, UT 84020 Customer Service: 1-844-373-6981 healthequity.com