# LEIDOS HOLDINGS, INC.

**(AND DESIGNATED SUBSIDIARIES)**

## VOLUNTARY SHORT-TERM DISABILITY INSURANCE (VSDI) PLAN

## AMENDED AND RESTATED AS OF JANUARY 1, 2023

***LEIDOS HOLDINGS, INC.***
**(*AND DESIGNATED SUBSIDIARIES*)**

**NAME:** Karen F. Kanjian

**TITLE:** VP Director of Corporate Benefits

**DATE:** January 1, 2023

# LEIDOS HOLDINGS, INC.

## VOLUNTARY SHORT-TERM DISABILITY INSURANCE (VSDI) PLAN

The principal purpose of the **Leidos and Subsidiaries Voluntary Short-Term Disability Insurance (VSDI) Plan** (the "Plan" or “Leidos VSDI Plan”) is to financially aid Participants in the event of Disability. This Plan does not replace other Disability benefit sources, which are available to Participants, such as Social Security, State Disability or Workers' Compensation. This Plan may provide a benefit supplement to such other benefit sources.

The **Leidos VSDI Plan** became effective on January 1, 1976 and has been amended and restated to read as set forth herein, effective for Disabilities commencing on or after January 1, 2023. The payment of benefits for any Disability commencing prior to January 1, 2023 will be governed by the terms of the Plan in effect when such Disability commenced.

# LEIDOS HOLDINGS, INC.
## VOLUNTARY SHORT-TERM DISABILITY INSURANCE PLAN

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# LEIDOS HOLDINGS, INC.
## VOLUNTARY SHORT-TERM DISABILITY INSURANCE PLAN

### PLAN DOCUMENT

### ARTICLE I

**The Leidos and Subsidiaries Voluntary Short-Term Disability Insurance (VSDI) Plan (the "Plan" or "Leidos VSDI Plan") became effective on January 1, 1976 and has periodically thereafter been amended and restated. The terms of the Plan, as stated below, are effective for Disabilities commencing on or after January 1, 2023. Leidos hereby further amends and restates, in its entirety, the Leidos VSDI Plan, so as to read as set forth below:**

### DEFINITIONS

### GENERAL

Wherever the following terms are used in this Plan, they will have the meaning specified below unless the context clearly indicates to the contrary.

### 1.01 BOARD OF DIRECTORS

*"Board of Directors"* means the Board of Directors of **LEIDOS HOLDINGS, INC.**

### 1.02 CLAIMANT

*"Claimant"* means a Plan Participant who is either in the process of applying for or who is presently receiving benefits under the Plan.

### 1.03 CLAIMS ADMINISTRATOR

*"Claims Administrator"* means Sedgwick, an independent Claims Administrator. Claims are sent to Sedgwick – P.O. Box 14435, Lexington, KY 40512-4435, 1-877-399-6443.

### 1.04 COMPANY

*"Company"* means LEIDOS HOLDINGS, INC. and to the extent that the Board of Directors of LEIDOS HOLDINGS, INC. will by resolution so provide, any existing or subsequently acquired subsidiary or affiliated entity thereof.

### 1.05 COMPENSATION

*"Compensation"* means an Employee's basic weekly pay for services rendered to the Company prior to any voluntary salary reduction, excluding overtime, shift differential pay, bonuses, commissions, stock transactions, expense reimbursements, moving expenses and employee benefit, during the last pay period immediately prior to the date of disability.

## 1.06 DISABILITY OR QUALIFIED DISABILITY

*"Disability"* means a covered disability described in Section 3.02.

## 1.07 EFFECTIVE DATE

*"Effective Date of the Plan"* means January 1, 1976.

## 1.08 EMPLOYEE

*"Employee"* means a person who, on or after the Effective Date of the Plan, is a Regular Full-time or Regular Part-time Employee on the payroll of the Company.

**A.** Regular Full-time "Employee" is an individual who is regularly scheduled to work thirty (30) hours or more per week.

**B.** Regular Part-time "Employee" is an individual who is regularly scheduled to work at least twelve (12) but less than thirty (30) hours per week.

**C.** Regular Employment is distinguished from temporary in that Regular Employment is expected to continue for at least six (6) months from the date of hire.

**D.** Excluded from the term "Employee" is any individual who is not classified for the relevant eligibility period by Leidos (or affiliated company) on its payroll records as an Employee. This includes, but is not limited to, individuals classified as consulting employees, independent contractors, non-employee consultants, temporary employees (whether hired by Company or through an agency), or as employees of any entity other than Leidos or affiliated company, such as payrollee, even if such classification is determined to be erroneous, or is retroactively revised by a governmental agency, by court order, as a result of litigation, or otherwise.

## 1.09 EMPLOYER

*"Employer"* means LEIDOS HOLDINGS, INC. or its designated subsidiary that employs a particular Employee.

## 1.10 HOSPITAL CONFINEMENT

*"Hospital Confinement"* means for the purposes of Section 3.01, any twenty-four (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. "*Hospital Confinement*" does not include Emergency Room visits and outpatient surgery.

## 1.11 OBJECTIVE MEDICAL EVIDENCE

*"Objective Medical Evidence"* means medical demonstration of anatomical, physiological, or psychological abnormalities manifested by signs or laboratory findings, apart from the Claimant's perception of his/her mental or physical impairments. These signs are observed through medically acceptable clinical techniques such as medical history and physical examination. Laboratory findings are manifestations of anatomical, physiological, or psychological phenomena demonstrated by chemical, electrophysiological, roentgenological, or psychological tests.

## 1.12 PARTICIPANT

*"Participant"* means an Employee who satisfies the eligibility requirements of Section 2.01 and has chosen to make voluntary contributions to the Plan.

## 1.13 PHYSICIAN

***"Physician"*** includes physicians and surgeons holding an M.D. or D.O. degree, physician's assistants (PA's), nurse practitioners (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. "Psychologist" means a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure under applicable 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.

A Physician must be someone other than the Employee or a member of the Employee's immediate family (spouse, daughter, son, father, mother, sister, or brother by blood, adoption or by marriage or registered domestic partner).

## 1.14 PLAN

*"Plan"* means the Leidos and Subsidiaries Voluntary Short-Term Disability Insurance Plan (VSDI) (with a Plan number of 515), as amended from time to time.

## 1.15 PLAN ADMINISTRATOR

*"Plan Administrator*" means **LEIDOS HOLDINGS, INC**. acting through designated officers to whom the Board of Directors ("Board") has delegated certain powers and authority to make financial, contractual and other decisions on behalf of Leidos. The Board has delegated these powers and authority to the Chief Human Resources and other executive officers of the Company. Specifically, the Board has delegated the authority to approve all Benefit Programs Administration items to the Chief Human Resources Officer ("CHRO"). The CHRO has delegated to the Director of Corporate Benefits the authority to approve all Benefit Programs Administration items, including but not limited to reviewing and executing contracts relating to corporate benefit plans and programs including the disability programs.

The Plan Administrator will also serve as the "Named Fiduciary" for the purpose of satisfying the requirements of Section 402 of the Employee Retirement Income Security Act of 1974.

## 1.16 PLAN YEAR

*"Plan Year"* means the calendar year ending each December 31.

## 1. 17 PRONOUNS

*"Pronouns"* means the masculine pronoun will include the feminine pronoun and the singular will include the plural, where the context so indicates.

## 1.18 RECURRING DISABILITY

*"Recurring Disability"* means 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, will be considered the same Disability. A new Elimination Period will not be required. The period of time worked will not 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 will be used.

## 1.19 REGULAR WAGES

*"Wages" or "Regular Wages"* (Compensation) for the purposes of benefit determination will mean:

**A.** With respect to Regular, Full-time Employees, the scheduled base salary amount of Compensation paid to the Participant and in effect during the last completed payroll period immediately prior to the date of commencement of the Employee's Disability prior to any voluntary salary reduction, excluding overtime, shift differential pay, bonuses, commissions, stock transactions, expense reimbursements, moving expenses and employee benefits.

**B.** With respect to all Part-time Employees, the average weekly Compensation paid to the Participant by the Company excluding overtime, shift differential pay, bonuses, commissions, and stock transactions during the previously completed twelve (12) week period immediately prior to the date of commencement of the Employee's Disability.

# ARTICLE II

# PARTICIPATION

## 2.01 ELIGIBILITY FOR PARTICIPATION

An Employee will be eligible to participate as of his first (1st) day of employment as a Regular Full-time or Regular Part-time Employee.

If an Employee is not actively at work on the day or during the period the Employee would ordinarily become covered by the Plan, the Employee's coverage will not become effective until the Employee reports to active work and the Employee elects the coverage in a method deemed appropriate by the Plan Administrator within thirty (30) days of returning to work.

Active pay status means an employee is receiving 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 Leave Without Pay (LWOP), or receiving disability benefits (DSL, SDI, VSDI or LTD).

## 2.02 ELECTION TO PARTICIPATE/NOT PARTICIPATE

Participation in the Plan on the part of each Employee is voluntary. Employees elect to accept coverage in writing by completing the appropriate information in a method deemed acceptable by the Plan Administrator. For enrollment-related questions, the Employee may contact Employee Services at 855-553-4367, option 3 or via email at LeaveAdmin@leidos.com within thirty (30) days of hire or within thirty (30) days of experiencing a corresponding qualified family change as detailed by IRS code.

Any Employee who is actively at work, and has elected not to participate in the Plan or who has withdrawn from the Plan and who subsequently elects to be covered by the Plan may do so during the Company's scheduled Open Enrollment. Coverage in this case will become effective on the date designated in the Open Enrollment literature if the employee is actively at work. If not actively at work, this benefit will take effect upon return to active status and meeting the eligibility requirements.

## 2.03 CESSATION OF PARTICIPATION

Participant will cease to participate in the Plan upon the earliest of the following dates:

A. On the last day of the benefit plan year if the Participant disenrolls during Open Enrollment.

B. The end date of the pay period in which the Participant ceases to be an eligible Employee.

C. On the end date of the pay period which marks the termination of employment by termination of the Employer-Employee relationship; or at the end of the pay period in which an approved leave of absence without pay commences, except as required by law, or at 12:00 midnight when a protected leave ends if the Participant fails to return to work, whichever is later.

D. The date upon which this Plan terminates; provided, however, that such Plan termination will be without prejudice to benefits payable for Disabilities commencing prior thereto.

E. On the date of the qualified status event, if the Employee notifies the employer that he has experienced a corresponding qualified status event as defined by the IRS.

F. On the end date of the pay period if the Participant fails to pay the required contribution.

G. On the date that the Participant first submits a fraudulent claim (as reasonably determined by the Plan Administrator).

H. On the end date of the pay period in which a strike occurs, if the Participant is a member of a bargaining unit that is participating in the strike.

## ARTICLE III

## DISABILITY BENEFIT

### 3.01 ELIMINATION PERIOD

**A.** A Participant who sustains a Disability within the meaning of Section 3.02 will, subject to the provisions of the Plan, become eligible to receive the benefit described in Section 3.04.

1. Benefits will commence on the earlier of: the eighth ($8^{th}$) day of Disability; or the first ($1^{st}$) day of Hospital Confinement.

Based on the Participant's Disability, if it should 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.

**B.** Recurring Disabilities of two (2) or more intervals of Disability, due to the same cause or condition, separated by less than thirty one (31) days of continuous active work with the Company will be considered the same Disability. A new Elimination Period will not be required. Should the Participant go out on an approved Disability related to the initial claim within 31 days, any period of time worked will not count against the total leave duration for purposes of calculating remaining benefits payable.

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 will be used:

**1.** If the Disability is due to an illness or injury found by the Plan Administrator to be entirely unrelated to the cause or condition of the previous Disability and the Disability commences after return to active work with the Company for at least one (1) day at the Participant's normal work schedule, the two (2) intervals of Disability will be considered as separate Disabilities for the purpose of calculating Plan benefits, and a new Elimination Period will be required.

**2.** Two (2) or more intervals of Disability due to separate and unrelated causes, which occur concurrently or overlap, will require only one (1) Elimination Period.

**3.** For each day of any period of Disability for which benefits are paid and which is less than a full week, the amount of benefits payable will be one-fifth ($1/5^{th}$) of the amount of weekly benefit.

### 3.02 DISABILITY DEFINED

*"Disability"* means any physical or mental condition arising out of illness, pregnancy or injury, which renders the Participant continuously unable to perform the material duties

pertaining to his/her regular and customary occupation. During such time the Participant must be under the regular and continuous care of a licensed Physician. However, a Participant will not be considered disabled if the Employer can provide alternative employment that is within the capabilities of the Participant and that has status and compensation comparable to the Participant's regular occupation, as determined solely by the Employer.

The Plan Administrator will in its sole discretion make a determination as to whether a Disability exists with respect to the Participant on the basis of Objective Medical Evidence and any other relevant evidence.

## 3.03 LIMITATIONS AND EXCLUSIONS

**A. No Participant will be entitled to a Disability benefit for any Disability that arises out of, relates to, is caused by, or results from the following:**

A Disability which is not supported by a certificate from a licensed treating Physician, with such certificate meeting the following criteria: (1) The certificate contains a diagnosis and diagnostic code prescribed in the International Classification of Diseases (or, where no diagnosis has yet been obtained, a detailed statement of symptoms); (2) the certificate also contains a statement of medical facts, including secondary diagnoses when applicable, within the Physician's knowledge based on a physical examination and a documented medical history; and (3) the Physician must (in the certificate or in other documentation) indicate his/her conclusion as to the existence of a Disability and provide a statement of his/her opinion as to the expected duration of the Disability.

**B. OTHER EXCLUSIONS FOR WHICH BENEFITS ARE NOT PAYABLE:**

1. An illness or injury caused by committing a violent act, assault, felony or an illegal activity or occupation.

2. An intentionally self-inflicted injury regardless of mental status at the time of injury.

3. An illness or injury due to any act of war, declared or undeclared, or insurrection, except while traveling overseas on Company business.

4. An illness or injury was incurred as result of service in the armed forces, except as required by law.

5. An illness or injury for which the Participant is not under the continuous care and treatment of a duly qualified licensed Physician (i.e., for the duration of the Disability, the Participant must be under the care of a Physician who can provide medical documentation supporting the Disability (including any extensions, if necessary)).

6. If 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 under this Plan.

7. If the Participant does not provide the Claims Administrator with Objective Medical Evidence in support of Disability (or does not arrange to have such Objective Medical Evidence provided to the Claims Administrator, e.g., directly from a Physician). Such Objective Medical Evidence includes, but is not limited to, data and records from the attending Physician, narrative reports, x-rays and other laboratory findings and consulting physicians' reports. This information is required at the initiation of the claim and periodically thereafter, as reasonably requested by the Claims Administrator.

8. The Participant was not receiving care or following a 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

9. For any day the Participant a) 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 b) who 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 conviction.

10. An illness or injury which was incurred while the Participant was receiving full time or part-time long term disability benefits from the Company or from any other entity (including, but not limited to, a governmental entity).

11. An illness or injury which was incurred during a period of time during which (a) the Employee was on unauthorized absence, or (b) was not an Employee.

12. An illness or injury which was incurred as a result of service in any armed forces, except where such an exclusion would be contrary to applicable law.

### C. VSDI BENEFITS MAY BE LIMITED IF:

1. The Participant is referred or recommended by a competent medical authority to participate as a resident in either an approved alcoholism recovery program or an approved drug-free residential program. Benefits for alcoholism recovery treatment will be paid for a period not to exceed thirty (30) days for a Period of Disability. Benefits for drug-free residential facility participation will be paid for a period not to exceed forty-five (45) days for a Period of Disability. If the referring physician certifies the need for continuing resident services, benefits will be payable for up to sixty (60) additional days for alcoholism recovery treatment and up to forty-five (45) additional days for drug-free residential facility participation.

2. The Participant receives compensation from Leidos for any day (excluding Paid Time Off), except that such benefits will be paid for any seven (7) day week or partial week, in an amount not to exceed his/her maximum weekly amount provided by this Plan, which together with compensation received, does not exceed his/her weekly compensation immediately prior to the commencement of the Participant's Disability.

## 3.04 AMOUNT OF PLAN BENEFITS

For each business day of any period of Disability for which benefits are paid and which is less than a full week, the amount of benefits payable will be one-fifth (1/5$^{th}$) of the amount of weekly benefit.

For the first (1$^{st}$) twenty-six (26) weeks of Disability (which includes the seven (7) day waiting period if applicable), but not to exceed 180 days, the amount of weekly benefit which an eligible Claimant is entitled to receive under the Plan is a maximum weekly benefit of eighty percent (80%) **(not to exceed $4808)** of the Maximum Benefits defined as follows:

If hospitalized as defined, the Participant will receive:

- For weeks one (1) through nine (9) of Disability, Maximum Benefits means one-hundred percent (100%) of regular Compensation **(up to a maximum weekly benefit of $4808).**
- For weeks ten (10) through eighteen (18) of Disability, Maximum Benefits means eighty percent (80%) of regular Compensation **(up to a maximum weekly benefit of $3846).**

- For weeks nineteen (19) through twenty-six (26) of Disability, Maximum Benefits means sixty-six and two-thirds percent (66 2/3%) of regular Compensation, not to exceed 180 days **(up to a maximum weekly benefit of $3202).**

If not hospitalized as defined, the Participant will receive:

- For week one, no benefits payable due to the seven (7) day waiting period
- For weeks two (2) through ten (10) of Disability, Maximum Benefits means one-hundred percent (100%) of regular Compensation **(up to a maximum weekly benefit of $4808).**
- For weeks eleven (11) through nineteen (19) of Disability, Maximum Benefits means eighty percent (80%) of regular Compensation **(up to a maximum weekly benefit of $3846).**
- For weeks twenty (20) through twenty-six (26) of Disability, Maximum Benefits means sixty-six and two-thirds percent (66 2/3%) of regular Compensation, not to exceed 180 days **(up to a maximum weekly benefit of $3202).**

**Home Confinement** – Illnesses 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 after the onset of Disability, based on approval from the claims administrator.

**Hospice –** A disabled Participant admitted to hospice care will not be required to complete the 7-day waiting period.

**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.

**Pregnancy** – Participants who are considered to be disabled due to pregnancy must follow the same process that applies to all other disabilities. However, the 7-day waiting period for non-hospitalization will not apply to Participants who give birth at home or at birthing centers.

**Public Health Emergencies and Pandemics** – The Plan reserves the right to temporarily waive the 7-day waiting period in the event of a pandemic or public health emergencies (declared or undeclared), as determined in the reasonable discretion of the Plan.

**Bereavement, Jury Duty, Voting Time or Holiday**
A Participant will receive VSDI pay if on Qualified Disability on a day bereavement, jury duty, voting time or holiday occurs. The Participant will not receive separate paid time off for bereavement, jury duty, voting time or holiday.

**Intermittent Disability**
A participant with a Qualified Disability may be approved for intermittent disability if the physician provides medical documentation supporting medically accepted and necessary intermittent treatments (e.g. cancer treatments).

## A. Reduction of Benefits

Benefits under this Plan will be reduced by the amount of any of the following benefits (converted to comparable weekly or daily equivalents, as appropriate) which the Plan Administrator determines are available to the Participant, (whether or not such benefits are applied for or received) for the same period of Disability for which benefits are payable hereunder:

**1.** Any Federal Social Security or Supplemental Security Income for which the Participant is eligible because of the Participant's Disability or retirement under Social Security (Old Age, Survivors, Disability and Health Insurance) [OASDHI] of the United States. However, if the receipt of Social Security retirement benefits commenced prior to the Participant's Disability, such benefits will not be offset. For purposes of computing this offset, any statutory cost of living increases awarded after the initial Social Security Award date will not be used. However, if the initial award is subsequently adjusted to give credit for additional earnings or for any other reason, other than a statutory cost of living increase, the new award will be offset.

**2.** Workers' Compensation benefits (temporary total disability and/or total disability benefits, and permanent disability benefits), including single sum awards or settlements. Single sum awards and/or settlements will not include approved medical expenses and attorney fees which were incurred prior to the award.

**3.** Benefits will be reduced by disability benefits payable from any state disability plan, e.g., California, New Jersey, New York, Rhode Island, Hawaii or Puerto Rico, whether applied for or not or any Company Plan established in lieu thereof. Disability benefits may also be offset by paid medical leave benefits for employee's own serious health condition payable under any federal or state law.

**4**. Pursuant to the procedures outlined in Section 4.05, the amount of any award or settlement the Participant receives, directly or indirectly, from a third party if the Participant's Disability is the result of the acts or omissions of such third party.

**5.** Any Employer sponsored program, which provides for a periodic Disability benefit or a lump sum Disability payout except that only the portion of these benefits attributable to contributions made by the Employer will be integrated with the Plan benefits.

**6.** Any salary (excluding vacation), income or sick pay from any employer or from self-employment.

**7.** Any income or wages earned during rehabilitation employment.

**8.** Any state disability plan or any plan providing disability payments pursuant to a compulsory benefit act or law, where applicable.

**9.** Any government retirement or disability plan that is initiated or increased as a result of a Participant's Disability.

**10.** Any period of Disability for which benefits are paid or payable under any Unemployment Compensation Act of the United States or of any state.

### B. Recovery of Overpayment

In the event that an overpayment exists because the Participant's Plan benefits were not sufficiently reduced by any of the above mentioned reductions at the time they were paid, the Plan Administrator will recalculate the claim and inform the Participant of its findings. Any overpayment will become payable by the Participant immediately upon request or will, at the Plan's election, be subtracted from future Plan benefits for the same Participant**.**

### C. Benefit Integration

In the event that a Participant either fails to apply for, elects to defer, or fails to request any of the benefits set forth in Paragraphs one (1) through ten (10) of Section 3.04A, the Plan Administrator will consider, for the purpose of determining the reduction in payments under this Plan, the benefit that the Plan Administrator determines, at its sole discretion, would have been paid had the Participant made application for and received such benefits on the earliest date he was eligible.

If the Participant provides the Claims Administrator with written evidence that applications have been made for any benefits to which he may be entitled, the Claims Administrator will have the option of paying the Participant the full Plan benefits while awaiting receipt of other benefit payments if the Participant signs a promise to repay the Plan the appropriate integrable amount. Failure to sign the promise to repay will result in a delay in the payment of all or some of the benefits under this Plan.

## 3.05 COMMENCEMENT AND DURATION OF PLAN BENEFITS

Plan benefits will be payable as of the first (1st) day that a Participant applies and becomes eligible therefore, and thereafter will be payable so long as such eligibility continues.

Eligibility for benefits will commence on the earlier of: the eighth (8th) day of Disability; or the first (1st) day of Disability if the Claimant is subject to Hospital Confinement.

A Participant's Plan benefit payments will cease on the earliest of the following events:

**A**. The date following twenty-six (26) weeks of Disability benefit payments, provided that any applicable elimination period will be included for purposes of such calculation, and provided further that in no event will benefits payments (including, for calculation purposes, any applicable elimination period) exceed a maximum of 180 days of Disability.

**B.** The death of the Participant.

**C.** A determination by the Plan Administrator that the Participant's Disability no longer exists based on Objective Medical Evidence provided by the Claimant's Physician or the findings of an Independent Medical Examination or other appropriate evidence.

**D.** A failure by the Participant to cooperate in any examination by one (1) or more Physicians or vocational specialists of the Plan Administrator's choice within thirty (30) days following a written request by the Plan Administrator unless doing so would jeopardize the patient's health.

**E.** A refusal by the Participant to provide information requested in writing by the Plan Administrator for the purpose of determining whether the Participant is entitled to benefits under the Plan; failure to provide such information within thirty (30) days following such request will be considered to constitute a refusal, provided that the Plan Administrator may, in its sole discretion, extend this period for good cause (for example, physician's delay in providing the requested information).

**F.** The date the Participant is no longer under the regular and continuous care of a licensed Physician, or refuses, as reasonably determined by the Plan Administrator, to follow or rejects the terms of a written treatment plan recommended by his/her attending Physician, unless the Participant disputes such treatment on the advice of another Physician. "Regular Care" means a planned program of observation and treatment by a licensed Physician, as required by applicable medical standards.

If the Participant's Disability started prior to termination of employment, benefit payments 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.

# ARTICLE IV

# PAYMENT OF BENEFITS

## 4.01 APPLICATION FOR BENEFITS

To be entitled to any Plan benefits for which a Participant is otherwise eligible under the Plan, a Participant must be in compliance with such procedures and requirements as the Plan Administrator has prescribed, with respect to the completion and filing of an application for such benefits, and submission of evidence that such Participant is entitled to such benefits.

The Plan Administrator will have the right to:

A. Require proof of Disability, at the Participant's expense, except as provided in Section 4.02, during the pendency of a claim.

B. Require information with respect to the Participant's age, address, marital status, dependent(s), employment record, and medical history

C. Require evidence that such Participant has, if eligible, applied for Social Security benefits, or other benefits as outlined in Section 3.04, or has provided evidence satisfactory to the Plan Administrator to establish that Participant is not eligible for such benefits.

D. Personally contact and interview the Participant, the Participant's Physician, employer or any other persons who can provide relevant information regarding the Participant's Disability. Failure to cooperate with the Plan Administrator in a reasonable investigation or processing of a claim may result in benefits being denied, or terminated.

E. Require any other information reasonably relevant to a determination of whether such Participant is eligible to receive Plan benefits.

The Plan Administrator may require documentation or information that cannot be obtained without a written authorization from the Participant. The Plan Administrator may consider failure to provide written authorization, where reasonably requested, as grounds to delay or deny coverage. Such written authorization may be requested to:

(1) Obtain information from all the Physicians of a Participant applying for Plan benefits, with respect to such Participant's physical condition, diagnosis, prognosis, date of expected return to work and related matters;

(2) Request and receive relevant medical records on file in any hospital, Physician's or government office; and

(3) Obtain such other records from any company having information reasonably relevant to a determination.

## 4.02 MEDICAL EXAMINATIONS

The Plan Administrator may require that a Participant applying for Disability benefits, or appealing an adverse benefit determination, submit to an examination by one or more Physicians or vocational experts designated by the Plan Administrator, for a medical examination, as to whether such Participant is disabled so as to meet the eligibility requirements under the Plan for Plan benefits, and whether the Disability has existed for the prerequisite Elimination Period. Notwithstanding the foregoing, to the extent that a Physician or vocational expert makes any determination regarding the Plan's eligibility requirements or application of any other Plan provision, such determination will not be binding on the Plan Administrator, and Plan Administrator retains full discretionary authority to interpret and apply the terms of the Plan. Reexaminations of a Participant receiving Plan benefits may be directed by the Plan Administrator from time to time for the purpose of assisting the Plan Administrator in determining whether continued eligibility for such benefits exists. The fees of such Physicians or vocational experts and the expenses of such examinations will be paid by the Plan.

## 4.03 NON ALIENATION OF BENEFITS

The interest and property rights of any person in the Plan or in any payment to be made under the Plan will not be subject to option nor be assignable either by voluntary or involuntary assignment, or by operation of law, including (without limitation) bankruptcy, garnishment, attachment or other creditor's process, and any act in violation of this Section 4.03 will be void.

## 4.04 PAYMENT TO REPRESENTATIVE

In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made, in good faith, to the legal representative making claim therefore, and any such payment so made will be in complete discharge of the liabilities of the Plan therefore and the obligations of the Plan Administrator and the Company.

## 4.05 ACTS OF THIRD PARTIES

In the event that a Participant is injured through the acts or omissions of another person or organization, the Plan Administrator will provide the benefits of the Plan only on condition that the Participant will agree in writing to the provisions below. If a Participant is incapacitated and unable to sign the reimbursement agreement, the Plan Administrator will approve the claim and pursue reimbursement at a later time. The Plan will pursue reimbursement regardless of whether a signed reimbursement agreement is in place (for example, in the case of incapacitated Participants as well as in situations in which a signed reimbursement agreement was not otherwise obtained).

With regard to any matter which may be subject to subrogation and/or recovery (in accordance with and consistent with the terms of this Plan), the Plan will have the following rights:

A. The Plan will be subrogated to all rights of recovery that the Participant, his/her heirs, guardians, executors, agents or other representatives (hereafter individually and

collectively “Participant”) may have as a result of the injury, including, without limitation, rights to recovery pursuant to:

1. any legal action initiated by this Plan;

2. any action in intervention;

3. any action, at law or in equity, legally permissible to enforce this Plan’s rights of recovery against any person or entity that caused, contributed to or is in any way responsible for the injury;

4. any action, at law or in equity, legally permissible to enforce this Plan’s rights of recovery against any person, insurance Company, health care provider or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury;

5. any action, at law or in equity, legally permissible to enforce this Plan’s rights of recovery against any person who received payment of funds from either (a) a person or entity that caused, contributed to or is in any way responsible for the injury; or (b) any insurance Company, health care provider or other entity that is in any way responsible for providing indemnification, coverage, compensation or other payment as a result of the injury;

6. any suit to impose a constructive trust on funds paid by any source as a result of the injury;

7. any suit to enforce an equitable lien on funds paid by any source as a result of the injury;

8. a no fault, personal injury protection, financial responsibility, uninsured motorist and underinsured motorist insurance;

9. a motor vehicle medical and wage loss reimbursement insurance;

10. a homeowners, renters, premises and owners, landlords and tenants insurance including medical reimbursement coverages; and

11. a group accident and health insurance, and athletic team, sporting event, school, club and other specific risk insurance coverages or accident benefit Plans.

B. The Plan Administrator will have a lien on the proceeds described above, to the extent of the full amount of payments made under the terms of this Plan. Said lien may be filed with the person or organization whose act or omission injured the Participant, with his, her or its agents, or may be filed with the Court. When this Plan provides a Notice of Lien regarding a subrogation claim to any person, insurer, attorney or other responsible party, the notice is sufficient to protect the Plan’s subrogation rights and, except as required by ERISA, the Plan may not be compelled to initiate or to intervene in any legal action in order to establish or maintain its right of subrogation.

C. The Plan Administrator has the right to assess a credit against payments to be made in the future under this Plan, with said credit to be equal to the proceeds above described, less any amount paid to the Plan by the way of reimbursement.

D. The Plan's subrogation interest will be deducted first from any recovery by or on behalf of the Participant. This Plan reserves the right to reduce the amount of its recoverable subrogation interest where in the discretion of the Plan a reduction is in the best interests of this Plan and its Participants and warranted by the circumstances. This Plan will not be responsible for expenses or attorney's fees incurred by a Participant in connection with any recovery unless the Plan will have agreed in writing to pay those expenses or fees. This Plan also reserves the right to initiate an action in the name of the Plan or in the name of the Participant to recover its subrogation interest. In no instance will the recoverable subrogation interest exceed total Plan benefits paid with respect to the injury.

# ARTICLE V

# PLAN FINANCING

## 5.01 EMPLOYEE CONTRIBUTIONS

The Company has established this voluntary Short-Term Disability Plan to cover eligible Employees in all states. This Plan is funded by pre-tax deductions amounts collected from Employees participating in this Plan. Plan benefits, when received, will be taxable to the Employees. Employees will be advised of any Employee contribution rate change as such changes are made (generally, in conjunction with the Company's annual open enrollment).

## 5.02 EMPLOYER CONTRIBUTIONS

Plan costs are designed and intended to be entirely funded by the Employee contributions to the Plan. The Company is not required to make contributions toward the cost of this Plan, and the Company retains full and absolute discretion to take necessary measures to ensure adequate funding of the Plan.

## 5.03 LIMITATION OF LIABILITY

No liability for the payment of benefits under the Plan will be imposed upon the Company's officers, directors, employees or shareholders.

## 5.04 RIGHT TO INSURE

The Plan is currently totally self-funded by the Employee contributions to the Plan but the Company reserves the right to insure all or a portion of the Plan benefits with a certified insurance carrier in the future, if deemed to be appropriate by the Plan Administrator.

## 5.05 SURPLUS CONTRIBUTIONS

Any surplus contributions that may be accumulated under the Plan will be applied toward, 1) the further improvement of Plan benefits 2) the reduction in Plan Participant's costs, 3) refunds to the Plan Participants or 4) the purchase of other employee benefits, at the discretion of the Plan Administrator and in compliance with applicable law.

## 5.06 THE COMPANY'S LIABILITY IN THE EVENT OF AMENDMENT, SUSPENSION OR TERMINATION OF THE PLAN

No amendment, suspension or termination will occur that would (a) cause or permit the Plan assets to be used for any purpose other than the defrayal of administrative expenses and for payment to Participants of benefits provided herein, (b) cause or permit Plan assets to inure (other than through payments made pursuant to the Plan) to the benefit of any private shareholder or individual or (c) except as may otherwise be required by law, impair the right of a Participant upon the adoption of such amendment to receive benefits provided for herein to which he/she already became entitled prior to such amendment.

Upon termination of the Plan, the Company will make provision for the payment of (a) benefits hereunder to each Participant to whom benefits are payable on the date of termination, and (b) all expenses and charges properly payable hereunder, including all expenses incurred and to be incurred in the liquidation and distribution of the Plan assets.

# ARTICLE VI

# ADMINISTRATION OF PLAN

## 6.01 APPOINTMENT OF PLAN ADMINISTRATOR

The Board has delegated certain powers and authority to make financial, contractual and other decisions on behalf of Leidos to the Chief Human Resources and other executive officers of the Company. Specifically, the Board has delegated the authority to approve all Benefit Programs Administration items to the CHRO. The CHRO has delegated to the Director of Corporate Benefits the authority to approve all Benefit Programs Administration items, including but not limited to reviewing and executing contracts relating to corporate benefit plans and programs including the disability programs.

Plan Administrator, is defined in the Employee Retirement Income Security Act of 1974 (ERISA), and is the named fiduciary with respect to control over and management of the operation and administration of the Plan. Any insurance carrier or other entity issuing an administrative services contract will be solely responsible with respect to the matters for which it is made responsible under such administrative services contract as well as to the extent as may be required by ERISA (regardless of whether or not described in the administrative services contract).

## 6.02 DUTIES OF PLAN ADMINISTRATOR

The Plan Administrator will have sole and exclusive power and discretionary authority to construe the terms of the Plan, including any ambiguous terms; to determine eligibility for benefits; to interpret and apply the Plan; to decide all issues of fact arising thereunder; and to make such rules, benefit computations, and eligibility determinations and take such other actions in administering the Plan as it deems appropriate. The interpretations, applications, decisions, rules, benefit computations, eligibility determinations, and other actions of the Plan Administrator will be final, binding, and conclusive on all persons and will be subject to review only if shown to be arbitrary, capricious, contrary to law, or contrary to the terms of the Plan. In administering the Plan, the Plan Administrator will at all times discharge its duties in accordance with the standards set forth in Section 404(a)(1) of ERISA.

The Plan Administrator will have such power and perform such duties as are necessary for the proper operation of the Plan. This will include, from time-to-time, designating representatives who will carry out the delegated responsibilities on behalf of the Plan Administrator. Contemplated designees include but are not limited to a Claims Administrator. All such designees will serve at the pleasure of the Plan Administrator. Designees may be paid reasonable compensation by the Plan, provided that, if a designee is an employee of the Company, such designee will not receive any compensation from the Plan and will serve without additional compensation from the Company.

## 6.03 PERFORMANCE OF DUTIES AND RESPONSIBILITIES

The Company will carry out its duties and responsibilities under the Plan through its directors, officers, and Employees acting on behalf of and in the name of the Company in their capacities as directors, officers, and Employees, and not as individual fiduciaries. The Company may engage such attorneys, actuaries, accountants, consultants or other persons to render advice or to perform services with regard to any of its responsibilities under the Plan as it will determine to be necessary or appropriate. The Company may designate by written instrument (signed by both parties) one or more actuaries, accountants or consultants as fiduciaries to carry out, where appropriate, fiduciary responsibilities of the Company. The Company may, to the fullest extent permitted under applicable law, rely on the actions of the Claims Administrator or the written opinion or advice of counsel or any actuary prudently retained by the Company.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

## 6.04 TIME LIMIT FOR APPLICATION OF BENEFITS

A Participant who submits a claim for Plan benefits will submit such claim to the Claims Administrator or to such other individuals as the Plan Administrator will designate in writing. Such claims will be submitted in the manner prescribed by the Plan Administrator and will include the Claimant's statement of his/her disability and a statement by a Physician attending the Claimant for the illness or injury upon which the Claimant's claim for Disability benefits is based. Except for good cause, written notice of claim must be given to the Claims Administrator no later than sixty (60) days after the first (1st) day of a Disability (i.e., the first day the Participant is continuously unable to perform the material duties pertaining to his/her regular and customary occupation due to any physical or mental condition arising out of illness, pregnancy or injury).

Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, will a claim be accepted more than twelve (12) months after commencement of Disability. A claim may be submitted by a legally appointed representative of the Participant if the Participant is not reasonably able to do so.

## 6.05 CLAIM DETERMINATION

An application for benefits will be submitted to the Plan's Claims Administrator by the Participant or the Participant's representative. References in this Section 6.05 to "Participant" should be read to include the Participant's Representative, as and where appropriate. The Participant will provide an Employee/Claimant's Statement, an authorization for release of medical information and a Physician's Statement. The Physician's Statement will be from a Physician attending the Participant for the illness or injury which is the basis of the Disability claim.

Supporting medical documentation from the physician must be provided to the Claims Administrator within thirty (30) days of the date on the initial packet letter or thirty (30) days from the first date of absence, if a claim is future dated. If the duration of an existing disability needs to be extended, medical documentation that supports extending the duration of the disability must be submitted within twenty (20) days of the date the employee requests the extension or the claim may be denied. The Claims Administrator will make a decision on the disability claim within a reasonable period of time after receiving supporting medical documentation (generally two (2) business days after receipt of such medical documentation). Any fees associated with obtaining medical records and medical certification forms related to the disability claim are the responsibility of the Participant. However, the Plan will pay for document translation services if necessary.

If it is determined that the Participant is entitled to benefits, a written claims determination will be provided to the Participant. The claims determination will include the method by which the amount of the benefit payment was computed.

If it is determined that a Participant is not entitled to benefits, a written claims determination will be provided to the Participant which sets forth the specific reasons for the denial and specify the Plan provisions upon which the denial was based. The letter will also include instructions on how to appeal the denial.

## 6.06 CLAIMS REVIEW PROCEDURES

A Participant whose claim has been denied, in whole or in part, may, within one hundred and eighty (180) days after receipt of notice of such denial, make written request for review of the claim to the Plan Administrator. The Participant will have the right to review, on written request, and free of charge, all documents pertinent to his/her claim. The Participant will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The review will take into account all comments, documents, records, and other information the Participant submits, without regard to whether such information was submitted or considered in the initial benefit determination. In connection with the review procedure, the Plan Administrator or its representative will have discretionary authority to interpret the Plan, including any ambiguous provisions, and to determine eligibility for benefits.

The appeal will not defer to the initial adverse determination, and it will be conducted by a fiduciary that is neither the individual who made such initial determination, nor the subordinate of such individual. The appeal of a claim that was denied based on a medical judgment will be reviewed by the Plan Administrator or its representative in consultation with a qualified health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional cannot be an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor the subordinate of such individual. The Plan Administrator or its representative must identify for the Participant medical or vocational experts whose advice was obtained by it in connection with an adverse determination, without regard to whether the advice was relied upon in making the benefit determination.

The Plan Administrator or its representative will provide the Participant with a written decision. In the case of an adverse benefit determination, the notice will include the specific reasons for the adverse determination, reference to the specific plan provisions on which the determination is based, and a statement that the Participant is entitled to receive, upon request and free of charge, documents, records and other information relevant to the claim for benefits. If the Plan Administrator or the representative relied on an internal rule, guideline, protocol or other similar criterion in making the determination, the Plan Administrator or representative will inform the Participant and will offer, at the Participant's request and free of charge, a copy of the rule, guideline, protocol or similar criterion. The notice will also include the following statement: "You and your Plan may have other voluntary, alternate dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." This decision will be provided within a reasonable period of time, but no more than forty-five (45) days of receipt of the request for review. If special circumstances require an extension of the time for review, written notice indicating the reason for such extension will be given to the Participant within such forty-five (45) day period. In case of an extension, the decision will be provided within a reasonable period of time but no more than ninety (90) days after receipt of the request for review. If the Participant is asked to provide additional information, the time frame for processing the review will stop until the Participant has responded to the request. The participant has up to thirty (30) days to provide the additional requested information;

if no additional information is provided within this thirty (30) day period, the claim will be processed based on the information and evidence before the Plan at that time. Once the review is complete, the Participant will be notified in writing of the decision.

No action for benefits may be commenced against the Plan Sponsor, Plan Administrator, or designated representative of the Plan prior to the completion of this Claims Review Procedure, except as permitted by law.

Failure to follow this procedure may not necessarily qualify or validate an otherwise unqualified and/or unsupported claim.

## 6.07 ARBITRATION TO RESOLVE DISPUTES

In the event of any dispute in any way arising from the Plan that is not resolved in accordance with Section 6.05 and 6.06, the parties will submit to arbitration of any and all claims. This will include claims for benefits under the Plan, suits for personal injury, or any kind of civil action. Neutral arbitration will be in accordance with the Commercial Arbitration Rules as set forth by the American Arbitration Association. The decision reached by the arbitrator (s) will be in writing and will be determinative and binding upon all parties to such dispute.

## 6.08 LIMITATION OF LIABILITY

The Plan Administrator and any representative thereof will be entitled to rely upon any information from any source assumed in good faith to be correct. Neither the Plan Administrator nor any of its representatives, nor the Company or any officer or other representative of the Company, will be liable because of any act or failure to act on the part of the Plan Administrator or any of its Associates, to any person whomsoever, except that nothing herein will be deemed to relieve any individual from liability for his/her own fraud, bad faith or gross negligence. The Company may acquire such insurance coverage for the Plan Administrator and its representatives as is permitted by law.

## 6.09 CLAIMS PROCEDURE REGULATIONS

Notwithstanding anything to the contrary just set forth, claims and appeals will be handled in accordance with the U.S. Department of Labor's claims procedure regulations, set forth (as of the date of this Plan restatement) in 29 CFR 2560.503-1 *et seq.*, which are incorporated by reference herein.

## ARTICLE VII

## DURATION AND AMENDMENT OF THE PLAN

**7.01 PERMANENCE OF & RIGHT TO AMEND THE PLAN** The Plan will continue in full force and effect unless terminated, modified, altered, or amended by the Company as provided in this Article.

Although the Company has established the Plan with the bona fide intention and expectation that it will be able to continue the Plan indefinitely, nevertheless the Company is not, and will not be, under any obligation or liability whatsoever to continue or to maintain the Plan for any given length of time. The Company may, in its sole and absolute discretion, terminate, modify or amend either prospectively or retrospectively the Plan in accordance with its provisions, at any time, without any liability. In the event that the Plan is terminated, the Plan Administrator will continue to pay all benefits due and payable to Participants for Disabilities originating prior to the Plan termination date, and the Company will contribute such amounts as may be necessary to assure the continuance of such benefit payments. A Plan amendment will not affect benefits due to any Disability, which Benefits were applied for before the effective date of an amendment.

The Company reserves the right, at any time and from time to time, to modify, alter, or amend, in whole or in part, any or all of the provisions of the Plan.

No modification, alteration or amendment will have any retroactive effect so as to deprive any Participant of any benefits then payable. Notwithstanding the foregoing, any modification, alteration, or amendment of the Plan may be made retroactive to the extent necessary for the Plan to comply with any applicable law.

## ARTICLE VIII

## GENERAL PROVISIONS

### 8.01 NO LIMITATION OF MANAGEMENT RIGHTS

Participation in the Plan will not lessen or otherwise affect the responsibility of an Employee to fully perform his/her duties in a satisfactory and efficient manner, nor will it affect the Company's right, which right is hereby expressly reserved, to discipline, discharge (with or without cause or notice), or take any other action with respect to an Employee.

### 8.02 PARTICIPANT'S RESPONSIBILITY

Each Participant will be responsible for providing the Administrator with his/her current address. Any notices required or permitted to be given hereunder will be deemed given if directed to such address and mailed by regular United States mail. Neither the Plan Administrator nor the Company will have any obligation or duty to locate a Participant. In the event a Participant becomes entitled to a payment under the Plan and such payment cannot then be made (a) because the current address referred to above is incorrect, (b) because such Participant fails to respond to the notice sent to the current address referred to above, (c) because of conflicting claims to such payment, or (d) because of any other reason, the amount of such payment, if and when made, will be that determined under the provisions of Article III hereof without interest thereon.

### 8.03 MISSING PERSONS

If, within one (1) year after any amount becomes payable hereunder to a Participant, the same will not have been claimed, provided due and proper care will have been exercised by the Plan Administrator in attempting to make such payment, the amount thereof will be forfeited, and will cease to be a liability of the Plan.

### 8.04 GOVERNING LAW

The Plan and all matters arising thereunder will be governed by ERISA and, to the extent not preempted by ERISA, by the laws of the State of Virginia.

### 8.05 PAYMENT IN EVENT OF DEATH

In the event that the final payment of Disability income is payable as the result of the death of a Participant, such payment will be made in the following order of preference (with beneficiary designations, as described below, to be determined by reference to any such designations made under the Company’s group life insurance): 1.) to the person or persons, if any, designated by such Participant in his/her designation of beneficiary (as of the date of death); 2.) if such Participant has no surviving designated

beneficiary, to his/her spouse, if any; and 3.) if such Participant left no designated beneficiary and does not have a surviving spouse, to the authorized representative of the Participant's estate.

## 8.06 Fraud and False Representation

A Participant who knowingly and willfully submits false information to Leidos to obtain disability benefits will be considered in violation of Leidos' Code of Conduct and will be subject to disciplinary action, up to and including termination of employment. The Plan may terminate coverage and seek reimbursement from the Participant for claims paid by the Plan as a result of false representation or fraud and the Plan may pursue appropriate legal action.

## ARTICLE IX

## ERISA RIGHTS

As a Participant in the Leidos and Subsidiaries Voluntary Short-Term Disability Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

### 9.01 RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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 Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan 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.

### 9.02 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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### 9.03 ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have 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 you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to one-hundred and ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

## 9.04 ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.