Leidos Benefits Summary Plan Description

Disability Plans

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

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

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

Short-Term Disability (STD)

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

- Disability Sick Leave(DSL)
- Voluntary Short-Term Disability Insurance (VSDI)
- Leidos California Voluntary Disability Plan (Leidos CA VDP)
- Other State-Mandated Short-Term Disability Plans:
    - California State Disability Insurance (CA SDI)*
    - Hawaii Short-Term Disability
    - New Jersey Temporary Disability Insurance
    - New York Voluntary Disability Plan
    - Puerto Rico Temporary Disability Insurance
    - Rhode Island State Temporary Disability Insurance

* All Leidos employees living in California, excluding those working at Varec & BD Systems are automatically covered by the Leidos' California Voluntary Disability Plan (Leidos CA VDP). Leidos employees working for certain subsidiaries in California locations are covered by the State of California SDI program. If you are unsure which plan you participate in, HR Employee Services at 855-553-4367, option 3 or email AskHR@leidos.com.

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

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

- **Active Pay Status** — Employee receives pay for a normal scheduled day of work, including regular pay, comprehensive leave, bereavement, or jury duty benefits. Active pay status does not include employees who are on leave of absence, on whole-week voluntary or involuntary LWOP, or receiving disability benefits (DSL, CA VDP, VSDI, or LTD).
- **Claims Administrator** — The organization that is accountable for receiving the participant's application, determining which benefits are payable and ensuring that payments are made:
    - For DSL, VSDI and Leidos CAVDP, Sedgwick CMS administers the plans.
    - For the Hawaii state disability plan, Life Insurance Company of North America administers the plan.
    - For the New Jersey, New York, Rhode Island, and Puerto Rico state disability plans, the respective states administer the plans.
- **Hospital Confinement** — any 24-hour period of time, or any part thereof, for which a claimant is properly charged a full day's rate for room and board as a registered bed patient in a hospital, or in a nursing home as defined in Section 1395X of Title 42 of the United States Code. This includes hospital admission under inpatient status or observation status. Emergency Room Visit and Outpatient Surgery are excluded.
- **Physician** – Includes physicians and surgeons holding an M.D. or D.O. degree, physician's assistants (PA's), nurse practitioner's (NP's), psychologists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by state law and acting within the scope of their practice as defined by state law. For disability related to normal pregnancy or childbirth, medical certification may be provided by a midwife or nurse practitioner.
- **Psychologist** – a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two (2) years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.
- **Qualified Disability** — A disability that has been certified by a physician or other health care provider, based on objective medical evidence, and subsequently reviewed and approved by the claims administrator. Each plan may have different definitions as to what types of conditions are disabling (for example, some state plans differ from the private insurance plans). Keep in mind that not all disabilities will be approved.

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

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

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

- **Recurring Disability** — Recurring Disability shall mean two or more intervals of disability, due to the same cause or condition, separated by less than 31 days of continuous active work with the Company, shall be considered the same disability. A new waiting period will not be required. The period of time worked will count against the total leave duration approved in the initial claim. For purposes of calculating the claimant's amount of benefits under the Plan, regular wages as of the date of the original onset of disability shall be used.
- **Regular Wages**
  - With respect to Regular, Full-time Employees, regular wages shall mean the scheduled base salary amount of compensation prior to any voluntary salary reduction, excluding overtime, shift differential pay, bonuses, commissions, stock transactions, expense reimbursements and moving expenses in effect during the last completed payroll period immediately prior to the date of commencement of the employee's disability.
  - With respect to all Part-time Employees, regular wages shall mean the average weekly compensation paid by the Company excluding overtime, shift differential pay, bonuses, commissions, and stock transactions during the previously completed 12-week period prior to the date of commencement of the employee's disability.

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

Overview of the Short-Term Disability (STD) Plans

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

- **Disability Sick Leave (**DSL) hours, which are provided by Leidos at no cost to eligible employees;
- **Voluntary Short-Term Disability Insurance (VSDI)**, which is elected and paid for by the participant;
- **Leidos California Voluntary Disability Plan (Leidos CAVDP),** which is paid for by the participant; and
- **Other state-mandated disability insurance** in California, Hawaii, New Jersey, New York, Puerto Rico and Rhode Island, which is paid for by the participant.

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

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

The STD Program components are outlined below:

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

How Short-Term Disability Works

How to File a Claim

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

- Notify supervisor and HR POC.
- If enrolled in the DSL, VSDI or Leidos CAVDP, the participant should call Sedgwick CMS, Leidos' disability claims administrator, at 1-877-399-6443. Participants can contact Sedgwick CMS to file a claim 7 days a week/24 hours a day. The participant will need to provide Sedgwick CMS with the following information:
    - The participant's personal information (including name, address, phone number, employee number, and supervisor's name and phone number);
    - The participant's health care provider's name, mailing address, phone number and fax number; and
    - The participant's anticipated length of time away from work due to the qualified disability.
- If the participant lives in Hawaii, New Jersey, New York, Rhode Island or Puerto Rico, or if the participant lives in California and is not eligible to enroll in the Leidos CAVDP, the participant will also need to file for state disability benefits. See the Other State-Mandated Short-Term Disability Plans section for more information.

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

How STD Benefits Are Paid

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

A participant will receive disability benefits, not to exceed 180 days, based on the following schedule:*

- **Week 1:** 7 calendar day waiting period unless hospitalized as defined;
- **Weeks 2 — 10:** Up to 100% of weekly wages to a maximum plan benefit;

- **Weeks 11 — 19:** Up to 80% of weekly wages to a maximum plan benefit;
- **Weeks 20 — 26*:** Up to 66 2/3% of weekly wages to a maximum plan benefit.

*If hospitalized as defined, the participant will receive:

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

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

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

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

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

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

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

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

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

Pregnancy

Pregnancy is treated like any other disability. Participants who are considered to be disabled due to pregnancy must follow the same process as for all other disabilities.

Participants on Rotation

A participant on a rotational work schedule (e.g. 90 days on/90 days off) who has a qualifying disability, will be paid disability benefits even if the disability falls on a period the participant is scheduled to be off.

Home Confinement

Illnesses or disabilities that involve home confinement and that have been certified by a physician or other health care provider qualify employees for disability benefits as of the 8th calendar day, based on approval from the claims administrator.

Confidentiality

All medical information that a participant and his or her physician or health care provider supply to the disability plans is kept confidential and will be protected from unauthorized use. Certain claims may require the use of a special, written authorization form. The participant will need to sign and return the form as soon as possible so there is no delay in processing the claims.

STD Claims Management

All STD plans require that the participant cooperate in collecting the medical information necessary to review the claims and make a benefit determination. The most common reason that claim payments are delayed is the failure of the participant's health care provider to return calls, return forms or otherwise provide requested medical documentation.

A participant can help the claims administrators make more timely decisions by:

- Explaining to the health care provider that the administrator will be contacting them;
- Following up with the health care provider's office after a request for information has been made to ensure that the information is being collected and sent to the administrator; and

- Notifying the claims administrator immediately if the participant's return-to-work plans change, or if the health condition significantly changes (for example, if a surgery is needed). This will allow the plan administrator to help the employee file for an extension of benefits, if appropriate.

Some state plans insist that the documentation be provided only on specific forms. The health care provider should be aware of these requirements. However, a participant who receives a letter from the state indicating that the documentation was not provided in the appropriate format should contact his or her health care provider immediately.

For the DSL, VSDI and Leidos CAVDP, Sedgwick CMS will contact the participant's physician or healthcare provider to request the appropriate documentation. In addition, Sedgwick CMS will make a determination as to the expected return-to-work date based on objective medical evidence provided by the participant's physician or health care provider. If a participant's qualified disability extends beyond the original estimated return-to-work date, the participant should have his or her physician or health care provider complete the extension form provided by Sedgwick CMS. Failure to provide disability extension documentation could result in delayed or denied benefits.

Coordination Among the STD Plans

The STD Program is designed to provide a certain degree of income protection if a participant is unable to work. The individual STD plans coordinate with each other so that participants do not receive duplicate benefits. In addition, some offsets or deductions may be made for other plans for which the participant might be eligible. In general, STD benefits will be offset by:

- Social Security benefits (except family Social Security benefits) for any period of time during which disability benefits are paid. Once disability benefits begin, however, they will not be further reduced by any statutory increase in Social Security benefits. If the receipt of Social Security retirement benefits commenced prior to the Participant's disability such benefits will not be offset
- Any benefits based on wages payable to the participant under any worker's compensation law;
- Disability benefits payable to the participant under any employer-sponsored group policy other than the Leidos disability plans;
- Disability/medical leave benefits for employee's own serious health condition payable under any federal or state law;
- Any salary (excluding vacation pay), income or sick pay from any employer or from self-employment.
- Retirement benefits, paid or due from a Leidos-sponsored Pension Plan or Savings Plan offset net disability dollar for dollar paid during the disability.

- Any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any Compulsory Benefit Act or law of any government.
- Any government retirement or disability plan that is initiated or increased as a result of a participant's disability.
- Some portion of income or wages earned during rehabilitation employment; (refer to the individual plan's SPD or evidence of coverage for more information)
- Any financial settlement, award, benefit or other monetary recovery the participant receives — through litigation or otherwise — attributable in whole or in part to the negligence, the wrongful act or any other civil or criminal incident that resulted, in whole or in part, in the disease, illness, incapacity or injury that substantiates the disability claim. (This offset can be made for the entire amount of the third party recovery, regardless of whether it is attributable to lost wages, incurred medical expenses or punitive damages.)

Although the coordination of benefits may reduce the amount received from the STD plans, all benefits together will still equal the total amount the participant is eligible for under the STD plan(s) that he is enrolled in.

STD Participation and Benefit Payment Duration

When Participation in the STD Plan Ends

Participation in the STD Plans generally ends on the earliest of the following:

- On the end date of the pay period which marks the termination of employment
- On the end date of the pay period in which an approved leave of absence without pay commences, except as required by law
- At 12:00 midnight when a protected leave ends, if the participant fails to return to work
- On the end date of the pay period in which an employee ceases to be eligible
- On the end date of the pay period in which a strike occurs
- On the date of termination of the Plan

When STD Benefit Payments End

STD benefits generally end when the participant:

- Returns to work as cleared by the participant's physician
- Is no longer disabled as defined by the particular disability plan

- Reaches the maximum duration payable under that plan
- Refuses to submit to an independent medical examination (arranged and paid for by the claims administrator) or fails to comply with any request, by the claims administrator, to help substantiate that the participant is disabled
- Is no longer under the regular and continuous care and treatment of a qualified Physician
- Dies

If a participant's disability started prior to termination of employment, disability benefits will continue to be paid up to the maximum duration approved under the plan.

For collectively bargained participants, disability benefits will continue to be paid if a strike occurs and the disability started prior to the strike. Benefits will be paid up to the maximum duration approved under the plan.

For more information on when participation or benefit payments end for all disability plans, refer to the Plan Document or Certificate of Insurance for each plan.

Returning to Work

Leidos requires that all participants returning from a disability leave provide a "fitness for duty" or "doctor's release" clearly stating the date he is no longer considered to be disabled, as well as the date he is able to return to work. This document is usually a note from the health care provider stating that the participant may return to full duty. If the health care provider is requesting modified duty or limited hours, this should be discussed with the claims administrator and the workplace in advance of the participant's return to work. A participant who does not present a release may not be allowed to work until the release is presented.

If the Participant Becomes Disabled Again

If a participant recovers from an illness or injury and returns to full active employment with Leidos (other than in rehabilitation employment), the participant may again be eligible for disability benefits if, within 31 days, the participant suffers another period of disability caused by, related to, and based on the same diagnosis as the prior period of disability. If these conditions are met, the participant will not be required to satisfy another waiting period.

However, should the participant go out on an approved disability again related to the initial claim within 31 days, the period of time worked will count against the total leave duration for the initial claim. For example, if a participant is on approved disability for eight weeks, returns to work for two weeks and

then takes disability leave again for the same issue within 31 days, the participant is considered to have been disabled for a total of ten weeks. Therefore, disability benefits will reflect the benefits level payable for that week. In this example, benefits payable at week eleven will decrease to 80% of weekly wages. Successive disability benefits will begin on the most recent date the participant was unable to work.

The participant must notify **SedgwickCMS** within five days of the successive disability. Participants in a state-mandated plan must also notify the appropriate state claims administrator.

For more information about what happens when a participant becomes disabled again, refer to the Plan Document or Certificate of Insurance for each Plan.

Important: State-mandated plans have different maximum benefit durations.

STD Limitations and Exclusions

In general, benefits may be limited or not available at all, if:

- The participant is not in an employment status that is eligible for disability benefits
- The disability leave is not supported by objective medical evidence from a treating physician or other health care provider and approved by the claims administrator
- The participant is confined, pursuant to commitment, court order, or certification, in an institution, or other place, as a dipsomaniac, drug addict or sexual psychopath
- The participant has reached the maximum benefits or duration allowed under the plan
- The participant receives benefits or is eligible for benefits payable under any Unemployment Compensation Act of the United States or of any state during any period of disability leave
- The participant receives wages from Leidos (excluding Paid Time Off pay) for any day. However, benefits will be paid for any seven-day week or partial week, in an amount that does not exceed the participant's maximum weekly benefit amount and which, when added to the wages received, does not exceed the participant's weekly wages, exclusive of the wages paid for overtime immediately prior to the commencement of the participant's qualified disability.
- The participant, for any day of unemployment or disability, receives or is entitled to receive benefits or cash payments for:

  - Temporary or permanent disability under a workers' compensation or employer liability law of this state or any other state, or of the federal government; or
  - If the cash payments for temporary or permanent disability or a maintenance allowance, combined with permanent disability benefits, are less than the amount of disability benefit the participant would have received, the participant will be entitled to receive disability benefits, reduced by the amount of such cash payments, if otherwise eligible
- The participant:
  - Is incarcerated in any federal, state, or municipal penal institution, jail, medical facility, public or private hospital, or in any other place because of a criminal conviction of a federal, state or municipal law or ordinance; or
  - Commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.
- For any period of disability the participant records uncompensated time, overtime, bereavement, jury duty, voting, or holiday on his or her timecard.
- The employer can provide alternative employment that is within the capabilities of the employee, and that has status and compensation comparable to the employee's regular occupation as determined solely by the employer.
- The participant has willfully, for the purpose of obtaining benefits, either made a false statement or representation, with actual knowledge of the falsity thereof, or withheld a material fact, in order to obtain any benefits from the Plan.
- The disability is:
  - Not disabling (i.e., do not prevent the employee from doing his or her job)
  - Incurred during, or as a result of, engaging in a criminal act
  - Incurred while on layoff or leave of absence (FMLA and similar protected leaves), severance, military leave, or any other status where the participant was not engaged in active employment with Leidos
  - Incurred while on full-time or part-time long-term disability
  - Incurred while the employee was on unauthorized absence, or was not an employee
  - Incurred as a result of service in any armed forces, except as required by law
  - Intentionally self-inflicted

  - Incurred because the participant was not receiving care or following the prescribed treatment plan that is:
    - From a health care provider whose training and clinical experience are suitable for treating the disease, illness, incapacity or injury
    - Consistent in type, frequency and duration of treatment with relevant guidelines of national medical, research, and health coverage organizations and governmental agencies
    - Consistent with the diagnosis of the condition
    - For the purpose of maximizing medical improvement
- The participant is not under the continuous care and treatment of a duly qualified physician
- The illness or injury is caused by any act of war, declared or undeclared, or insurrection, except while traveling overseas on company business.
- The disability is filed more than 60 days after the qualified disability began.

For more information on limitations and exclusions, refer to the Plan Document or Certificate of Insurance for each plan.

Disability Sick Leave (DSL)

Disability Sick Leave (DSL), which is company provided and administered by Sedgwick CMS, provides participants with paid time off for short-term illness or injury (less than 180 days). If a participant becomes sick or is injured, DSL can be used to replace income or augment other short-term disability payments to the maximum level of DSL benefits available, based on the length of disability leave.

A participant receives DSL hours on the first day of hire or transfer date into a benefit-eligible status. Thereafter, a participant receives DSL hours on each employment anniversary. A participant receives up to 80 hours of DSL each year. Participants can accumulate up to 1,560 hours of DSL. Unused DSL hours are not payable upon termination. Employees scheduled to work less than 40 hours per week will receive a prorated number of DSL hours equivalent to two times their scheduled work week on their DSL anniversary date.

The commencement of DSL benefits depends on the circumstances of the participant's disability. DSL is payable:

- On the first day of a qualified disability if the participant is hospitalized as **defined**;
- On the eighth calendar day of a qualified disability.

Should it be medically necessary for the participant to reduce work hours by 25% or more, but not cease work entirely, the reduced workday will be applied to serve the waiting period consecutively for seven calendar days.

DSL benefits are payable for up to 180 days for any one period of disability. DSL may not be used to supplement Long-Term Disability (LTD) benefits, even if the participant has DSL available.

Any DSL benefits participants receive are taxable, and payroll deductions for elected benefits will continue to be made while a participant receives DSL benefits.

Based on the length of disability and the DSL hours available:

- A participant who is unable to work due to a qualified disability may receive a weekly benefit of up to 100% of his regular wages after satisfying the waiting period. These benefits are available for weeks two (2) through ten (10) of disability.
- If eligibility continued, after 10 weeks of disability, a participant may receive up to a maximum of 80% of his regular wages. These benefits are available through the 19th week of disability.
- If the participant remains eligible after the 19th week of disability, he may receive up to 66 2/3% of his regular wages. These benefits are available through the 26th week of disability not to exceed 180 days.

Voluntary Short-Term Disability Insurance (VSDI)

Eligible employees can purchase additional STD coverage through Voluntary Short-Term Disability Insurance (VSDI). This plan is intended to integrate with other Leidos plans such as DSL, Leidos CAVDP and state-mandated programs. Contributions are made on a pre-tax basis. VSDI is administered by Sedgwick CMS.

VSDI benefits begin:

- On the first day of a qualified disability if the participant is hospitalized as defined; or
- On the eighth calendar day of a qualified disability.

Should it be medically necessary for the participant to reduce his or her hours by 25% (minimum two hours for an eight hour workday) or more, but not cease work entirely, the reduced workday will be applied to serve the waiting period consecutively for seven calendar days.

A participant who elects VSDI will be eligible to receive up to 80% of his or her total disability benefit (not to exceed plan maximums) from the VSDI plan.

The VSDI schedule illustrates the integration of VSDI with other disability plans such as DSL and other state plans for periods of up to 26 weeks, not to exceed 180 days.

VSDI Schedule			
PERIOD OF DISABILITY	**TOTAL PAY (From all sources)**	**VSDI (Integrated with state plan, if applicable)**	**DSL PORTION**
WEEK 1	0 (7-day waiting period)	0 (7-day waiting period)	0 (7-day waiting period)
WEEKS 2 – 10	100% of regular weekly wages	80% (maximum weekly benefit of $4,808)	20%, as available
WEEKS 11 – 19	80% of regular weekly wages	80% (maximum weekly benefit of $3,846)	20%, as available
WEEKS 20 – 26*	66 2/3% of regular weekly wages	80% (maximum weekly benefit of $3,202)	20%, as available

* Not to exceed 180 days

Example: For a participant who does not live in a state with a mandated plan, has enrolled in VSDI and is making $1,000 per week, he or she would be eligible for the following disability benefits:

Example VSDI Payment Schedule			
LENGTH OF DISABILITY	**TOTAL BENEFIT (From all sources)**	**VSDI (Integrated with state plan, if applicable)**	**DSL BENEFIT**
WEEK 1	0	0	0
WEEKS 2 – 10	$1,000	$800	$200**
WEEKS 11 – 19	$800	$640	$160**
WEEKS 20 – 26*	$667	$534	$133**

* Not to exceed 180 days
** Based on DSL balance

If hospitalized as defined, the participant will receive:

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

For the same participant who has elected not to enroll in VSDI, all benefits would be paid from the DSL plan and state plan where applicable.

Any VSDI benefits participants receive are taxable, and payroll deductions for elected benefits will continue to be made while a participant receives VSDI benefits.

Leidos California Voluntary Disability Plan (Leidos CA VDP)

Employees who work for a covered California Leidos organization are automatically enrolled in a special short-term disability insurance plan, the Leidos California Voluntary Disability Plan (Leidos CA VDP). This excludes employees working for subsidiaries who are covered by the State of California Short-Term Disability Insurance (CA SDI) program.

The Leidos CA VDP is administered by Sedgwick CMS and meets or exceeds the requirements of the state of California.

Participants pay for coverage through contributions that are no higher than the contribution rate for the California State Disability Insurance Plan. These rates are established each year by the California Employment Development Department. For the 2020 plan year, the contribution rate has been set at 1.0 percent of taxable wages. The maximum salary subject to this contribution is $122,909. The maximum contribution is $1,229.09 in 2020.

If a participant is enrolled in Leidos CA VDP and is unable to work due to a qualified disability, the plan pays benefits equal to 60% to 70% of a participant's regular base wages. The current weekly maximum is $1,300 per week (as of January 1, 2020). The weekly benefit maximum is set each year by the State of California. This is a calendar-day plan, so each day's benefit during a qualified disability is one-seventh of a participant's weekly benefit.

The Leidos CA VDP will pay benefits after a mandatory seven-calendar-day waiting period, but for no more than 52 weeks (or 52 times the weekly amount). If a participant does not cease work entirely, but there is a medical necessity to reduce his or her hours by 25% or more because of a disabling condition, the waiting period may be satisfied with seven consecutive days of partial disability.

Participants who also work for employers other than Leidos are entitled to receive a prorated benefit from those employers' disability plans in addition to any Leidos CA VDP benefit payments. Payments from each plan depend on the number of plans involved. The total amount a participant can receive from each disability plan will equal the portion payable under the California State Disability Insurance Plan. If the participant's employer has a private disability plan (as Leidos does) additional benefits may be payable.

Leidos CA VDP benefit payments are non-taxable, and certain payroll deductions will continue to be made while a participant is receiving Leidos CA VDP benefits.

If you have any questions about this Voluntary Plan or wish to withdraw from the Leidos CA VDP, contact HR Employee Services at 855-553-4367, option 3 or email AskHR@leidos.com.

To report a claim, contact Sedgwick, Leidos' disability claims administrator, at 1-877-399-6443.

Leidos CA VDP Benefit Limitations

Leidos CA VDP benefits may be limited or not available at all, if:

- The participant is not an employee as defined in the plan;
- The participant did not meet the seven-day consecutive waiting period;
- The participant does not work for an Leidos organization that participates in this program;
- The disability is not supported by a certificate from a physician or health care provider stating a diagnosis, the medical facts within his or her knowledge, a conclusion with respect to the disability and an opinion with respect to the probable duration of the disability:
    - Physicians or other health care providers are required to submit an ICD diagnostic code or a detailed description of symptoms. The physician's or other health care provider's certificate must be based on a physical examination;
    - If the participant has been referred or recommended by a competent medical authority to participate as a resident in an alcoholism recovery program or drug residential program, the participant need not show actual disability;
    - Certification of disability may also be accepted from any duly authorized medical officer of any

medical facility of the United States government; the registrar of a county hospital in this state; the duly authorized or accredited practitioner of any bona fide church sect, denomination, or organization, which depends for healing entirely upon prayer and spiritual means;

- Certification is not required if the participant submits evidence of receipts of temporary or permanent benefits under a workers' compensation law for any day for which he or she is entitled to receive disability benefits reduced by such temporary or permanent worker's compensation benefits;

- The participant is receiving unemployment benefits;
- The participant is receiving wages or regular wages from any employer, except that benefits will be paid for any week or partial week not to exceed the maximum weekly benefit amount which, when added to the wages or regular wages, does not exceed the participant's weekly regular wages prior to the beginning of the disability;
- The participant is confined by court order or certification as a dipsomaniac, drug addict or sexual psychopath;
- The participant has knowingly made a false statement or representation in order to receive any benefits under this plan;
- The participant is incarcerated because of a criminal conviction or he or she commits a crime and becomes disabled due to an illness or injury in any way caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction; or
- The participant is receiving or is entitled to receive benefits or cash payments for temporary disability, vocational rehabilitation maintenance allowance or permanent disability benefits under workers' compensation law. However, if these benefits are less than the amount the participant would otherwise receive as benefits under this plan, he or she will be entitled to receive disability benefits reduced by the amount of these workers' compensation payments. Benefits will be limited to the state plan rate for disabilities occurring during the extended coverage period following the beginning of a layoff without pay or a leave of absence without pay.

Other State-Mandated Short-Term Disability Plans

In certain states, other short-term disability plans will pay benefits. These state-mandated plans include:

- California State Disability Insurance*;
- Hawaii Short-Term Disability;

- New Jersey Temporary Disability Insurance;
- New York Voluntary Disability Plan;
- Puerto Rico Temporary Disability Insurance; and
- Rhode Island State Temporary Disability Insurance.

*Leidos employees working for certain subsidiaries in California locations are covered by the State of California SDI program. All other Leidos employees living in California are covered by the Leidos California Voluntary Disability Plan (CA VDP). If you are unsure of which plan you participate in, contact Leidos Employee Services at 855-553-4367, option 3 or email AskHR@leidos.com.

The California, New Jersey, New York, Puerto Rico and Rhode Island plans are administered by the participant's respective states. The Hawaii Plan is administered through Life Insurance Company of North America (a Cigna company). The New York plan is administered through The New York State Insurance Fund insurance company. Both the Hawaii and New York plans were purchased by Leidos as required by state law.

DSL and VSDI are supplements to these plans, which means that the State plans pay first and DSL/VSDI will make up the difference, up to the benefit level that the plans would normally pay. The state disability plans that integrate with DSL and VSDI are outlined above.

Contact Information for State-Mandated Plans

For more detailed information about these state-mandated plans, contact the following:

Contact Information for State-Mandated Plans	
State Mandated Short-Term Disability	**Contact Information**
California State Disability Insurance	Employment Development Department 800 Capitol Mall Sacramento, CA 95814 1-800-480-3287 If you are covered under the Leidos California Voluntary Disability Plan (CA VDP), contact Sedgwick at 1-877-399-6443.
Hawaii Temporary Disability Insurance	**For claims:** ESIS P.O. Box 1639 Honolulu, HI 96806 ESIS Phone: 1-800-779-6249 **State Plan General Contact Information:** Disability Compensation Division 830 Punchbowl Street, Room 209 Honolulu, HI 96813 808-586-9188

Contact Information for State-Mandated Plans	
State Mandated Short-Term Disability	**Contact Information**
New Jersey Temporary Disability Insurance	Division of Disability Insurance Service Department of Labor P.O. Box 387 Trenton, New Jersey 08625 609- 292-7060
New York Voluntary Disability Insurance	**For claims:** New York State Insurance Fund Disability Benefits P.O. Box 66698 Albany, NY 12206 866-697-4332 **State Plan General Contact:** Disability Benefits Bureau Workers Compensation Board P.O. Box 9029 Endicott, NY 13761-9029 800-353-3092
Puerto Rico Temporary Disability Insurance	Bureau of Employment Security Disability Insurance Program 505 Ave Munoz Rivera San Juan, Puerto Rico 00918-3514 797-625-7900 or 787-754-5824
Rhode Island State Temporary Disability Insurance	Dept. of Labor and Training Temporary Disability Insurance 1511 Pontiac Avenue Cranston, Rhode Island 02920-4407 401- 462-8420

Voluntary Long-Term Disability (LTD)

After 180 days of disability, a participant may be eligible to receive benefits through Long-Term Disability (LTD) insurance if elected. LTD benefits are designed to provide you with income if you are absent from work for six consecutive months or longer due to an eligible illness or injury.

In some states, LTD benefits may be paid at the same time as STD benefits. When this occurs, benefits will be integrated with other sources (refer to your LTD evidence of coverage for more information).

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

- **Qualified Disability** — One where a participant cannot perform his or her own occupation in the first two years of disability. After two years of disability, a qualified disability is one where a participant is unable to perform any occupation that he or she is reasonably qualified to hold. Refer to the LTD evidence of coverage, issued by Life Insurance Company of North America (LINA), a CIGNA company, for more information on criteria for "own occupation" versus" any occupation."
  The participant will be required to provide objective medical evidence to CIGNA, the claims administrator, to qualify for benefits. The plan administrator will determine the types of medical documentation needed and how frequently the documentation must be updated.
- **Claims Administrator** — **Life Insurance Company of North America** (LINA), a CIGNA company.
- **Claims Fiduciary** — **Life Insurance Company of North America** (LINA), a CIGNA company.

The plan administrator has appointed **Life Insurance Company of North America** (LINA), a CIGNA company, as the claims fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on Participants and Beneficiaries to the full extent permitted by law.

Important: This document provides only a summary of general plan provisions. A separate evidence of coverage is available from CIGNA, which serves as the legal document that governs the plan.

Overview of LTD Benefits

If a participant is unable to work after 180 days of continuous disability, he or she may become eligible to receive LTD benefits if elected. LTD provides a monthly benefit equal to 60 percent of an employee's base monthly salary not to exceed $14,500 per month.

Employees enrolled in LTD pay 100 percent of the cost on an after-tax basis thereby providing a tax-free benefit when received.

LTD is underwritten by LINA (a CIGNA company), and a participant must meet the Plan's criteria for disability to qualify for income replacement under this program. Refer to the Plan's evidence of coverage for more information about qualifying for income replacement.

The following maximum benefit periods apply:

Duration of LTD Benefit	
AGE WHEN PARTICIPANT'S DISABILITY BEGINS:	**MAXIMUM BENEFIT PERIOD:**
AGE 62 OR UNDER	The employee's 65th birthday or the date the 42nd Monthly Benefit is payable, whichever is later
AGE 63	The date the 36th Monthly Benefit is payable
AGE 64	The date the 30th Monthly Benefit is payable
AGE 65	The date the 24th Monthly Benefit is payable
AGE 66	The date the 21st Monthly Benefit is payable
AGE 67	The date the 18th Monthly Benefit is payable
AGE 68	The date the 15th Monthly Benefit is payable
AGE 69 OR OLDER	The date the 12th Monthly Benefit is payable

How LTD Works

What to Do in Case of a Long-Term Disability

If a participant is unable to work due to a qualified disability lasting more than 180 days, he or she may be eligible for LTD benefits if elected.

To assist the employee in transitioning from short-term to long-term disability claim with Cigna, the following will occur 45 days prior to Short-Term Disability (STD) maximum duration:

1. Sedgwick CMS, the Short-Term Disability claim administrator, will submit the claim to CIGNA.
2. Sedgwick CMS will copy and send by overnight mail the medical records, job description, and payment history from the disability claim file. In addition, the Examiner will complete the form "Integrated Disability Management Transition Information" and send the form to Cigna.
3. Sedgwick CMS will send a letter notifying the claimant that the claim was referred to Cigna for evaluation of LTD Benefits.
4. Cigna will acknowledge receipt of claim by sending out a confirmation letter to the employee once the online submission is completed.
5. Within 10 days, a dedicated claim manager will contact the employee via telephone to introduce themselves and notify the employee of the process. A follow-up letter will be sent following this conversation to notify the claimant of any outstanding information and all applicable policy provisions.

Definition of Disability / Disabled

A participant is disabled if, because of injury or illness:

- He or she is unable to perform all the duties of his or her regular occupation, or only because of the injury or illness he or she is unable to earn more than 80% of his or her indexed covered earnings; and
- After disability benefits have been paid for 24 months, he or she is unable to perform all the duties of any occupation for which he or she may reasonably become qualified based on education, training or experience, or only because of the injury or illness he or she is unable to earn more than 80% of his or her indexed covered earnings. Refer to the evidence of coverage for more information about indexed covered earnings.

How LTD Benefits Are Paid

If the participant is receiving benefits from the LTD plan:

- Disability benefits are paid once a month;
- Benefits can be sent through the mail, or electronically deposited;
- If not directed otherwise, the participant will receive a check mailed to his or her home or address of record from the insurance company; and
- There are no deductions other than applicable taxes and offsets (see the evidence of coverage for more details).

Pre-Existing Conditions

LTD benefits will not be paid for any disability caused by, contributed to or resulting from a pre-existing condition that is diagnosed or treated within a three month time period before the LTD coverage effective date. For this policy, a "pre-existing condition" means any injury or illness for which the participant:

- Received medical treatment, care or services including diagnostic measures; or
- Took prescribed drugs or medicines; or
- Incurred expenses

The pre-existing condition limitation will not apply to a participant covered under a prior plan who satisfied that plan's pre-existing condition limitation, if any. It will still apply to any benefit amount greater than that of the prior plan. If the participant did not completely satisfy the pre-existing condition limitation of the prior plan, he or she will receive credit for any time that was satisfied.

Time will not be credited for any day a participant is not actively at work due to his or her injury or illness. The pre-existing condition limitation will be extended by the number of days the participant is not actively at work due to his or her injury or illness.

Benefit Maximums for Certain Conditions

LTD benefits will be paid on a limited basis during a participant's lifetime for a disability caused by, or contributed to by, any of the following conditions. Once 24 monthly disability benefits have been paid, no further benefits will be paid for any of the following conditions:

- Alcoholism
- Anxiety disorders
- Delusional(paranoid) disorders
- Depressive disorders
- Drug addiction or abuse
- Eating disorders
- Mental illness
- Somatoform disorders(psychosomatic illness)

If before reaching the lifetime maximum of 24 monthly benefits, a participant is confined in a hospital for more than 14 consecutive days for the appropriate care of any of the conditions listed above, that period will not count against the lifetime limit.

For a complete list of the LTD plan's limitations and exclusions, refer to the plan's evidence of coverage.

The Plan Determines Eligibility and Certifies Disability

The plan's claims administrator, Cigna, determines eligibility and makes a determination of disability.

Cigna, at its expense, has the right to examine, as often as reasonably required, any participant with a pending claim. Cigna may also require an autopsy, at its expense, unless prohibited by law.

There is a formal appeal process if the participant disagrees with the determination of the claims administrator. For more information on the appeal process, refer to the plan's evidence of coverage.

Confidentiality

All medical information that a participant and his or her physician supply to the LTD plan is kept confidential and will be protected from unauthorized use. Certain claims for non-occupational disability benefits may require the use of a special, written authorization form. If a participant receives one of these forms, he or she will need to sign and return it as soon as possible so there is no delay in processing the claim.

LTD Claims Management

The LTD plan will require that the participant cooperate in collecting the medical information necessary to review the claim and make a benefit determination. The most common reason that claim payments are delayed is the failure of the participant's health care provider to return calls, return forms or otherwise provide medical documentation. A participant can help the plan administrators make more timely decisions by:

- Explaining to the health care provider that the administrator will be contacting them;
- Following up with the health care provider's office after a request for information has been made to ensure that the information is being collected and sent to the administrator; and
- Notifying Cigna immediately if the participant's return-to-work plans change, or if the health condition significantly changes (for example, if a surgery is needed). This will allow the plan administrator to help the employee file for an extension of benefits, if appropriate.

Continuation of Insurance

Disability insurance continues if a participant's active service ends because of a disability for which covered benefits are or may become payable. Premiums for the participant will be waived while disability benefits are payable. If the participant does not return to active service, this insurance ends when the disability ends or when benefits are no longer payable, whichever occurs first.

If a participant's active service ends due to an employer-approved unpaid leave of absence, insurance for that participant will continue for up to 24 months if the required premium is paid.

If a participant's active service ends due to family medical leave of absence, insurance for that participant will continue for up to 12 weeks if the required premium is paid.

Rehabilitation During a Period of Disability

If, while a participant is disabled, the plan determines that he or she is a suitable candidate for rehabilitation, he or she may participate in a rehabilitation plan. The terms and conditions of the rehabilitation plan must be mutually agreed upon by the participant and the plan.

The plan may require a participant to participate in a rehabilitation assessment or a rehabilitation plan at its expense. The plan will work with the participant, the employer and the participant's physician and others, as appropriate, to develop a rehabilitation plan. Disability benefits will not be paid if the participant refuses to participate in the rehabilitation efforts.

The rehabilitation plan may, at the plan's discretion, allow payment of the participant's medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

A "rehabilitation plan" is a written agreement between the participant and the plan in which the plan agrees to provide, arrange or authorize vocational or physical rehabilitation services.

Work Incentive Benefits

For the first 12 months the participant is eligible for a disability benefit, the disability benefit is determined based on the minimum and maximum disability benefit. If for any month during this period, the sum of the participant's disability benefit, current earnings and any additional other income benefits exceeds 100% of his or her indexed covered earnings, the disability benefit will be reduced by the excess amount.

After the first 12 months, the disability benefit is determined based on the minimum and maximum disability benefit, reduced by 50% of his or her current earnings received during any month he or she returns to work. If the sum of the participant's current earnings and any additional other income benefits exceeds 80% of his or her monthly indexed covered earnings, the disability benefit will be reduced by the excess amount figured above. No benefits will be paid if the plan determines the participant is able to work under a transitional work arrangement or other modified work arrangement and he or she refuses to do so.

Current earnings include any wage or salary for work performed while disability benefits are payable. If participant is working for another employer on a regular basis when disability begins, current earnings will include any increase in the amount he or she earns from this work during the period for which disability benefits are payable.

Survivor Benefits

The plan will pay a survivor benefit if a participant dies while monthly benefits are payable. The benefit will equal 100% of the sum of the last full disability benefit payable to the participant plus any current earnings by which the disability benefit was reduced for that month. A single lump sum payment equal to 6 monthly survivor benefits will be payable.

Benefits will be paid to the participant's spouse or registered domestic partner. If there is no spouse or registered domestic partner, benefits will be paid in equal shares to the participant's surviving children. If there are no spouse/registered domestic partner and no children, no benefits will be paid.

"Spouse" means a participant's lawful spouse. "**Registered Domestic Partner**" is defined in the Eligibility section. "Children" means a participant's unmarried children under age 21 who are primarily dependent upon the participant for support and maintenance. The term includes a stepchild living with the participant at the time of his or her death.

Coordination with Other Benefits

Social Security Disability Benefits

When a participant is unable to work for an extended period of time, he or she may be eligible for Social Security Disability Income (SSDI). SSDI allows an employee to receive income.

A participant who is disabled should apply for SSDI as soon as it is clear that the duration of the disability will be longer than six months. When the participant applies for LTD benefits, CIGNA will require that the participant apply for SSDI benefits, and will offer assistance throughout the SSDI application process.

If the participant is eligible for Social Security disability benefits, any such payment will be subtracted from disability benefits he or she receives from the disability plans.

It is not uncommon for the SSDI application and approval process to take several months, and for benefits paid to be retroactive back to a certain date of disability. A participant receiving LTD benefits will be asked by CIGNA to sign an Overpayment Reimbursement Agreement stating that he or she will reimburse CIGNA for any Social Security benefits received for the same period of time he or she was receiving disability benefits.

Other LTD Benefits

The LTD plan is designed to provide a certain degree of income protection if a participant is unable to work for long periods of time. However, the plan may reduce the disability benefit paid if, while a participant is disabled, he or she may be eligible for benefits from other income sources. If so, benefits may be reduced by the amount of these other income benefits, including:

- Any amounts which the participant or any dependents receive (or are assumed to receive) under:
    - the Canada and Quebec Pension Plans;
    - the Railroad Retirement Act;
    - any local state, provincial or federal government disability or retirement plan or law as it relates to the participant;
    - any employer sick leave plan;
    - any work loss provision in mandatory "No-Fault" auto insurance;
    - any Workers' Compensation, occupational disease, unemployment compensation law or similar state or federal law, including all permanent as well as temporary disability benefits. This includes any damages, compromises or settlement paid in place of such benefits, whether or not liability is admitted;

- Any Social Security disability benefits the participant or any third party receives (or are assumed to receive) on the participant's behalf or for his or her dependents; or, which his or her dependents receive (or are assumed to receive) because of the participant's entitlement to such benefits;
- Any employer-funded retirement plan benefits. "Retirement plan "means any defined benefit or defined contribution plan sponsored or funded by a participant's employer. It does not include:
    - an individual deferred compensation agreement;
    - a profit sharing or any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution pension plan;
    - any participant savings plan including a thrift, stock option or stock bonus plan, individual retirement account or 401(k) plan;
- Any proceeds payable under any franchise or group insurance or similar plan. If there is other insurance that applies to the same disability claim, and which contains the same or a similar provision for reduction because of other insurance, the plan will pay the proportion of the total benefit payable under the policy, without other insurance, as it applies to the total benefits under all such policies;
- Any amounts paid because of lost earnings or loss of earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined;

- Any wage or salary for work performed. If a participant is covered for Work Incentive Benefits, the plan will only reduce disability benefits to the extent provided under the Work Incentive Benefit in the Schedule of Benefits.

Although this coordination of benefits may reduce the amount received from the LTD plan, all benefits together will still equal the total amount the participant is eligible for under the LTD plan.

When LTD Benefits End

Returning to Work

Leidos requires that all participants returning from LTD provide a "fitness for duty" or "doctor's release" when he or she returns to work. This document is usually a note from the health care provider clearly stating he or she is not considered to be disabled, as well as the date he or she is able to return, as well as the date of release that the participant may return to full duty. If the health care provider is requesting modified duty or limited hours, this should be discussed with CIGNA and the workplace in advance of the participant's return to work. A participant who does not present a release may not be allowed to work until the release is presented.

When LTD Benefit Payments End

LTD benefits end:

- When the participant is eligible for coverage under a plan intended to replace this coverage;
- When the insurance policy is terminated;
- When the participant is no longer eligible;
- On the day after the period for which premiums are paid; or
- When the participant dies.

If a participant's disability started prior to termination of employment, disability benefits will continue to be paid up to the maximum duration approved under the Plan.

For collectively bargained participants, disability benefits will continue to be paid if a strike occurs and the disability started prior to the strike. Benefits will be paid up to the maximum duration approved under the Plan.

For more information about when LTD benefits end, refer to the plan's evidence of coverage.

If a Participant Becomes Disabled Again

Once a participant is eligible to receive LTD disability benefits, separate periods of disability resulting from the same or related causes are considered a continuous period of disability unless the participant returns to active service with Leidos for more than six consecutive months. A period of disability is not continuous if separate periods of disability result from unrelated causes or the later disability occurs after coverage ends.

If a participant is eligible for coverage under a plan that replaces this disability plan, the successive periods of disability provision will not apply.

For more information about what happens when a participant becomes disabled again, refer to the plan's evidence of coverage.

What the LTD Plan Does Not Cover

LTD benefits will not be paid for a disability that results, directly or indirectly, from:

- Suicide, attempted suicide, or whenever a participant injures himself or herself on purpose;
- War or any act of war, whether or not declared (For Class 1 employees only);
- Serving on full-time active duty in any armed forces. If the participant sends proof of military service, the plan will refund the portion of the premium paid to cover the participant during a period of such service;
- Active participation in a riot;
- Commission of a felony; or
- Revocation, restriction or non-renewal of a participant's license, permit or certification necessary to perform the duties of his or her occupation unless that is due only to covered injuries or illnesses.

LTD benefits will not be paid for any period of disability during which the participant:

- Is incarcerated in a penal or corrections institution;
- Is not receiving appropriate care under a licensed physician;
- Fails to cooperate with the plan in the administration of the claim, such as providing any information or documents needed to determine whether benefits are payable or the actual

benefit amount due;

- Refuses to participate in rehabilitation efforts as required by the plan; or
- Refuses to participate in a Transitional Work Arrangement or other modified work arrangement.

"Transitional Work Arrangement" means any work offered to the participant by Leidos or an affiliated company while the participant is disabled and which may be his or her own or any occupation. The term includes but is not limited to reassigned duties, work site modification, flexible work arrangements, job adaptation or special equipment.

For more information about what the LTD Plan does not cover, refer to the plan's certificate of coverage.

Conversion Privilege

If a participant's coverage ends because employment with Leidos ends, or a participant is laid off or on an uninsured leave of absence, he or she may be eligible for long-term disability conversion insurance. To be eligible, a participant must have been insured for disability benefits and actively at work for at least 12 months. A participant must apply for conversion insurance within 62 days after coverage ends. The benefits of the conversion plan will be those benefits offered at the time a participant applies. The premium will be based on the rates in effect for conversion plans at that time.

Conversion insurance is not available if any of the following conditions apply:

- A participant is retired or age 70 or older;
- A participant is not in active service because of disability; or
- The insurance policy is canceled for any reason.