# Leidos Benefits Summary Plan Description

## *Participating in the Plans*

Leidos' benefit programs are intended to provide a competitive and comprehensive level of protection for our employees and their families through health care plans, disability income protection, life insurance and other employee benefits.

The benefits described in this document are not applicable to employees of Leidos Biomedical Research, Inc., QTC. 1901 Group or Dynetics.

Pre-existing condition clauses do not apply to any of Leidos' medical plans.

Please refer to the Dental Plan section of this SPD site for information on the dental plan exclusions. Additionally, the individual dental carriers should be contacted for information on the specific exclusions for dental work in progress.

Please review Life and LTD plan types for language describing pre-existing conditions and exclusions.

For more information on participating in the plans:

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

## Eligibility

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

- Employees
- Dependents (including Spouse)
- Registered Domestic Partners

## Employees

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

| **Employee Eligibility** | |
|---|---|
| **Type of Coverage** | **Eligibility Requirements** |
| Medical, Dental, Vision, Employee Assistance Program, Flexible Spending Accounts, Health Savings Account, Well-Being, Disability, and Life and Accidental Death and Dismemberment Insurance Programs | • Must be an active, regular full-time employee working at least 30 hours per week; or<br>• Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and<br>• Consulting Employees (CEs) are eligible for Leidos-sponsored medical coverage only.<br>• Must live in the geographic area served by a particular plan.<br>• For salary based plans (i.e., Disability, Life Insurance and Accidental Death & Dismemberment Insurance) the benefit is pro-rated for part-time employees working at least 12 hours per week |
| Cigna International Medical and Dental Plan | Available to expatriate employees scheduled to be overseas for at least six months or more. |

## Dependents

Participants may also enroll their eligible dependents in some Leidos benefit programs. Dependents that are eligible to be enrolled in these programs are:

- The participant's legal spouse or registered domestic partner (See "Registered Domestic Partners");
- Each child of the participant or registered domestic partner* younger than age 26**, including:
    - A natural child or stepchild***;
    - An adopted child (coverage begins as of the earlier of the date the child was placed in the participant's home or the date of final adoption); and
    - Any other child who depends on the participant for support and lives with the participant in a parent-child relationship, if the participant provides proof of legal guardianship.
- Unmarried children, age 26 and older who are incapable of self-sustaining employment because they are mentally or physically disabled, as long as:

- The mental or physical disability existed while the child was covered under the plan and began before age 26;
- The child is primarily dependent on the participant for support; and
- The participant provides periodic evidence of incapacity

Participants must notify the Employee Services, in writing, within 31 days of any change in dependent eligibility.

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

** TRICARE Supplement coverage is available to unmarried dependent children under age 21 (or under age 23 if a full-time student). It is available to unmarried dependent children younger than age 26 if the participant is enrolled in the TRICARE Young Adult (TYA) program and as long as the children are not eligible for other employer-sponsored health coverage. Domestic partners and domestic partner children are not eligible for coverage under the TRICARE Supplement plan.

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

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

No one can receive "double coverage" under Leidos' benefit programs. Therefore, participants may not cover a spouse, registered domestic partner or dependent child if that spouse, registered domestic partner or child is also a Leidos employee and has elected his or her own coverage.

If a participant and his or her spouse or registered domestic partner are both Leidos employees, each can choose individual coverage or one can cover the other as a dependent — but not both.

If the participant has children, only the participant or spouse or registered domestic partner can choose coverage for dependent children.

## Registered Domestic Partners

The participant may enroll his or her registered domestic partner and the registered domestic partner's eligible dependent children in participating medical, dental and vision plans in which the participant is enrolled.

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

For purposes of Leidos coverage, a registered domestic partnership is a committed same-sex or opposite-sex relationship, in which registered domestic partners:

- Live together at the same address and have lived together continuously for at least one year;
- Are not legally married to one another or anyone else;
- Do not have another registered domestic partner and have not signed a registered domestic partner declaration with another within the past year;
- Are mentally competent to consent to a contract or affidavit;
- Are not related by blood in such a way as would prohibit legal marriage; and
- Are jointly responsible for each other's common welfare and are financially interdependent

A *Declaration of Domestic Partnership* must be completed, notarized and submitted with any other required documents in order to enroll a registered domestic partner. The Declaration must be presented to insurers upon request. Contact Leidos Employee Services for additional information on enrolling in registered domestic partner coverage. The *Declaration of Domestic Partnership* form can be found on Prism.

Registered domestic partner coverage is different from spouse coverage. For instance:

- Participant contributions for registered domestic partner coverage and their eligible children must be paid on an after-tax basis;
- The value of benefits provided to a registered domestic partner and/or his or her eligible children is considered taxable income. As a result, the Leidos employee must pay any state, federal, FICA and other applicable tax withholding in the form of imputed income. This amount is based on the value of the coverage Leidos provides to the partner.

## Dependent Eligibility Verification (DEV) Process

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

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

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

If an employee receives a request from Budco to verify current dependents, even if the dependent has been verified before, it is critical that the request is not ignored. Failure to provide the requested documentation within the specified timeframe will result in the dependent(s) being deemed ineligible and removed from our plans.

Covering ineligible dependents is a violation of the company's Code of Conduct and could expose the company to sanctions from the government. The company's eligibility verification process helps ensure that we are compliant with our requirements as a government contractor.

Questions about the dependent eligibility verification program may be directed to Budco at 866-488-2001, or Employee Services at 855-553-4367, option 3 or via email at ASKHR@Leidos.com.

## When Coverage Begins

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

## New Employees

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

Changes may not be made to benefit elections until the following Open Enrollment period unless a qualified status change occurs. Please see Changing Coverage (Qualified Status Changes). Coverage changes are generally effective on the date of the qualified status change.

## Current Employees

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

# Cost of Coverage

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

## How Pre-Tax Premium Contributions Affect Take-Home Pay

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

In exchange for lowering a participant's taxable income, the IRS restricts his or her ability to change coverage during the year unless the participant or dependent experiences a qualified status change or changes coverage during an Open Enrollment period.

# Enrolling for Coverage

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

Participants will select from among a number of plan options prior to enrolling for coverage. The plan the participant chooses during enrollment will apply to the participant and each of his or her covered dependents and will remain in effect for the entire plan year. In the case of a qualified status change, under most circumstances, the participant will be able to change only the level of coverage (i.e., Employee Only, Family Coverage) but not change coverage options (switch from one plan to another). The participant may also choose to drop coverage. If a participant does not make an election during the Open Enrollment period, his or her current coverage choices will remain in effect for the next plan year, except for participation in Health Savings Account and Flexible Spending Accounts.

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

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

Levels of coverage may not be changed until the next Open Enrollment period unless the participant or dependents experience a qualified status change (see "Changing Coverage (Qualified Status Changes)"for more information).

## Open Enrollment

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

**Important: Annual Enrollment for Health Savings Accounts and Flexible Spending Accounts**

Participants may not roll over their elections in a Health Savings Account or a Flexible Spending Account from year to year. They must re-enroll annually and elect the amount of pre-tax contributions they wish to make. If they do not re-enroll in the Flexible Spending Account each plan year, they will not be able to participate and will have to wait until the following Open Enrollment period to re-enroll.

## Changing Coverage (Qualified Life Event Changes)

Because contributions for most benefits are deducted on a pre-tax basis, IRS regulations require that a participant, once enrolled, may not change his or her election until the next Open Enrollment period unless he or she experiences a qualified status change.

Experiencing a qualified life event change allows a participant to change the level of coverage (but not to switch plans) within 31 days of the event. Qualified status changes include, but are not limited to:

- *Adding a dependent* through marriage, registered domestic partnership, birth, adoption or legal guardianship;
- *Losing a dependent* through legal separation, annulment, divorce, dissolving of a registered domestic partnership or death;
- *Dependent's loss of eligibility* by attaining age 26;
- *Loss of other health insurance* coverage through the employer of a spouse or registered domestic partner (for example, because of layoff, termination, disability, severance, substantial reduction in benefits or reduction in work hours);
- *Gaining eligibility for other coverage* through the Health Insurance Marketplace, a spouse's or registered domestic partner's plan, COBRA or Medicare (or MediCal in California);
- *Receiving a court order* — a **Qualified Medical Child Support Order (QMCSO)** — requiring the addition of medical coverage for children not in the participant's custody;
- *Changing residence* and thereby affecting access to a plan service area; and
- *Changing child or adult care situations*, such as providers or costs.

**Important: Benefit Change Must be Consistent with Qualified Status Change.**

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

**Participants must contact Employee Services within 31 days of a qualified status change event.**

## When Coverage Ends

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

- Termination of employment*;
- Failure to pay required premiums;

- Commencement of a leave of absence;
- Loss of eligibility status;
- Strike**

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

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

Coverage for a permanently disabled child continues as long as the child qualifies as a disabled dependent as determined by the plan. Periodic proof of continued disability (generally once every 24 months) will be required.

**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.*

## Family and Medical Leave

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

## Disability

If a participant is totally disabled and the disability continues for more than 180 days, disability benefits may continue but health coverage under the active group plan will end. Participants may choose to continue medical, dental, and/or vision coverage at their own expense under **COBRA**. Under certain

circumstances, the participant may participate in the **Health Care Flexible Spending Account** — on an after-tax basis — under COBRA.

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

- The date the employee is no longer disabled;
- The date the maximum benefit period ends:
    - For **Basic Term Life Insurance**, the maximum benefit period is 30 months from the date of disability;
    - For **Group Universal Life Insurance**, coverage ends on the date placed on disability. Continuation of coverage may be available through Prudential;
    - For **Basic Dependent Life Insurance**, the maximum benefit period is 30 months from the date of disability;
- The day after the period for which premiums are paid.

### Military Leave

If a participant is on a military leave of absence, he or she is eligible to elect COBRA continuation coverage.

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

### Reinstatement of Benefits

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

## Continuing Coverage

A federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA) enables a participant and his or her covered dependents to continue health insurance if their coverage ends due to a reduction

of work hours or termination of employment (other than for gross misconduct). Federal law also enables a participant's dependents to continue health insurance if their coverage stops due to the participant's death or entitlement to Medicare; divorce; legal separation; dissolution of 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 health care 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.

## Eligibility for COBRA

Who Is eligible For COBRA:

- A covered participant who loses coverage due to termination (other than termination for gross misconduct) or reduction in work hours. Termination includes voluntarily quitting, layoff, and lack of work due to a work location closure.
- The spouse, registered domestic partner and/or dependent children of a covered participant who are covered under the plan and who lose coverage as a result of any of the following qualifying events:
  - The death of a covered employee;
  - The termination of a covered employee (excluding termination due to gross misconduct);
  - The divorce, legal separation, or dissolution of a domestic partnership of the covered employee from his or her spouse or domestic partner;
  - A dependent's ceasing to qualify as a "dependent child" under the terms of the plan; or
  - The covered employee's becoming entitled to Medicare benefits

## Continuing Coverage Through COBRA

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

## COBRA End Date

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

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

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

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 more information.

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).

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