

Leidos Benefits Summary Plan Description (SPD)

Want to find out more about your benefits? Then, you've come to the right place! This site is designed to provide you with important information you need to know about your benefits at Leidos.

As an eligible Leidos employee, you have the flexibility to choose from a wide variety of benefits that offer you and your family important health and financial protection. Simply use the links to learn more about:

- [Participating in the Plans](#)
- [Medical Plan Options](#)
- [Dental Plan Options](#)
- [Vision Plans](#)
- [Life and Accidental Death and Dismemberment \(AD&D\) Insurance](#)
- [Disability Program](#)
- [Flexible Spending Accounts](#)
- [Plan Information](#)

If you cannot find what you're looking for here or have further questions about your benefits, contact [Leidos Employee Services](#).

We have also included a [Life Events](#) section, which can help you quickly find information about what to do and what benefit choices you can make when you experience life changing situations like getting married or entering into a registered domestic partnership, having a child, moving to a new home, and more.

Please note: Although the information contained within this web site has gone through extensive review by the plans insurance carriers, some portions may require additional confirmation and finalization, and may be subject to change. To verify whether certain information has been finalized, contact Corporate Benefits.

The benefits described in this document are not applicable to employees of Leidos Health, Leidos Biomedical Research, Inc., Leidos Cyber or QTC. This document contains only highlights of the Leidos benefit plans. Plan documents and insurance contracts contain full provisions. If there is a discrepancy between the information on this web site and in plan documents/insurance contracts, the plan documents or insurance contracts will govern. Leidos reserves the right to amend, change or terminate the plans, programs and policies described on this web site. Any payment of benefits depends on your eligibility to receive them.

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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.

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 \(Qualified Status Changes\)](#)
- [When Coverage Ends](#)
- [Continuing Coverage](#)

Eligibility

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

- [Employees](#)
- [Dependents](#)
- [Registered Domestic Partners](#)

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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 Plan , Flexible Spending Accounts , Disability Income Protection , and Life and Accidental Death and Dismemberment Insurance Programs	<ul style="list-style-type: none">• Must be an active, regular full-time employee working at least 30 hours per week; or• Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and• Must live in the geographic area served by a particular plan.
Salary-based plans such as Short Term Disability , Long Term Disability and Life and Accidental Death and Dismemberment Insurance	Benefit is pro-rated for part-time employees working at least 12 hours per week.
CIGNA International Plan	Available to expatriate employees if scheduled to be overseas for six months or more.

The benefits described in this document are not applicable to employees of Leidos Commercial Health, Leidos Biomedical Research, Inc., Leidos Cyber or QTC. In addition, consulting employees, temporary employees, leased workers, payrollees and people classified by Leidos as independent contractors are not eligible to participate in Leidos benefit programs.

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](#)");

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- 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 Leidos 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.

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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 the Prism Benefits hub.

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 Leidos Employee Services at 855-553-4367, option 3 or via email at ASKHR@Leidos.com.

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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 periodically reviewed 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.

Leidos Benefits Summary Plan Description

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 [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 dependent 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 Status 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 status 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 Leidos Employee Services within 31 days of a qualified status change event.

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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

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.

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 status change**.

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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, vision, and/or EAP 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](#).

LEIDOS Benefits Summary Plan Description

Medical Plans

Leidos offers eligible employees two comprehensive Consumer Directed Health Plans (CDHP) featuring a Health Savings Account (HSA):

- [Healthy Focus Advantage Plan](#)
- [Healthy Focus Essential Plan](#)

Both CDHP plans feature a Health Savings Account (HSA) to help you save and budget for eligible healthcare expenses, with tax-free advantages.

The company may contribute to the Health Savings Account (HSA) if you enroll in either the Healthy Focus Advantage or Healthy Focus Essential plan. The biweekly company contribution will be based on an employee's annual salary* and the coverage level elected for medical coverage.

***Note:** Company's HSA contribution will be based on an employee's base salary as of their benefit eligibility/new hire date, whichever occurs later. The Company's contribution will not change in the event that salary and/or coverage level (e.g. Employee Only to Employee+ Spouse) later change.

The plans listed above are self-insured by Leidos, which means that Leidos fully funds the plans. In addition, employees living in certain areas may also be eligible to elect medical coverage through [Health Maintenance Organizations \(HMOs\)](#) or [CIGNA International Plans](#).

Eligibility

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

Employee Eligibility	
Type of Coverage	Eligibility Requirements
Medical Program	<ul style="list-style-type: none">• Must be an active, regular full-time employee working at least 30 hours per week; or• Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and• Must live in the geographic area served by a particular plan.

LEIDOS Benefits Summary Plan Description

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 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 Leidos Employee Services, in writing, within 31 days of any change in dependent eligibility.

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.

LEIDOS Benefits Summary Plan Description

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 the Benefits Prism page.

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.

LEIDOS Benefits Summary Plan Description

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 Leidos Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

How the Medical Plans Work

The Healthy Focus Medical Plans are Consumer Directed Health Plans (CDHP). For all non-preventive care, the plans pay the majority of the cost for in-network coverage after you meet the annual deductible. Your share is a percentage called coinsurance. In-network preventive care is covered 100 percent, no deductible. Once you meet the out-of-pocket maximum, the plan pays 100 percent of covered costs. Both CDH Plans feature a Health Savings Account (HSA) to help save and budget for eligible healthcare expenses, with tax-free advantages.

Pre-existing condition clauses do not apply to the Leidos medical plans. For more information about the medical plan options that Leidos offers, participants should read the information in this summary.

LEIDOS Benefits Summary Plan Description

Comparing the Healthy Focus Medical Plans

The chart below provides some basic plan information about the Leidos self-insured plans.

	Healthy Focus Advantage Plan		Healthy Focus Essential Plan	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Annual Deductible - - Employee Only - Family	\$1,350 \$2,700	\$1,350 \$2,700	\$2,000 \$4,000	\$2,000 \$4,000
Annual Out-Of-Pocket (OOP) Maximum (includes deductible) - Employee Only - Family Embedded OOP	\$3,000 \$6,000 N/A	\$3,000 \$6,000 N/A	\$5,000 \$10,000 \$7,900 Individual within Family	\$5,000 \$10,000 \$7,900 Individual within Family
Office Visits – Preventive Care	Covered at 100% (no deductible)	You pay 50% after deductible	Covered at 100% (no deductible)	You pay 50% after deductible
Office Visits – Non-preventive	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Emergency Room	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Hospital Admission	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Periodic Health Assessments (Preventive Care)	Covered at 100%; one exam every calendar year	You pay 50% after deductible; one exam every calendar year	Covered at 100%; one exam every calendar year	You pay 50% after deductible; one exam every calendar year
Well-Child Care (Preventive Care)	Covered at 100%	You pay 50% after deductible	Covered at 100%	You pay 50% after deductible
Lab and X-Ray	You pay 20% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible	You pay 35% after deductible for non-routine lab & x-ray services provided outside the office visit	You pay 50% after deductible

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	Healthy Focus Advantage Plan		Healthy Focus Essential Plan	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Lab and X-Ray	You pay 20% after deductible for non-routine lab & x-ray	You pay 50% after deductible	You pay 35% after deductible for non-routine lab	You pay 50% after deductible
Outpatient Surgery	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Routine Mammograms	Covered at 100%; Age 40 and over: maximum one per calendar year	You pay 50% after deductible; Age 40 and over: maximum one per calendar year	Covered at 100%. Age 40 and over: maximum one per calendar year	You pay 50% after deductible; Age 40 and over: maximum one per calendar year
Routine Pap Smears	Covered at 100%; maximum one per calendar year	You pay 50% after deductible; maximum one per calendar year	Covered at 100%; maximum one per calendar year	You pay 50% after deductible; maximum one per calendar year
PSA/DRE Over age 40	Covered at 100%; over age 40: max 1 visit per year	You pay 50% after deductible	Covered at 100%; over age 40: max 1 visit per year	You pay 50% after deductible
Skilled Nursing Facility	You pay 20% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement	You pay 35% after deductible for up to 60 days per confinement	You pay 50% after deductible for up to 60 days per confinement
Home Health Care (maximum visits combined with skilled nursing care and private duty nursing)	You pay 20% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 35% after deductible for up to 100 visits per year, up to 4 hours = 1 visit	You pay 50% after deductible for up to 100 visits per year, up to 4 hours = 1 visit
Private Duty Nursing (maximum visits combined with Home Health Care benefit)	You pay 20% after deductible for up to 100 visits per year, up to 8 hours = 1 visit	Not covered	You pay 35% after deductible for up to 100 visits per year, up to 8 hours = 1 visit	Not covered
Hospice Care (up to 30 days per lifetime for inpatient and \$10,000 per lifetime)	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Outpatient Rehabilitation – Physical and Speech (as medically necessary)	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible

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	Healthy Focus Advantage Plan		Healthy Focus Essential Plan	
	NETWORK	OUT-OF-NETWORK	NETWORK	OUT-OF-NETWORK
Durable Medical Equipment	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Mental Health and Substance Abuse – Outpatient)***	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Mental Health and Substance Abuse – Inpatient***	You pay 20% after deductible	You pay 50% after deductible	You pay 35% after deductible	You pay 50% after deductible
Retail & Mail Order Prescriptions	After Deductible	Not Covered	After Deductible	Not Covered
Generic:	You pay \$5		You pay \$5	
Brand Formulary:	You pay 30%		You pay 30%	
Brand non-formulary:	You pay 50%		You pay 50%	

Healthy Focus Advantage Plan

The Healthy Focus Advantage plan is a Consumer Driven Health care plan that gives participants a choice when it comes to getting medical care. Participants may go to any provider they wish; however, when they use a provider participating in the CDHP network, they receive a higher level of benefits.

Most network services are covered at 80% after the deductible, while most out-of-network services are covered at 50% after the deductible. Regardless of whether a participant uses a network or out-of-network provider, the Healthy Focus Advantage plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers prescription drugs purchased at a retail pharmacy or through the mail order program.

Healthy Focus Advantage Plan: Cost of Coverage

This section will help participants understand how they pay for medical coverage under the Healthy Focus Advantage plan.

Employee Contributions

Leidos and participants share in the cost of coverage. Every pay period, employee contributions are deducted from the participant's paycheck on a **pre-tax basis**. Leidos pays for the rest of the cost. The employee contribution amount will vary based on the coverage level elected:

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

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The individual (employee only coverage) deductible is \$1,350; the family deductible is \$2,700. For all non-preventive care, the deductible must be met before the plan begins to pay benefits.

The annual deductible is waived for certain services provided by in-network physicians, including preventive care office visits, periodic health assessments, well-child care, preventive lab and x-ray, routine mammograms, routine pap smears, and PSA/DRE. Services must be provided in physician's office as part of the preventive care office visit. Services provided by third parties are subject to annual deductible and coinsurance.

LEIDOS Benefits Summary Plan Description

Coinsurance

"Coinsurance" is the percentage of eligible expenses a participant pays for medical services once the participant meets the annual deductible.

Annual Out-of-Pocket Maximum

The "out-of-pocket maximum" is the amount of coinsurance payments a participant must pay each calendar year before the Healthy Focus Advantage plan begins paying 100% of eligible expenses up to the negotiated rate (for in-network providers) or reasonable and customary (R&C) limit (for out-of-network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "[Network Benefits](#)" in the Healthy Focus Advantage plan section for more information about negotiated rates, and "[Out-of-Network Benefits](#)" for more information about R&C limits.

The following expenses do not count toward a participant's annual out-of-pocket maximum:

- Payments for eligible expenses incurred in a different calendar year;
- Charges that are not covered under the plan;
- Charges that exceed R&C limits; and
- Charges that exceed the maximum benefits for that year

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of-pocket maximum must be met before the plan begins paying 100 percent for any individual. The individual (employee only coverage) annual out-of-pocket maximum is \$3,000; the family annual out-of-pocket maximum is \$6,000.

Healthy Focus Advantage Plan: Plan Design

This section will help participants understand how benefits are payable under the Healthy Focus Advantage plan.

Network Benefits

If a participant receives services from a network provider, he or she generally saves money because providers in the [CDHP network](#) have agreed to charge patients lower, negotiated rates. The participant must meet the [annual deductible](#) for most services. Then, whenever the participant receives medical services, he or she pays a percentage of the provider's negotiated rate ([coinsurance](#)), whichever applies. The plan pays the remaining amount.

There are no claim forms to file because the CDHP network provider submits claims for the participant.

LEIDOS Benefits Summary Plan Description

Out-of-Network Benefits

When a participant uses a provider who does not participate in the [CDHP network](#), that provider is considered to be out of network.

The participant must meet the [annual deductible](#). Then, whenever the participant receives medical services, the plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage ([coinsurance](#)) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own [claims](#) for reimbursement. Participants should check with their provider for information on their payment and claim filing policies.

Reasonable and Customary (R&C) Limit

The R&C limit is the maximum amount the plan will pay for a covered service received from an out-of-network provider, based on what providers in the participant's geographic area charge for similar services. Participants are responsible for paying any difference between the R&C limit and the amount billed. The determination of what the reasonable and customary limit is for a specific medical service is within the sole discretion of the [Claims Administrator](#) and is not subject to challenge or review.

Multiple and Bilateral Surgical Procedures

Multiple surgical procedures consist of more than one surgical procedure performed on the same date of service during the same surgical session. Bilateral surgeries consist of surgery performed during the same surgical session through separate incisions to matching parts of the body (e.g., both shoulders). When multiple or bilateral surgical procedures are performed during the same operative setting, the allowed amount of secondary and subsequent procedure is reduced.

Major (first) procedure - 100% of R&C; Second procedure - 50% of R&C; Subsequent procedure - 25% of R&C

If multiple or bilateral surgical procedures are performed by network providers, participants will not have to pay any more as a result of the reduced amount. Participants who choose out-of-network providers could incur additional costs if the provider chooses to bill the member for the remaining balance.

Multiple Scan/Images Procedure

When multiple images of body parts are taken during a single session, a reduction will be applied to the technical component of the services performed. Professional fees billed separately are not affected.

Initial scan/imaging - 100% of R&C; Subsequent scan/imaging - 50% of R&C.

LEIDOS Benefits Summary Plan Description

Prescription Drug Program

Prescription drugs under the Healthy Focus Advantage plan are provided through Express Scripts. Prescription drugs are covered when they are purchased from a retail pharmacy or through the Express Scripts pharmacy mail-order program.

Retail Pharmacies

A participant who needs to take medication for a short period of time (up to 30 days) should have their prescription filled at a retail pharmacy.

To find an Express Scripts participating pharmacy, participants can log on to [Express Scripts \(www.express-scripts.com/leidos\)](https://www.express-scripts.com/leidos) website or call Express Scripts at 877-223-4721.

Mail Order

A participant who needs to use long-term, maintenance medication (usually a prescription for more than 30 days) can fill his or her prescription through the Express Scripts pharmacy mail order program. Through the Express Scripts pharmacy mail order program, participants can receive up to a 90-day supply of medication and prescriptions are mailed directly to the participant's home.

Types of Prescriptions Available

The amount a participant pays for a prescription depends on the type of drug he or she purchases:

Types of Prescriptions	
Type of Prescription	At an in-network retail pharmacy (up to a 30-day supply), or Through Mail Order (up to a 90-day supply), you pay:
Generic	\$5 after deductible
Brand formulary	30%, after deductible
Brand non-formulary	50%, after deductible

- **Generic drugs** have the same chemical composition and potency as brand-name equivalents, but are less costly.
- **Brand formulary drugs** are on a preferred list of prescriptions (called a formulary) due to significant discounts negotiated with the drug manufacturer and/or proven effectiveness.
- **Brand non-formulary drugs** are brand-name drugs that do not have a generic equivalent and are not included on the list of preferred drugs. Brand-name drugs that are not on the formulary require the highest copayment, since these drugs are the most costly to the plan.

Prescription drug formularies are subject to change. For up-to-date formulary information, participants should visit [Express Scripts \(www.expressscripts.com/leidos\)](https://www.expressscripts.com/leidos) website or call Express Scripts at 877-223-4721.

LEIDOS Benefits Summary Plan Description

Note: You must meet the annual medical plan deductible before the plan begins sharing the cost for non-preventive prescription drugs. The deductible does not apply to certain preventive drugs, such as medications to treat and prevent hypertension, high cholesterol, asthma and diabetes.

Prescription Drug Clinical Management Programs

Prior Authorization

Prior Authorization is a feature of your prescription benefits that helps ensure the appropriate use of selected prescription drugs. Certain prescription drugs require your doctor to get approval before they're covered. This process helps make sure you receive the right medicine in the correct dose, which is very important if you're taking a specialty drug.

Step Therapy

Step Therapy is an approach intended to control the costs and risks posed by certain prescription drugs. It begins by trying the safest and most cost-effective drug therapy for a medical condition and progresses to other more costly or risky drug therapies only if necessary.

Walgreens Smart90

The Walgreens Smart90 program is a feature of the Express Scripts prescription benefit. With this program, you have two ways to get a 90-day supply of your long-term maintenance medication — drugs you take regularly for ongoing conditions. You can conveniently fill these prescriptions through the Express Scripts mail service or any Walgreens network pharmacy. Your copay/coinsurance for your 90-day supply of medication will be the same whether you fill your prescriptions through Express Scripts home delivery or at a Walgreens network pharmacy.

Note: If you continue to fill 30-day supplies of your long-term medication after the first two fills, you will pay a penalty (100% of the prescription drug cost). Penalties paid for not filing prescriptions through Express Scripts (ESI) mail order or Walgreens will not count towards the deductible or out-of-pocket maximum. Additionally, participants will still pay penalties after they meet their out-of-pocket maximum.

Health Savings Account (HSA) Eligible

The HealthyFocus Advantage plan qualifies as a High Deductible Health Plan (HDHP) which, if elected, allows employees to qualify for a Health Savings Account (HSA) which is different from a healthcare flexible spending account. **A standard healthcare flexible spending account (the plan offered by Leidos) cannot be used in conjunction with an HSA.**

LEIDOS Benefits Summary Plan Description

What is a Health Savings Account ("HSA")?

A Health Savings Account (HSA) is an alternative to traditional health insurance; it is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. You must be covered by a High Deductible Health Plan (HDHP) to take advantage of HSAs.

You own and you control the money in your HSA. Decisions on how to spend the money are made by you without relying on a third party or a health insurer. You will also decide what types of investments to make with the money in the account in order to make it grow.

Getting money into your HSA

There are two ways money goes into your account:

From Leidos	From You:
<p>Leidos may contribute to your HSA on a biweekly basis when you enroll in the Healthy Focus Advantage Plan.</p> <p>The Leidos contribution is based on your annual salary, coverage level elected for medical coverage and your eligibility date.</p>	<p>You can make pre-tax contributions from your pay, up to:</p> <ul style="list-style-type: none">• \$3,500 for individual coverage• \$7,000 for family coverage• An extra \$1,000 if you are age 55 or older <p>Any money you have in your account at the end of the plan year rolls over into the next year.</p> <p><i>Note: This is the 2019 HSA Account maximum, and is subject to change annually. Maximums include both Leidos and employee contributions.</i></p> <p><i>If you do not meet HSA eligibility requirements for the full tax year, you may not be able to contribute the maximum amount.</i></p>

Making Changes to your HSA Contributions

You can increase or decrease your HSA contribution at any time.

LEIDOS Benefits Summary Plan Description

Healthy Focus Essential Plan

The Healthy Focus Essential plan is a Consumer Driven Healthcare Plan (CDHP) that gives participants a choice when it comes to getting medical care. Participants may go to any provider they wish; however, when they use a provider participating in the [CDHP network](#), they receive a higher level of benefits.

Most [network services](#) are covered at 65% after the [deductible](#), while most [out-of-network services](#) are covered at 50% after the [deductible](#). Regardless of whether a participant uses a network or out-of-network provider, the Healthy Focus Essential plan covers a broad range of medical services and supplies, including office visits, emergency care, hospital stays and surgical procedures. The plan also covers [prescription drugs](#) purchased at a retail pharmacy or through the mail-order program.

Health Focus Essential Plan: Cost of Coverage

This section will help participants understand how they pay for medical coverage under the Healthy Focus Essential plan.

Employee Contributions

Leidos and participants share in the cost of coverage. Each pay period, employee contributions are deducted from the participant's paycheck on a biweekly basis. The employee contribution amount will vary based on the coverage level elected:

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

Annual Deductible

Your deductible depends on who you cover. The individual deductible applies to employee only coverage; if you enroll one or more dependents, the family deductible applies. The applicable deductible must be met before the plan shares in the cost of non-preventive care. The individual (employee only coverage) deductible is \$2,000; the family deductible is \$4,000.

The annual deductible is waived for certain services, provided by in-network physicians, including preventive care office visits, periodic health assessments, well-child care, preventive lab and X-ray, routine mammograms, routine pap smears, and PSA/DRE. Services must be provided in physician's office as part of the preventive care office visit. Services provided by third parties are subject to annual deductible and coinsurance.

LEIDOS Benefits Summary Plan Description

Coinsurance

"Coinsurance" is the percentage of eligible expenses a participant pays for medical services once the participant meets the annual deductible.

Annual Out-of-Pocket Maximum

The "out-of-pocket maximum" is the amount of coinsurance payments a participant must pay each calendar year before the Healthy Focus Essential plan begins paying 100% of eligible expenses up to the negotiated rate (for in-network providers) or **reasonable and customary (R&C) limit** (for out-of-network providers), whichever applies. This maximum is designed to protect a participant from catastrophic costs. See "**Network Benefits**" in the Healthy Focus Essential plan section for more information about negotiated rates and "**Out-of-Network Benefits**" for more information about R&C limits.

The following expenses do not count toward a participant's annual out-of-pocket maximum:

- Payments for eligible expenses incurred in a different calendar year;
- Charges that are not covered under the plan;
- Charges that exceed **R&C limits**; and
- Charges that exceed the maximum benefits for that year

Your out-of-pocket maximum depends on who you cover. The individual out-of-pocket maximum applies to employee only coverage; if you enroll one or more dependents, the family out-of-pocket maximum must be met before the plan begins paying 100 percent for any individual. The individual (employee only coverage) annual out-of-pocket maximum is \$5,000; the family annual out-of-pocket maximum is \$10,000 (with an embedded individual max of \$7,900).

Healthy Focus Essential Plan: Plan Design

This section will help participants understand how benefits are payable under the Healthy Focus Essential plan.

Network Benefits

If a participant receives services from a network provider, he or she generally saves money because providers in the CDHP network have agreed to charge patients lower, negotiated rates. The participant must meet the annual deductible for most services. Then, whenever the participant receives medical services, he or she pays a percentage of the provider's negotiated rate (coinsurance). The plan pays the remaining amount.

There are no claim forms to file because the CDHP network provider submits claims for the participant.

LEIDOS Benefits Summary Plan Description

Out-of-Network Benefits

When a participant uses a provider who does not participate in the [CDHP network](#), that provider is considered to be out of network.

The participant must meet the [annual deductible](#). Then, whenever the participant receives medical services, the plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage ([coinsurance](#)) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own [claims](#) for reimbursement. Participants should check with their provider for information on their payment and claim filing policies.

Reasonable and Customary (R&C) Limit

The R&C limit is the maximum amount the plan will pay for a covered service received from an out-of-network provider, based on what providers in the participant's geographic area charge for similar services. Participants are responsible for paying any difference between the R&C limit and the amount billed. The determination of what the reasonable and customary limit is for a specific medical service is within the sole discretion of the [Claims Administrator](#) and is not subject to challenge or review.

Multiple and Bilateral Surgical Procedures

Multiple surgical procedures consist of more than one surgical procedure performed on the same date of service during the same surgical session. Bilateral surgeries consist of surgery performed during the same surgical session through separate incisions to matching parts of the body (e.g., both shoulders). When multiple or bilateral surgical procedures are performed during the same operative setting, the allowed amount of secondary and subsequent procedures is reduced.

Major (first) procedure – Covered at 100% of R&C
Second procedure – You pay 50% of R&C
Subsequent procedure – You pay 75% of R&C

If multiple or bilateral surgical procedures are performed by network providers, participants will not have to pay any more as a result of the reduced amount. Participants who choose out-of-network providers could incur additional costs if the provider chooses to bill the member for the remaining balance.

Multiple Scan/Images Procedure

When multiple images of adjacent body parts are taken during a single session, a reduction will be applied to the technical component of the services performed. Professional fees billed separately are not affected.

Initial scan/imaging – Covered at 100% of R&C
Subsequent scan/imaging – You pay 50% of R&C

LEIDOS Benefits Summary Plan Description

Prescription Drug Program

Prescription drugs under the Healthy Focus Essential plan are provided through Express Scripts. Prescription drugs are covered when they are purchased from a retail pharmacy or through the Express Scripts pharmacy mail order program.

Retail Pharmacies

A participant who needs to take medication for a short period of time (up to 30 days) should have their prescription filled at retail pharmacy.

To find an Express Scripts participating pharmacy, participants can log onto [Express Scripts \(www.express-scripts.com/leidos\)](http://www.express-scripts.com/leidos) website or call Express Scripts at 877-223-4721.

Mail Order

A participant who needs to use a long-term, maintenance medication (usually a prescription for more than 30 days) can fill his or her prescription through the Express Scripts pharmacy mail order program. Through the Express Scripts pharmacy mail order program, participants can receive up to a 90-day supply of medication and prescriptions are mailed directly to the participant's home.

Types of Prescriptions Available

The amount a participant pays for a prescription depends on the type of drug he or she purchases:

Types of Prescriptions	
Type of Prescription	At an in-network retail pharmacy (up to a 30-day supply), or through Mail Order (up to a 90-day supply), you pay:
Generic	\$5 after deductible
Brand formulary	30%, after deductible
Brand non-formulary	50%, after deductible

- **Generic drugs** have the same chemical composition and potency as brand-name equivalents, but are less costly.
- **Brand formulary drugs** are on a preferred list of prescriptions (called a formulary) due to significant discounts negotiated with the drug manufacturer and/or proven effectiveness.
- **Brand non-formulary drugs** are brand-name drugs that do not have a generic equivalent and are not included on the list of preferred drugs. Brand-name drugs that are not on the formulary require the highest copayment, since these drugs are the most costly to the plan.

Prescription drug formularies are subject to change. For up-to-date formulary information, participants should visit [Express Scripts \(www.expressscripts.com/leidos\)](http://www.expressscripts.com/leidos) website or call Express Scripts at 877-223-4721.

LEIDOS Benefits Summary Plan Description

Note: You must meet the annual medical plan deductible before the plan begins sharing the cost for non-preventive prescription drugs. The deductible does not apply to certain preventive drugs, such as medications to treat and prevent hypertension, high cholesterol, asthma and diabetes. Click here to view the [Preventive Drug List](#).

Prescription Drug Clinical Management Programs

Prior Authorization

Prior Authorization is a feature of your prescription benefits that helps ensure the appropriate use of selected prescription drugs. Certain prescription drugs require your doctor to get approval before they're covered. This process helps make sure you receive the right medicine in the correct dose, which is very important if you're taking a specialty drug.

Step Therapy

Step Therapy is an approach intended to control the costs and risks posed by certain prescription drugs. It begins by trying the safest and most cost-effective drug therapy for a medical condition and progresses to other more costly or risky drug therapies only if necessary.

Walgreens Smart90

The Walgreens Smart90 program is a feature of the Express Scripts prescription benefit. With this program, you have two ways to get a 90-day supply of your long-term maintenance medication — drugs you take regularly for ongoing conditions. You can conveniently fill these prescriptions through the Express Scripts mail service or any Walgreens network pharmacy. Your copay/coinsurance for your 90-day supply of medication will be the same whether you fill your prescriptions through Express Scripts home delivery or at a Walgreens network pharmacy.

Note: If you continue to fill 30-day supplies of your long-term medication after the first two fills, you will pay a penalty (100% of the prescription drug cost). Penalties paid for not filing prescriptions through Express Scripts (ESI) mail order or Walgreens will not count towards the deductible or out-of-pocket maximum. Additionally, participants will still pay penalties after they meet their out-of-pocket maximum.

Health Savings Account (HSA) Eligible

The Healthy Focus Essential plan qualifies as a High Deductible Health Plan (HDHP) which, if elected, allows employees to qualify for a Health Savings Account (HSA) which is different from a healthcare flexible spending account. **A standard healthcare flexible spending account (the plan offered by Leidos) cannot be used in conjunction with an HSA.**

LEIDOS Benefits Summary Plan Description

What is a Health Savings Account ("HSA")?

A Health Savings Account (HSA) is an alternative to traditional health insurance; it is a savings product that offers a different way for consumers to pay for their health care. HSAs enable you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis. You must be covered by a High Deductible Health Plan (HDHP) to be able to take advantage of HSAs.

You own and you control the money in your HSA. Decisions on how to spend the money are made by you without relying on a third party or a health insurer. You will also decide what types of investments to make with the money in the account in order to make it grow.

Getting money into your HSA

There are two ways money goes into your account:

From Leidos	From You:
<p>Leidos may contribute to your HSA on a biweekly basis when you enroll in the Healthy Focus Essential Plan.</p> <p>The Leidos contribution is based on your annual salary, coverage level elected for medical coverage and eligibility date.</p> <p>.</p>	<p>You can make pre-tax contributions from your pay, up to:</p> <ul style="list-style-type: none">• \$3,500 for individual coverage• \$7,000 for family coverage• An extra \$1,000 if you are age 55 or older <p>Any money you have in your account at the end of the plan year rolls over into the next year.</p> <p><i>Note: This is the HSA maximum, and is subject to change annually. Maximums include both Leidos and employee contributions.</i></p> <p><i>If you do not meet HSA eligibility requirements for the full tax year, you may not be able to contribute the maximum amount.</i></p>

Making Changes to your HSA Contributions

You can increase or decrease your HSA contribution at any time.

Inpatient and Emergency Pre-admission Certification

When inpatient care is necessary, the participant must notify Aetna or Anthem and obtain authorization in advance, whether he or she is using Aetna or Anthem or an out-of-network provider.

If an emergency occurs, and it is not possible to get advance authorization, the participant must notify Aetna or Anthem of all inpatient treatment within 48 hours of the admission (or the next business day if the patient receives treatment on a weekend or holiday). The participant must contact Aetna or Anthem regarding an emergency admission, regardless of whether he or she is in an Aetna or Anthem or non-contracting facility.

Precertification

If a participant is enrolled in the **HealthyFocus Advantage Plan** or the **HealthyFocus Essential Plan** and needs hospitalization, skilled nursing care, home healthcare, hospice care or convalescent facility care, the participant is responsible for following the requirements for Preadmission Certification and Continued Stay Review (also known as "precertification"). Preadmission Certification and Continued Stay Review are procedures used to certify the medical necessity and length of any hospital confinement for inpatient care.

If a participant or a dependent is scheduled for a hospital admission, the participant should call the number on his or her Medical ID card before admission and request precertification. Obtaining precertification is the participant's responsibility. Even if the doctor agrees to initiate admission, the participant must follow-up to ensure that it has been accomplished.

A [CDHP network](#) customer service representative will work with a participant's doctor to ensure that the hospitalization is appropriate, medically necessary, and timely, and then let the participant know the number of days for which admission has been certified.

What the Medical Plans Cover

Services or supplies must be considered medically necessary by the [Claims](#), be delivered for the treatment of illness or injury, and be performed or prescribed by a licensed physician to be covered by the Leidos self-insured medical plans. The services listed below are subject to any applicable annual deductibles, coinsurance, co-payments, and plan maximums. See [Comparing the Leidos Medical Plans](#) for more detail.

The Leidos self-insured medical plan covers:

- Physician's office visits;
- Other physician's services;

LEIDOS Benefits Summary Plan Description

- Emergency or urgent care;
- Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first hospital where treatment is given;
- Hospital expenses including:
 - *Inpatient hospital expenses:* Charges for room and board, and other hospital services and supplies for a person confined as a full-time inpatient;
 - *Outpatient hospital expenses:* Charges for hospital services and supplies for a person who is not confined as a full-time inpatient; and
 - *Convalescent facility expenses:* Charges for a person who is confined to convalesce from a disease or injury for room and board and general expenses made in connection with room occupancy, use of special treatment rooms, X-ray and lab work; physical, occupational or speech therapy; oxygen and other gas therapy; and medical supplies. Benefits will be paid for up to the maximum number of days during any one convalescent period for the same or related cause beginning on the day the person is confined in a convalescent facility if he or she:
 - Was confined in a hospital while covered under the plan for treatment of a disease or injury;
 - Is confined in the facility within 15 days after discharge from the hospital; and
 - Is confined in the facility for services needed to convalesce from the condition that caused the hospital stay.
- Benefits end when the person has been confined in a hospital, convalescent facility or other place giving nursing care for 90 days in a row.
- Periodic health assessments (preventive care) includes one exam every calendar year;
- Immunizations;
- Home healthcare expenses when the charge is made by a home health care agency, the care is given under a home health care plan, and the care is given to a person in his or her home for part-time or intermittent care by an R.N. (or L.P.N. when an R.N. is not available); part-time or intermittent home health aide patient care services; and physical, occupational and speech therapy. There is a maximum of 100 visits covered in a plan year and a visit equates to up to four hours by a home health aide;
- Hospice care expenses for part-time or intermittent care by an R.N. (or L.P.N. when an R.N. isn't available) up to eight hours a day, medical social services under the direction of a physician, psychological and dietary counseling, consultation or case management services by a physician, and physical and occupational therapy. This includes charges for bereavement counseling if it is given to the person's immediate family, is given during three months following the person's death, and is directly related to the person's death;
- Drugs and medicines which by law need a physician's prescription, including medically necessary weight control drugs;
- Acupuncture- when performed by a physician or certified acupuncturist for treatment of a disease or injury, to alleviate chronic pain given, or as a form of anesthesia in connection with a surgery;
- Diagnostic lab work and X-rays- routine and non-routine- up to plan maximum;
- X-ray, radium and radioactive isotope therapy;

LEIDOS Benefits Summary Plan Description

- Anesthetics and oxygen;
- Rental of durable medical or surgical equipment, including repair of such equipment or replacement when it is proved that it is needed due to a change in the person's physical condition;
- Maternity;
- Mammograms;
- Routine pap smears - one diagnostic test per calendar year;

- Chiropractic care, if medically necessary;
- Prostate specific antigen (PSA) age 40+;
- Infertility treatment for a female employee, the wife or registered domestic partner of an Leidos employee, including in vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra fallopian tube transfer (GIFT), zygote intra fallopian tube transfer (ZIFT), low tubal ovum transfer and prescription drug therapy used specifically for infertility, will be covered up to \$5,000 per lifetime. The following conditions must be met:
 - The female participant must have been unable to conceive after having unprotected intercourse for one year or more;
 - The female participant must have been unable to attain a successful pregnancy through less costly treatment covered under the plan;
 - The female participant must have FSH levels which are less than or equal to 19 miU on day 3 of her menstrual cycle;
 - The procedure cannot involve surrogates; and
 - The procedure must be performed at a medical facility that conforms to generally accepted medical standards.

- Artificial insemination;
- Voluntary sterilization;
- Skilled nursing care expenses made by an R.N. or L.P.N. or a nursing agency for skilled nursing care, which includes visiting nursing care from an R.N. or L.P.N. for up to four hours for the purpose of performing skilled nursing tasks, and private duty nursing from an R.N. or L.P.N. for up to eight hours if the person's condition requires skilled nursing services and visiting nursing care is not adequate. Private duty nursing benefit is combined with home health care benefits with a maximum of 100 visits per year;
- Spinal disorders;
- Treatment of the mouth, jaws and teeth due to a medical condition affecting the teeth, mouth, jaws, jaw joints or supporting tissue (including bones, muscles and nerves) based on medical, not dental, necessity;
- TMJ or malocclusion involving the joints or muscles (includes medically necessary, non-dental, bite blocks, splints, arch bars, and occlusal guards);
- Physical therapy, if medically necessary, and maintenance therapy (both limited to 52 visits, with pre-certification being required after the 24th visit) for certain chronic medical conditions seriously limiting a member's activities of daily living;

- Occupational therapy, if medically necessary;

LEIDOS Benefits Summary Plan Description

- Speech therapy for loss of speech, or speech impaired or developmentally delayed due to a diagnosed disease, injury or congenital defect;
- Artificial limbs and eyes;
- Sex-change surgery or any treatment of gender identity disorders;
- Wigs for hair loss due to injury, disease or treatment of disease, including costs for repair or replacement
- Listed transplants are covered only if performed by the Administrator's contracted Institutes (or Centers) of Excellence (IOE) facilities. List of IOE Procedure and Treatment types - heart transplant, lung transplant, liver transplant, bone marrow transplant, heart/lung transplant, kidney transplant, pancreas transplant, kidney/pancreas transplant.
- For IOE procedure and treatments- The Plan will pay for transportation and lodging between participant's home and the IOE to receive services in connection with IOE procedure or treatment. Travel and lodging expenses for IOE patient and one companion/parent/guardian traveling with the IOE patient must be approved in advance by **Administrator**. The Plan will reimburse a maximum of \$50 per person per night for lodging expenses.

The Plan will reimburse travel and lodging expenses incurred up to a maximum of \$10,000 per episode of care. The Plan will pay expenses incurred during a period which begins on the day a participant becomes an IOE patient and ends on the earlier of one year after the day the procedure is performed or the date the IOE patient ceases to receive any service from the IOE in connection with the procedure.

What the Medical Plans Do Not Cover

The following services and supplies are not covered by the Leidos self-insured medical plans:

- Treatment for the mouth, jaws and teeth when an injury or illness is dental in nature, including restorative dental and/or surgical treatment of the mouth or jaw, including but not limited to:
 - Non-accident related diagnosis and treatment of teeth and their supporting structures;
 - Treatment relating to or secondary to treatment of dental caries (cavities);
 - Extraction of a diseased or decayed tooth or for surgical removal or impacted teeth; and
 - Root canal therapy, periodontal surgery or X-rays and other diagnostic tests;
- Cosmetic surgery, unless required because of an accidental injury that takes place while the participant is covered by the plan, or the congenital malformation of a child born to the participant or his or her spouse or registered domestic partner while the participant has dependent coverage under the plan;
- Charges above the reasonable and customary limits as determined by the applicable Claims Administrator;
- Custodial care;
- Eyecare exams and eyeglasses;
- Hearing aids;
- Orthopedic shoes or other devices to support the feet;
- Experimental, investigational or educational treatment or services as determined by the Claims

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Administrator;

- Treatment for accidents related to employment or an illness covered under Workers' Compensation or similar laws;
- Assistant surgeon services when the services of an assistant surgeon are not medically necessary for the surgical procedure;
- Treatment in a convalescent facility for drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation and any other mental disorder;
- Skilled nursing care that does not require the education, training and technical skills of an R.N. or L.P.N. (such as transportation, meal preparation, charting of vital signs), any private duty nursing care given while the person is an inpatient in a hospital or other health care facility, care provided to help a person in the activities of daily life, such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting or care provided solely for skilled observation. Any service provided solely to administer oral medicines except where applicable law requires that such medicines be administered by a R.N. or L.P.N.;
- Examinations to determine the need for, or adjustment of, hearing aids;
- Foot treatment for:
 - Weak, strained, flat, unstable or unbalanced feet; metatarsalgia; or bunions, except open cutting operations; and
 - Corns, calluses or toenails, except the removal of nail roots and medically necessary services prescribed by a doctor (M.D. or D.O.) in the treatment of metabolic or peripheral-vascular disease;
- Treatment resulting from an intentionally self-inflicted injury;
- Illness or injury due to an act of war (whether declared or undeclared) or an injury sustained while the participant is in military service for any country at war;
- Services, treatment, education testing or training related to learning disabilities or developmental delays;
- Care furnished mainly to provide a surrounding free from exposure that can worsen the participant's illness or injury;
- Treatments involving:
 - Bioenergetic therapy;
 - Carbon dioxide therapy; ○
 - Megavitamin therapy; ○
 - Primal therapy;
 - Psychodrama;
 - Rolfing; or
 - Vision perception training;
- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as part of their training in that field;
- Services of a resident doctor or intern rendered in that capacity;
- Education or special education or job training whether or not given in a facility that also provides

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medical or psychiatric treatment;

- Therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Career, social adjustment, pastoral or financial counseling;
- Speech therapy except for loss of speech, or speech impairment or developmentally delayed speech due to a diagnosed disease, injury or congenital defect;
- Reversal of a sterilization procedure;
- Medical services performed or provided by a close relative;
- Services of "standby" surgeons;
- Services received before coverage begins or after coverage ends;
- Charges that participants are not legally required to pay or charges that would not have been made if the plans were not available;
- Charges above any maximum amounts shown;
- Convenience or personal care services, such as use of a telephone or television; and
- Medical expense not specifically described in the plans

Mental Health and Drug or Alcohol Treatment

The **Healthy Focus Advantage Plan** and the **Healthy Focus Essential Plan** include mental health and substance abuse benefits. These benefits are administered by Aetna or Anthem.

How Mental Health and Substance Abuse Benefits Work

The mental health and substance abuse benefits are network-based and give participants a choice when it comes to receiving mental health and substance abuse treatment:

- **For outpatient care**, under the **Healthy Focus Advantage Plan** and the **Healthy Focus Essential Plan**, a participant must meet the deductible and pay the applicable coinsurance.
- **For inpatient care**, under the **Healthy Focus Advantage Plan** and the **Healthy Focus Essential Plan**, a participant must meet the deductible and pay the applicable coinsurance.

Participants must call Aetna or Anthem (depending on their state of residence) to receive information and guidance on how to locate a network provider or participants can search for a provider on the Aetna or Anthem website. If a participant elects to use an out-of-network provider, the participant will be responsible for additional out-of-pocket costs.

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Network Benefits

Participants receive the highest plan benefits for mental health and substance abuse treatment by using network providers:

For outpatient care, you pay as follows:

- Healthy Focus Advantage Plan: 20% after deductible
- Healthy Focus Essential Plan: 35% after deductible

For inpatient care, you pay as follows:

- Healthy Focus Advantage Plan: 20% after deductible
- Healthy Focus Essential Plan: 35% after deductible

Note: Coinsurance for mental health and substance abuse services received through Aetna or Anthem count toward the annual out-of-pocket maximums for the Healthy Focus Advantage and Healthy Focus Essential plans.

Out-of-Network Benefits

If a participant chooses to use an out-of-network provider to obtain mental health and substance abuse treatment outpatient services, you pay a percentage of the cost as follows:

- **Healthy Focus Advantage Plan:** 50% of Reasonable & Customary charges after deductible
- **Healthy Focus Essential Plan:** 50% of Reasonable & Customary charges after deductible

The participant pays the remaining amount (the coinsurance).

Note: Deductibles and coinsurance for mental health and substance abuse services received through Aetna or Anthem count toward the deductible or the annual out-of-pocket maximums.

What is Covered – Mental Health and Substance Abuse Benefits

Services or supplies must be considered medically necessary by the [Claims Administrator](#), be delivered for the treatment of illness or injury, and be performed or prescribed by a licensed physician to be covered by the Leidos self-insured medical plans. The services are subject to any applicable annual deductibles, coinsurance, and co-payments. See [Comparing the Leidos Plans for](#) more detail.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan prescribed and supervised by a behavioral health provider;
- This Plan includes follow-up treatment; and
- This Plan is for a condition that can favorably be changed.

What is Not Covered — Mental Health and Substance Abuse Benefits

No payment will be made by Aetna or Anthem for the following care, services or supplies:

- Educational rehabilitation or treatment of learning disabilities, regardless of the setting in which such services are provided;
- Educational/academic testing and services;
- Residential Coverage for Wilderness Programs or Military Schools;
- Residential treatment facilities that do not meet Aetna or Anthem medical necessity requirements; Custodial care;
- Treatment for personal or professional growth development, or training or professional certification;
- Evaluations, consultations or therapy for educational or professional training or for investigational purposes relating to employment;
- Therapies which do not meet national standards for mental health professional practice;
- Experimental or investigational therapies;
- Court-ordered psychiatric or substance abuse treatment, except when certified by Aetna or Anthem as medically necessary;
- Psychological testing, except when considered medically necessary by Aetna or Anthem;
- Services, supplies or treatment that are covered for benefits under the medical portion of this plan;
- Prescription drugs;
- Private duty nursing, except when pre-certified by Aetna or Anthem as medically necessary;
- Treatment of congenital and/or organic disorders; Non-abstinence-based or nutritionally-based treatment for substance abuse;
- Treatment or consultations provided via telephone;
- Services, treatment or supplies:
 - Provided as a result of Worker's Compensation laws or similar legislation;
 - Obtained through, or required by, any governmental agency or program whether federal, state or any subdivision thereof (exclusive of Medicaid/Medi-Cal); or
 - Caused by the conductor omission of a third-party for which the Member has a claim for damages or relief, unless the participant provides Aetna or Anthem with a lien against such claim for damages or relief in a form and manner satisfactory to Aetna or Anthem;
- Treatment or consultations provided by the member's parents, siblings, children or current or former spouse or domiciliary partner;
- Sexual therapy programs;
- Remedial education beyond evaluation and diagnosis of learning disabilities, education rehabilitation, academic education, and educational therapy for learning disabilities;

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- Marital therapy;
- Treatment for caffeine or nicotine intoxication, withdrawal or dependence;
- Treatment in a convalescent facility for drug addiction, chronic brain syndrome, alcoholism, senility, mental retardation and any other mental disorder.

Coordination of Benefits

If a participant or a participant's dependents are covered under more than one medical plan, all of the medical plans that provide coverage can work together to coordinate benefits. The participant is responsible for filing or submitting any necessary paperwork to the appropriate plans.

Under Leidos' coordination of benefits provisions, the plans will pay benefits up to the level which would have been paid if the Leidos plan had been the primary plan. This coordination of benefits provision applies to:

- [The Healthy Focus Advantage Plan](#);
- [The Healthy Focus Essential Plan](#);

When the Leidos medical plan is the primary plan, benefits are paid first without regard to any other plans. The participant is responsible for coordinating any benefits by submitting the Explanation of Benefits and itemized bill to the secondary plan.

See information on additional coordination of benefits, such as third party recovery (subrogation), overpayments, etc.

Determining Which Plan Pays First

Leidos uses the following insurance industry guidelines for determining the primary and secondary payers for employees and dependents.

Employees

The plan that covers the participant as an employee is the primary payer. The plan that covers the participant as a dependent is the secondary payer.

Dependents

For an employee's spouse or registered domestic partner, a plan that covers him or her as an employee is the primary payer for his or her claims. If an employee has elected coverage for his or her spouse or registered domestic partner as a dependent and he or she has coverage through another employer, the Leidos medical plan is the secondary payer.

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For an employee's dependent children, the plan of the parent whose birthday occurs first in the calendar year is usually the primary payer. If the plan of an employee's spouse or registered domestic partner plan does not follow this "birthday rule," then the "gender rule" applies. That is, the plan covering the child's father as an employee pays first.

In the case of divorced or separated parents, benefits are determined in the following order:

- The plan of the parent who has financial responsibility by court decree;
- The plan of the stepparent who is the spouse of the parent who has custody of the child; and
- The plan of the parent who does not have custody of the child.

When none of these rules establishes order, benefits are paid first by the plan that has covered the person for the longer period of time. An exception is a plan that covers a laid-off or retired employee. That plan is secondary to a plan that covers a person as an active employee.

Leidos Medical Plan Administrators

Aetna Inc. and Anthem administer the Leidos Consumer Directed Healthcare Plans (CDHP) – Healthy Focus Advantage Plan and Healthy Focus Essential Plan:

- [Aetna Open Access Plans](#)—Aetna Choice POS II network, administered by Aetna Inc.
- [BlueCard PPO network](#)—administered by Anthem

Aetna Open Access Plans (Healthy Focus Advantage and Healthy Focus Essential Plans)

Employees who live in these states/district are eligible for the Aetna Open Access Plans—Aetna Choice POS II network, administered by Aetna Inc.:

- Arkansas
- California
- Delaware
- District of Columbia
- Iowa
- Idaho
- Illinois
- Kansas
- Maine
- Maryland
- Michigan
- Minnesota

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- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New York
- North Dakota
- Oklahoma
- Oregon
- Pennsylvania
- South Dakota
- Vermont
- Virginia
- West Virginia
- Wisconsin
- Wyoming

Product Name: Aetna Open Access Plans – Aetna Choice POSII network

Leidos Group Number: 698685

Aetna Customer Service Phone: 800-843-9126

Submit Claims to:

Aetna, Inc.
P.O. Box 14089
Lexington, KY40512-4089

Web site: [Aetna\(www.aetna.com\)](http://www.aetna.com)

Mail Order: Express Scripts

Mail Order Address:

Express Scripts
P.O. Box-650322
Dallas, TX75265-0322

Participants may fill prescriptions by sending a prescription and mail-order pharmacy form to Express Scripts. For refills, participants can submit requests directly to Express Scripts:

- Through the [Express Scripts website \(www.express-scripts.com\)](http://www.express-scripts.com)
- By phone 877-223-4721

Blue Card PPO Network

Employees who live in these states/commonwealth are eligible for the Blue Card PPO network, administered by Anthem:

- Alabama
- Alaska
- Arizona
- Colorado
- Connecticut
- Florida
- Georgia
- Indiana
- Kentucky
- Louisiana
- Massachusetts
- Mississippi
- New Mexico
- North Carolina
- Ohio
- Puerto Rico
- Rhode Island
- South Carolina
- Tennessee
- Texas
- Utah
- Washington state

ProductName: BlueCard PPO network

Leidos Group Number: 170105

Anthem Customer Service Phone: 866-403-6183

Website: <https://www.anthem.com>

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Submit Claims to your local state Blue Cross or:

Anthem
P.O. Box 60007
Los Angeles, CA 90060

Mail Order: Express Scripts

Mail Order Address:

ExpressScripts
P.O. Box 650322 Dallas, TX 75265-0322

Participants may fill prescriptions by sending a prescription and mail order pharmacy form to Express Scripts. For refills, participants can submit requests directly to Express Scripts:

- Through the [Express Scripts website \(www.express-scripts.com\)](http://www.express-scripts.com)
- By phone 877-223-4721 or
- By returning the mail-order pharmacy order form

Filing Claims

If a participant receives medical care, mental health or substance abuse treatment from an out-of-network provider, he or she must pay the full cost of care, then file a claim for reimbursement.

Most medical claim forms should be submitted to the [Claims Administrator](#).

Aetna out-of-network claims should be submitted on the Aetna Medical claim form and mailed to:

Aetna Inc.

P.O. Box 14089

Lexington, KY 40512-4089

Anthem out-of-network claims should be submitted on the Anthem Medical Claim form and mailed to:

Anthem

P.O. Box 60007

Los Angeles, CA 90060

If a participant has concerns about how a claim has been administered or wishes to appeal a claims decision, he or she may refer to information on relevant procedures available in the [Claims Appeal and](#) in the Plan Information section.

Health Maintenance Organizations (HMOs)

HMOs offer healthcare for participants and their families through a limited network of health care providers.

How the Plans Work

HMOs require that participants receive all medical care exclusively from the HMO's network of providers in order for them to receive benefits. When a participant enrolls in an HMO, he or she, as well as his or her covered dependents, may need to select a primary care physician (PCP). This PCP would then provide all routine medical care and will refer the participant to a network specialist whenever he or she needs specialty care.

If a participant receives medical care *without* going through his or her PCP first, or if the participant's care is not authorized by the plan, the HMO may not pay any benefits, and the participant will pay the full cost of any out-of-network or unauthorized care. For most plans, emergency care received out-of-network or unauthorized by the plan will generally be covered.

In general, when the participant visits a provider, he or she pays the required copayment for covered services. No further payment is required. The participant does not have to file a claim form after receiving care.

HMOs generally include a prescription drug benefit.

For more information about how a specific HMO works and what payments are required, participants should refer to their evidence of coverage booklet.

Choosing a Primary Care Physician (PCP)

Generally, the participant and each of his or her covered dependents must select a primary care physician (PCP) from the HMO's network of providers. Each covered person may select his or her own PCP and each participant can generally change his or her PCP at any time during the year.

To select or change a primary care physician, participants should call the HMO's member services number on the back of their ID card.

ID Cards

When a participant enrolls in an HMO, he or she, and each of his or her covered dependents, will receive an ID card in the mail. Participants should be sure to keep their ID cards with them at all times.

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A participant must present his or her ID card when he or she:

- Visits a doctor's office;
- Is admitted to a hospital; and
- Fills a prescription at a retail pharmacy.

The participant's ID card contains important information about the participant and the HMO plan. By presenting the card to their health care provider, participants ensure that they receive the right level of coverage.

If a participant does not receive an ID card, he or she should contact the HMO's Member Services.

What the HMOs Cover and Do Not Cover

Generally, HMOs cover preventive, wellness, emergency, surgical, and hospital services. For a complete list of what is covered by an HMO, participants should refer to the HMO's

[Evidence of Coverage](#).

CIGNA International Medical Plan

If a participant is an expatriate and scheduled to be overseas for a minimum of six months, he or she may be eligible to elect coverage through a CIGNA International medical plan.

How the Plans Works

Participants in the Cigna International High Plan can receive medical care from any provider. Before the plan begins paying benefits, participants must pay an annual deductible.

For more information about how a CIGNA International plan works, participants should refer to the individual plan's [Evidence of Coverage](#).

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Medical Plan Benefit Charts

For more information about each insured medical plan, participants can download the following PDFs:

Self-Insured Medical Plan Benefit		
Self-Insured Medical Plan	Aetna	Anthem
Healthy Focus Advantage Plan	2019 Benefit Summary 2019 Evidence of Coverage	2019 Benefit Summary 2019 Evidence of Coverage
Healthy Focus Essential Plan	2019 Benefit Summary 2019 Evidence of Coverage	2019 Benefit Summary 2019 Evidence of Coverage
Fully Insured Medical Plan Benefit		
Fully Insured Medical Plan	Benefit Summary	Detailed Plan Information
CIGNA International High	2019	2019 Evidence of Coverage
HMSA - Hawaii	2019	2019 Evidence of Coverage
Kaiser Permanente - Hawaii	2019	2019 Evidence of Coverage
Kaiser Permanente - California	2019	2019 Evidence of Coverage
Kaiser Permanente of the Mid-Atlantic States	2019	2019 Evidence of Coverage
TRICARE Supplement Plan	2019	N/A

Mission for Life Wellness Program

The Mission for Life wellness program is a voluntary benefit that Leidos is providing as our investment in your long-term health and wellness. Leidos has contracted with Limeade, a corporate wellness technology company, to help support employees and their spouses/domestic partners, to bring activities and resources that help provide a clear picture of health.

The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disability Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable.

About the Program

The Mission for Life program is available to all benefit eligible employees and their spouse/domestic partner, if enrolled in the wellness benefit. The program supports you on your journey to your best health and well-being. By checking in on your health and completing engaging challenges, you will earn points toward great rewards. When you participate in the program, you can earn points towards achieving rewards.

Note: Incentive rewards are paid out as soon as administratively possible. You must be an active Leidos employee on the date of the incentive payment in order to be eligible to receive such incentive payment.

Equal Employment Opportunity Commission (EEOC) Notice for Employer-Sponsored Wellness Programs

The Mission for Life program is a voluntary wellness program and is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the Mission for Life wellness program, you will be asked to complete a voluntary wellbeing assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., diabetes, depression, or heart disease). The information from your wellbeing assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Health Coaching. You also are encouraged to share your results or concerns with your own doctor. You are not required to complete the well-being assessment in order to participate in the wellness activities.

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Employees who choose to participate in the Mission for Life wellness program will receive points towards rewards. Although you are not required to complete the well-being assessment, only employees who do so will receive any rewards.

Additional points are available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Leidos Employee Services at 1-855-553-4367, option 3.

Protections from Disclosure of Medical Information

Leidos is required by law to maintain the privacy and security of your personally identifiable health information. Although Limeade and Leidos may use aggregate information it collects to design a program based on identified health risks in the workplace, Limeade will never disclose any of your personal information either publicly or to Leidos, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Mission for Life wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Mission for Life wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Mission for Life wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Mission for Life wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Mission for Life wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the Mission for Life wellness program will be maintained by Limeade. Information stored electronically will be encrypted, and no information you provide as part of the Mission for Life wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Mission for Life wellness program, we will notify you immediately.

Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the Mission for Life wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Leidos Employee Services at 1-855-553-4367, option 3.

Medicare Part D Notice of Creditable Coverage

Important Notice from Leidos About Your Prescription Drug Coverage and Medicare

The key purpose of this notice is to advise you that the prescription drug coverage you have under your Leidos medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2019. (This is known as "creditable coverage.")

The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Leidos and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Leidos has determined that the prescription drug coverage offered by the company is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are covered under one of Leidos' prescription drug plans, your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage in 2019. Therefore, if you are or become eligible for Medicare, you can keep this coverage and not pay extra if you later decide to enroll in a Medicare prescription drug plan.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15th through December 7th. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

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You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in Medicare prescription drug plan and drop your Leidos prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enrolling a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with Leidos and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage...

You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through Leidos changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit the [Medicare website \(www.medicare.gov\)](http://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227) TTY users should call 1-877-486-2048

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the [Social Security Administration \(SSA\) online \(www.socialsecurity.gov\)](http://www.socialsecurity.gov), or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Continuing Medical Coverage After Plan Coverage Ends Consolidated Omnibus Budget Reconciliation Act (COBRA)

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 healthcare plans.

Continuation is subject to federal law, regulations, and interpretations.

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

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

Who Is Eligible for COBRA

- A covered participant who loses coverage due to termination (other than termination for gross misconduct) or reduction in work hours. Termination includes voluntarily quitting, layoff, and lack of work due to a work location closure.
- The spouse, registered domestic partner and/or dependent children of 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.

How to Continue Coverage Through COBRA

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

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When COBRA Coverage Will End

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

- 18 months in the case of termination of employment, layoff, or workforce 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).

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

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The following table summarizes COBRA benefits under the Leidos healthcare plans:

COBRA Benefits			
THE SITUATION:	OBTAINING INFORMATION:	WHO CAN BE COVERED:	HOW LONG COVERAGE CAN LAST:
The participant's employment with Leidos is terminated for reasons other than gross misconduct	It will be sent to the participant automatically by Leidos' COBRA administrator	The participant and the participant's dependents	18 months
There is a reduction in the participant's work hours to the point where the participant no longer qualifies for benefits coverage	It will be sent to the participant automatically by Leidos' COBRA administrator	The participant and the participant's dependents	18 months
The participant begins a military leave of absence	The participant must notify Leidos Employee Services ; forms sent upon notice of ineligibility	The participant and the participant's dependents	24 months
The participant is disabled according to Social Security	The participant must notify by Leidos' COBRA administrator	The participant and the participant's dependents	29 months
The participant dies	It will be sent to the covered dependents automatically by Leidos' COBRA administrator	The participant's currently covered dependents	36 months
The participant becomes divorced, legally separated, or dissolves a domestic partnership	The participant must notify Leidos Employee Services; forms sent upon notice of ineligibility by Leidos' COBRA administrator	The participant's former spouse or former registered domestic partner	36 months
The participant's dependent reaches age 26	The participant must notify the group Human Resources/Benefits POC; forms sent upon notice of ineligibility	The participant's dependent	36 months
The participant's child loses eligibility status (e.g., dependent is a stepchild and the participant is divorced)	It will be sent automatically upon notice to Leidos of ineligibility by Leidos' COBRA administrator	The participant's dependent	36 months

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

Leidos Benefits Summary Plan Description

Dental Plans

Leidos offers two different types of dental plan options. Depending on where a participant lives, he or she may be able to choose between:

- The [Leidos Dental PPO Plan](#)*, which allows participants to see any dentist they want; and
- [Dental Health Maintenance Organizations](#) (DHMOs), which have a network of dentists that participants can choose from to provide all of their care.

*The Leidos Dental PPO Plan is self-insured by Leidos, which means that Leidos fully funds the plan.

Eligibility

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

Employee Eligibility	
Type of Coverage	Eligibility Requirements
Dental Program	<ul style="list-style-type: none">• Must be an active, regular full-time employee working at least 30 hours per week; or• Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week; and• Must live in the geographic area served by a particular plan.

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.

Leidos Benefits Summary Plan Description

- 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 Leidos Employee Services, in writing, within 31 days of any change in dependent eligibility.

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.

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.

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 the Benefits page on Prism.

Leidos Benefits Summary Plan Description

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 Leidos Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

Leidos Benefits Summary Plan Description

How the Dental Plans Work

Leidos offers participants a choice when it comes to choosing the type of dental plan that works best for the participant and his or her family.

With the [Leidos Dental PPO Plan](#), a participant can use any dentist he or she wants. However, when a participant uses dentists who participate in the Delta Dental PPO (Plus Premier) network, he or she will receive a higher level of benefits and pay lower out-of-pocket costs. This is because the Delta Dental PPO (Plus Premier) (www.deltadentalva.com) network providers have agreed to charge lower, negotiated fees for services. When a participant uses dentists outside the Delta Dental PPO (Plus Premier) network, he or she will receive a lower level of benefits and pay higher total out-of-pocket costs.

A [Dental Health Maintenance Organization \(DHMO\)](#) works just like a health maintenance organization, or HMO. There is no deductible, and there are no claim forms to file. Participants must choose a network provider, who will coordinate and provide dental care services at a fixed cost. If a participant does not coordinate his or her care through the primary care dentist, the plan will not pay benefits. DHMOs are available only in areas where there are participating dentists.

Please carefully review the sections pertaining to what the dental plans will and will not cover to find information on the dental plan exclusions. Additionally, the individual dental plan carriers should be contacted for information on the specific exclusions for dental work in progress.

Leidos Dental PPO Plan

The Leidos Dental PPO Plan allows participants to choose any provider they wish and receive benefits. Whether a participant sees a [network provider](#) or an [out-of-network provider](#), the plan covers a broad range of dental services and supplies. More information on the Leidos dental plans:

- [Paying for Care](#)
- [Plan Design](#)
- [What the Leidos Dental Plan Covers](#)
- [Predetermination of Benefits](#)
- [What the Dental Plan Does Not Cover](#)
- [Filing Claims](#)
- [Coordination of Benefits](#)

Leidos Benefits Summary Plan Description

Paying for Care

This section will help participants understand how they pay for care under the Leidos Dental PPO Plan.

Employee Contributions

Leidos and participants share the cost of coverage. Each month, a participant who enrolls in the Leidos Dental PPO Plan contributes a set dollar amount to help pay for the cost of the plan. The contribution amount will vary based on the coverage level the participant has elected: employee only, employee plus spouse, employee plus one or more children or family coverage. These contributions are taken automatically from the participant's paycheck on a pre-tax basis. Premiums for domestic partners are paid by the participant on an after-tax basis.

Annual Deductible

The "deductible" is the initial \$50 each participant must pay for dental services he or she receives each calendar year before the plan begins to pay benefits.

Coinsurance

"Coinsurance" is the percentage of eligible expenses a participant pays for dental services once he or she meets the deductible.

Annual Maximum Benefit

The annual maximum benefit is the total amount a plan will pay for covered dental services for a participant each plan year. Once a participant meets this yearly maximum, the plan will not pay any more benefits until the next plan year.

Each year, the Leidos Dental PPO Plan will pay a maximum of \$1,500 per participant. **Note:** There is a separate \$1,500 lifetime maximum for orthodontic services per participant.

Plan Design

This section will help participants understand how the Leidos Dental PPO Plan pays benefits.

Network Benefits

If a participant goes to a network dentist, he or she saves money because dentists in the network have agreed to charge discounted fees. For most services, the participant must first meet the \$50 **annual deductible**. Then, whenever the participant receives dental services, the Leidos Dental PPO Plan pays a percentage of the cost. The participant pays the remaining amount (the **coinsurance**).

There are no claim forms to file because the Delta Dental PPO (Plus Premier) network dentist submits claims for the participant.

Leidos Benefits Summary Plan Description

Out-of-Network Benefits

When a participant uses a dentist who does not participate in the Delta Dental PPO (Plus Premier) network, that dentist is considered to be out of network.

For most services, each participant must first meet the \$50 [annual deductible](#). Then, whenever the participant receives dental services, the Leidos Dental PPO Plan pays a percentage of the cost of services, up to the reasonable and customary limit. The participant pays the remaining percentage (the [coinsurance](#)) plus any amount above the reasonable and customary limit.

Participants who go to out-of-network providers may be responsible for filing their own [claims](#) for reimbursement from the Leidos Dental PPO Plan. Check with your provider for information on their payment and claim filing policies.

Reasonable and Customary Limit

The reasonable and customary limit is the maximum amount the Leidos Dental PPO Plan will pay for a covered service, based on what dentists in the participant's geographic area charge for similar services. The determination of what the reasonable and customary limit is for a specific dental procedure is within the sole discretion of Delta Dental and is not subject to challenge or review.

What the Leidos Dental PPO Plan Covers

The Leidos Dental PPO plan includes only services in the list below.

- [Preventive Services](#)
- [Diagnostic Services](#)
- [Restorative Services](#)
- [Orthodontic Services](#)

Preventive Services

The Leidos Dental PPO Plan covers the following preventive services:

- Oral exam (two per participant per calendar year);
- Teeth cleaning (prophylaxis treatment to include scaling and polishing; two per participant per calendar year);
- Topical fluoride (limited to participants ages 18 and under; one per participant per calendar year);
- Bitewing X-rays (two per participant per calendar year);
- Full mouth X-rays (one per participant every 36 consecutive months); and
- Emergency treatment to relieve dental pain when no other definitive dental services are performed (not including X-rays)

Leidos Benefits Summary Plan Description

Diagnostic Services

The Leidos Dental PPO Plan covers the following diagnostic services:

- Diagnostic X-rays used to diagnose a condition;
- Single X-ray films;
- Additional X-ray films;
- Fissure sealants (limited to participants ages 13 and under; once per participant every three calendar years);
- Simple extractions;
- Surgical extractions (soft tissue impaction, partial bony impaction, complete bony impaction);
- Impactions;
- General anesthesia — only eligible in conjunction with the following:
 - Removal of one or more impacted teeth on the same day;
 - The extraction of five or more teeth;
 - More than one surgical extraction involving more than one quadrant on the same day
- Amalgam restoration of primary or permanent teeth;
- Composite restoration;
- Root canal therapy — any X-ray, test, lab exam, or follow-up care is part of the allowance for root canal therapy and not a separate dental service;
- Pulp capping;
- Pulpotomy;
- Apicoectomy and retro fill;
- Apicoectomy and retro fill on separate appointment;
- Subgingival curettage;
- Gingivectomy; and
- Space maintainers, fixed unilateral (limited to non-orthodontic treatment)

Restorative Services

The Leidos Dental PPO Plan also provides benefits for the following restorative services:

- Crowns (including, but not limited to, porcelain with gold, cast gold);
- Bridges;
- Stainless steel crowns;
- Recementation:
 - Inlay;
 - Crown; or
 - Bridge;

Leidos Benefits Summary Plan Description

- Complete upper or lower denture;
- Partial upper or lower denture;
- Denture and partial adjustments;
- Denture relines;
- Denture duplication;
- Denture and partial repairs; and
- Adding teeth or clasps to partial denture

Orthodontic Services

The Leidos Dental PPO Plan covers the following orthodontic services:

- X-rays and records;
- Initial banding;
- Periodic visits for comprehensive (usually 24 months) treatment for adults and children;
- Interceptive (extension of preventive orthodontics that may localize tooth movement) treatment; and
- Orthodontic retention (removal of appliances, construction and placement of retainer(s))

Important: Temporomandibular Joint Dysfunction (TMJ) Appliances

The Leidos Dental PPO Plan will cover TMJ appliances if the participant's medical plan does not cover them. In such a case, the plan will cover TMJ appliances at 50% after the deductible, and subject to the annual benefit maximum.

Prosthesis Replacement Rule

Certain replacements or additions to existing dentures or bridgework will be covered under the Leidos Dental PPO Plan. However, to be covered by the plan, satisfactory proof must be given that:

- The replacement or addition of teeth is required to replace those that were extracted after the present teeth or bridgework was installed, and the participant must have been covered when the tooth was extracted;
- The present denture or bridgework cannot be made serviceable and must be at least five years old; or
- The present denture is a temporary one and cannot be made permanent, so a permanent denture is needed. The participant must have been covered under this plan when the original tooth was extracted, and replacement must take place within 12 months from the date the temporary one was first installed.

Predetermination of Benefits

If a participant needs extensive dental work and the total charges will be in excess of \$250, a Predetermination of Benefits is strongly recommended. This will help the participant and his or her dentist understand what is covered under the plan and what the participant's share of the costs will be before services are provided.

Leidos Benefits Summary Plan Description

To request an advanced claims review, dentists may submit their treatment plan to Delta Dental for review and estimation of coverage before procedures are started. Delta Dental advises the patient and the dentist of what services are covered and what the payment would be. The actual payment for these predetermined services depends on eligibility, any plan limitations, coordination of benefits and the remaining maximum at the time services are performed.

A predetermination plan is subject to change based on the dentist's participation status at the time of treatment and does not guarantee direct payment. Of course, predetermination is optional, but it is strongly recommended for dental services expected to exceed \$250.

What the Leidos Dental PPO Plan Does Not Cover

The Leidos Dental PPO Plan does not cover, or provide any payment for, the following:

- Services and supplies not necessary, as determined by Delta Dental, for the diagnosis, care or treatment of the disease or injury involved. This applies even if the service or supply is prescribed, recommended or approved by the person's attending physician or dentist;
- Care, treatment, services or supplies that are not prescribed, recommended and approved by the person's attending dentist;
- Initial bridges and dentures for the replacement of missing teeth, which were already missing prior to the effective date of coverage in Leidos' plan;
- Services or supplies that are determined by Delta Dental to be experimental or investigational. A drug, device, procedure or treatment will be determined to be experimental or investigational if:
 - Insufficient outcomes data is available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
 - Approval has not been granted for marketing, if required by the [Food and Drug Administration](http://www.fda.gov) (www.fda.gov);
 - A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
 - The written protocol or protocols used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes;
- Services of a resident physician or intern rendered in that capacity;
- Charges that are not reasonable, as determined by Delta Dental;
- Charges that are made only because there is health coverage;
- Charges that a covered person is not legally obliged to pay;

Leidos Benefits Summary Plan Description

- Services and supplies that are furnished or paid for, or for which benefits are provided or required:
 - By reason of the past or present service of any person in the armed forces of a government; or
 - Under any law of a government (this does not include a plan established by a government for its own employees or their dependents or by Medicaid);
- Plasticsurgery, reconstructive surgery, cosmeticsurgery or other servicesand supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent needed to repair an injury that occurs while the person is covered under this plan. Surgery must be performed:
 - In the calendar year of the accident that causes the injury; or
 - In the next calendar year; and
- Acupuncturetherapy, including when it is:
 - Performed by a physician; and
- As a form of anesthesia in connection with surgery that is covered under this plan;
- Orthodonticservicesand supplies for:
 - Retreatment
 - Changes in treatment required by an accident
 - Maxillofacial surgery
 - Myofunctional therapy
 - Treatment for cleft palate (unless for a child under 18)
 - Treatment of micrognathia (abnormal smallness of jaws) or macroglossia (congenital enlargement of tongue)
 - Treatment of primary or transitional dentition
- Dental expense not specifically described in the plan

Important: Malocclusion (Occlusal Guards)

The Leidos Dental PPO Plan will not cover Occlusal Guards since the participant's medical plan already provides coverage for them.

Filing Claims

If a participant receives dental care from an out-of-network provider, he or she may need to submit their own claim. To do so, complete a Delta Dental claim form. Submit all claims to:

Delta Dental of Virginia

4818 Starkey Road
Roanoke, VA 24018-8542

If a participant has concerns about how a claim has been administered or wishes to appeal a claims decision, information on relevant procedures is available in "[Claims Appeal and Review Procedures Under ERISA](#)" in the Plan Information section.

Leidos Benefits Summary Plan Description

Coordination of Benefits

If a participant or a participant's dependents are covered under another dental plan, then that plan and the Leidos Dental PPO Plan will work together to pay up to 100% of the charges or the normal level of benefits, whichever is less.

When the Leidos Dental PPO Plan is the primary plan, benefits are paid without regard to any other plans. The participant is responsible for coordinating any benefits by submitting the Explanation of Benefits and itemized bill to the secondary plan.

Determining Which Plan Pays First

Leidos uses the following insurance industry guidelines for determining the primary and secondary payers for employees and dependents.

Employees

The plan that covers the participant as an employee is the primary payer. The plan that covers the participant as a dependent is the secondary payer.

Dependents

For an employee's spouse or registered domestic partner, a plan that covers the spouse or registered domestic partner as an employee is the primary payer for his or her claims. If an employee has elected coverage for his or her spouse or registered domestic partner as a dependent and the spouse or registered domestic partner has coverage through another employer, the Leidos Dental PPO Plan is the secondary payer.

For an employee's dependent children, the plan of the parent whose birthday occurs first in the calendar year is usually the primary payer. If an employee's spouse's or registered domestic partner's plan does not follow this "birthday rule," then the "gender rule" applies. That is, the plan covering the child's father as an employee pays first.

In the case of divorced or separated parents, benefits are determined in the following order:

- The plan of the parent who has financial responsibility by court decree;
- The plan of the stepparent who is the spouse or registered domestic partner of the parent who has custody of the child; and
- The plan of the parent who does not have custody of the child.

When none of these rules establishes order, benefits are paid first by the plan that has covered the person for the longer period of time, except that a plan that covers a laid-off or retired employee is secondary to a plan that covers a person as an active employee.

Leidos Benefits Summary Plan Description

Dental Health Maintenance Organizations (DHMOs)

A DHMO is a network of dentists and specialists who provide dental care services at a fixed cost. With the DHMO, a participant does not have to meet a deductible or file any claim forms. The DHMO is available only in areas where there are participating dentists.

How the DHMOs Work

When a participant enrolls in a DHMO, he or she, as well as his or her dependents, must choose a primary care dentist. Each covered person may select his or her own primary care dentist. This primary care dentist will provide all routine dental care and will refer the participant to a network specialist whenever he or she needs specialty care.

For routine dental care — such as check-ups or fillings — a participant should make an appointment with his or her primary care dentist. When the participant goes in for the visit, he or she will pay the required copayment for covered services. The participant does not have to file a claim form after receiving care.

If a participant receives dental care without going through his or her primary care dentist first, or if the participant's care is not authorized by the plan, the DHMO will not pay any benefits. The participant will pay the full cost of any out-of-network or unauthorized care.

Choosing a Primary Care Dentist

The participant and each dependent must select a primary care dentist from the DHMO's network of providers.

Each participant can change his or her primary care dentist at any time during the year. To select or change a primary care dentist, a participant can call the Member Services number on the back of his or her ID card.

ID Cards

Participants enrolled in the Cigna DHMO plan will receive an ID card in the mail. This ID card contains important information about the participant, as well as about the benefits under the plan.

Participants enrolled in the Aetna DMO plan will not receive an ID card. However, Aetna will mail out a welcome letter that will contain the participant ID number and information regarding Aetna Navigator. The participant can register on the website and print out a paper ID card if they so choose.

Leidos Benefits Summary Plan Description

What the DHMOs Cover

The DHMOs generally cover preventive, basic and major services. The DHMOs also generally cover orthodontia services.

Refer to a DHMO's [certificate of coverage](#) for a complete list of what is covered by the plan.

DHMO Benefit Charts and Evidences of Coverage

For highlights of each DHMO, participants can use the following links:

DHMO Benefit Charts		
Dental Plan	Benefit Summary	Detailed Plan Information
Aetna DMO®	2019 Summary	Evidence of Coverage
CIGNA Dental	2019 Summary	Evidence of Coverage
CIGNA International Dental Plan	2019 Summary	Evidence of Coverage

Leidos Benefits Summary Plan Description

Comparing the Dental Plans

The chart below provides an overview of covered dental services in the [Leidos Dental PPO Plan](#) and the [DHMOs](#). For a complete list of DHMO benefits, a participant should refer to the plan's certificate of coverage.

[Download the Leidos Dental Plans Table](#)

Dental Benefits				
	Leidos DENTAL PPO PLAN (Administered by Delta Dental)	AETNA DMO Plan 58	CIGNA DENTAL F510X	CIGNA INTERNATIONAL DENTAL
Group Number:	700273	698685-51	3174168	0666A
Member Services Phone #:	800-237-6060	877-238-6200	800-244-6224	800-441-2668 or 302-797-3100 (collect)
Plan Web Site Address:	Delta Dental (www.DeltaDentalVA.com)	Aetna (www.aetna.com)	CIGNA (www.cigna.com)	CIGNA International Expatriates (www.cignaenvoy.com)
Availability:	Nationwide	Nationwide except for Alabama, Alaska, Arkansas, Louisiana, Maine, Mississippi, New Hampshire, North Dakota, South Carolina, South Dakota Vermont and Wyoming. Service area based on dental plan's zip code eligibility criteria.	Nationwide except for Alaska, Hawaii, Maine, North Dakota, New Mexico, South Dakota, and Wyoming. Service area based on dental plan's zip code eligibility criteria.	Available for participants on International Assignments of 6 months or more
Choice of Dentist:	Any dentist. Using a PPO dentist results in higher benefit levels.	Select a dentist from a list of participating dentists in your area.	Select a dentist from a list of participating dentists in your area.	Any Dentist – Online directory available to search for Dentists in 450+ countries.

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F510X	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	NETWORK*	OUT-OF-NETWORK**			
Annual deductible	\$50 per person		No deductible	No deductible	\$25 per person/ \$75 per family
Annual maximum benefit	\$1,500 per person		No maximum	No maximum	\$1,500 per person
Preventive Services***	Plan pays:		Plan pays 100% after		
<u>Periodic oral examination</u>	100% Not subject to deductible (2 per participant per calendar year)	100% of R&C Not subject to deductible (2 per participant per calendar year)	\$0 copay	\$0 copay	\$0 copay (2 per participant per calendar year)
<u>Prophylaxis/Cleanings, Adult/Child including scaling and polishing</u> (2 per year)	100% of R&C (2 per participant per calendar year)	100% of R&C (2 per participant per calendar year)	\$0 copay (Limit 2 per calendar year)	\$0 copay (Limit 2 per participant per calendar year; routine cleaning with no active periodontal disease; age frequency)	\$0 copay (2 per participant per calendar year)
<u>X-rays — Complete series</u>	100% (1 per participant every 3 years)	100% of R&C (1 per participant every 3 years)	\$0 copay	\$0 copay (1 per participant every 3 years)	\$0 copay (1 per participant every 3 years)
<u>X-rays — One Set Bitewings</u>	100% (2 per participant per calendar year)	100% of R&C (2 per participant per calendar year)	\$0 copay	\$0 copay (no limitation)	\$0 copay (2 per participant per calendar year)
<u>Topical application of sodium or stannous fluoride</u>	100% (ages 18 and younger; 1 per participant per calendar year)	100% of R&C (ages 18 and younger; 1 per participant per calendar year)	\$0 copay	\$0 copay (Limit 2 per calendar year)	\$0 copay (To age 18, 1 per participant per calendar year)

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F510X	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	NETWORK*	OUT-OF-NETWORK**			
Diagnostic Services	Plan pays:		Plan pays 100% after:		
<u>Diagnostic X-rays</u>	90%	80% of R&C	\$0 copay	\$0 copay	\$0 copay
<u>Single Film</u>	90%	80% of R&C	\$0 copay	\$0 copay	\$0 copay
<u>Fissure Sealant, per tooth</u>	90% (ages 13 and younger; once every 3 calendar years)	80% of R&C (ages 13 and younger; once every 3 calendar years)	\$5 copay (up to age 16)	\$10 copay	\$0 copay (1 per tooth every 3 years)
Oral Surgery					
<u>Simple Extraction</u>	90%	80% of R&C	\$0 copay (Extraction, erupted, exposed root)	\$5 copay	Plan pays 80%
<u>Surgical Extraction</u>	90%	80% of R&C	\$28 copay	\$30 copay	Plan pays 80%
<u>Impactions</u>	90%	80% of R&C	\$46 soft tissue; \$58 partially; \$100 completely	\$15-\$100 copay	Plan pays 80%
<u>General Anesthesia (only for Surgical Extractions)</u>	90%	80% of R&C	General Anesthesia (deep sedation) or Conscious IV Sedation (first 15 min): \$104 copay; \$83 copay for each additional 15 min	When medically necessary \$160 copay (first 30 min); \$75 copay (each	Plan pays 80% when determined to be medically necessary

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F510X	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	NETWORK*	OUT-OF-NETWORK			
Fillings					
<u>Amalgam Restoration of Primary Teeth/Permanent Teeth</u>	90%	80% of R&C	\$0 copay	\$0 copay	Plan pays 80%
<u>Composite Restoration</u>	90%	80% of R&C	\$0-\$50 copay depending on type	\$0-\$85 copay	Plan pays 80%
Endodontics					
<u>Root Canal Therapy</u>	90%	80% of R&C	Anterior: \$70 copay; Bicuspid: \$85 copay; Molar: \$240 copay	\$0 - \$280 copay (varies by tooth type)	Plan pays 80%
<u>Pulpotomy</u>	90%	80% of R&C	\$14 copay	\$10 copay	Plan pays 80%
<u>Apicoectomy and Retro Fill</u>	90%	80% of R&C	Anterior: \$85 copay; Bicuspid (1 root): \$85 copay; Molar (1 st root): \$90 copay; each additional root \$55 copay	\$60 - \$95 copay	Plan pays 80%
Periodontics					
<u>Periodontal Planning and Root Scaling</u>	90%	80% of R&C	\$55 copay	\$80 - \$165 copay	Plan pays 80%
<u>Gingivectomy (per quadrant)</u>	90%	80% of R&C	\$100 copay (Limit 1 per quadrant every 3 years)	\$80 - \$130 copay per quadrant	Plan pays 80%

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F510X	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	NETWORK*	OUT-OF-NETWORK **			
Restorative Services	Plan pays:		Plan pays 100% after:		
<u>Crowns – per unit</u>	60%	50% of R&C	\$176 - \$220 copay depending on type	\$185 - \$225 copay	Plan pays 50%
<u>Bridges – per unit</u>	60%	50% of R&C	\$210 copay per unit	\$185 copay	Plan pays 50%
<u>Stainless Steel Crowns</u>	90%	80% of R&C	\$35-\$50 copay	\$185 - \$225 copay	Plan pays 50%
Recementation	Plan pays:		Plan pays 100% after:		
<u>Inlay</u>	90%	80% of R&C	\$10 copay	\$12 copay	Plan pays 50%
<u>Crown</u>	60%	50% of R&C	\$10 copay	\$12 copay	Plan pays 50%
<u>Bridge</u>	60%	50% of R&C	\$15 copay	\$12 copay	Plan pays 50%
Prosthetics (Dentures)	Plan pays:		Plan pays 100% after:		
<u>Complete Upper or Lower Denture</u>	60%	50% of R&C	\$275 copay	\$150 copay	Plan pays 50% (1 per participant every 5 years)
<u>Partial Upper or Lower Denture</u>	60%	50% of R&C	\$275 copay	\$150 copay	Plan pays 50%
<u>Denture and Partial Adjustment</u>	60%	50% of R&C	\$10 copay	\$10 copay	Plan pays 50%
<u>Denture Reline</u>	90%	80% of R&C	\$45 copay (chair side) \$85 copay (laboratory)	\$35 copay (chairside)	Plan pays 50%
<u>Denture Duplication</u>	60%	50% of R&C	Not covered	Not covered	Not covered
<u>Denture and Partial Repairs</u>	90%	80% of R&C	\$20 - \$86 copay	\$30 copay	Plan pays 80%

Leidos Benefits Summary Plan Description

	Leidos DENTAL PPO PLAN (Administered by Delta Dental)		AETNA DMO Plan 58	CIGNA DENTAL F510X	CIGNA INTERNATIONAL DENTAL
COVERED SERVICES	NETWORK*	OUT-OF-NETWORK **			
Prosthetics (Dentures) continued	Plan pays:		Plan pays 100% after:		
<u>Adding Teeth or Clasps to Partial Denture – per unit</u>	90%	80% of R&C	\$35 - \$40 copay	\$30 - \$35 copay	Plan pays 80%
Orthodontia	Plan pays:		Plan pays 100% after:		
<u>Full Banded Case</u>	50% up to a separate \$1,500 lifetime maximum per participant: annual deductible applies; includes invisible braces	50% up to a separate \$1,500 lifetime maximum per participant ; annual deductible applies; includes invisible braces	\$1,545 copay, plus \$30 orthodontic screening exam; \$150 diagnostic records; \$275 retention fee. Other fees may apply per Aetna’s Dental Care Schedule	\$1,340 (child) to \$1,940 (adult) copay, plus \$275 retention fee; \$125 per-orthodontic treatment visit; \$270 orthodontic treatment plan & records; \$400 (child and adult); Other fees may apply per CIGNA’s patient charge scheduled.	50% after separate \$50 lifetime deductible; \$1,500 lifetime maximum; includes invisible braces
<u>Partial banded case</u>	50% up to a separate \$1,500 lifetime maximum per participant	50% up to a separate \$1,500 lifetime maximum per participant	Not covered	Varies	50% after separate \$50 lifetime deductible; \$1,500 lifetime maximum; includes invisible braces
Annual maximum benefit	\$1,500 per person		No maximum	No maximum	N/A

* Covered services received from a network provider will be paid based on the negotiated rate.

** Covered services received from an out-of-network provider will be paid based on the reasonable and customary (R&C) limit.

*** Preventive services are not subject to the annual deductible.

**** Participants are advised to refer to the Evidence of Coverage, contact the individual dental plan carrier and obtain a predetermination of benefits for services in excess of \$150.

Continuing Dental Coverage After Plan Coverage Ends

A federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA) enables a participant and his or her covered dependents to continue dental 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 dental insurance if their coverage stops due to the participant's death or entitlement to Medicare; divorce; legal separation; 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.

For more information about participants' rights under COBRA, the participant should refer to "[Continuing Health Care Coverage Through COBRA](#)" in the Plan Information section.

Participants in a DHMO should refer to that plan's certificate of coverage booklet for more information.

Leidos Benefits Summary Plan Description

Vision Plan

Participants may elect coverage for themselves and their families under the [Vision Service Plan — VSP \(www.vsp.com\)](#). This plan is designed to provide a variety of eye care services. More information available:

- [Eligibility](#)
- [Paying for Care](#)
- [Plan Design](#)
- [What VSP Covers](#)
- [What VSP Does Not Cover](#)
- [Continuing Vision Insurance After Plan Coverage Ends](#)
- [Filing Claims](#)

Eligibility

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

Employee Eligibility	
Type of Coverage	Eligibility Requirements
Vision Program	<ul style="list-style-type: none">• Must be an active, regular full-time employee working at least 30 hours per week; or• Must be a part-time employee, regularly scheduled to work at least 12 hours per week but less than 30 hours per week;•

Leidos Benefits Summary Plan Description

Dependents

Participants may also enroll their eligible dependents in some Leidos benefit programs. Dependents that are eligible to be rolled 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 Leidos Employee Services, in writing, within 31 days of any change in dependent eligibility.

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.

Leidos Benefits Summary Plan Description

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 the Benefits page 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.

Leidos Benefits Summary Plan Description

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 Leidos Employee Services at 855-553-4367, option 3 or via email at AskHR@Leidos.com.

Paying for Care

The entire cost of the VSP is paid by participants, who are responsible for the insurance premiums and applicable copayments for examinations and eyewear. Premiums are paid via bi-weekly pretax payroll deductions. The plan generally pays for prescription glasses, contact lenses and laser eye surgery, up to the applicable allowance. Prices are already discounted through VSP (www.vsp.com) network doctors.

Copayments

When a participant receives an eye exam from a VSP network doctor or a non-VSP provider, or obtains glasses or contacts, he or she is subject to the applicable copayment as shown in the table below.

When a participant receives services from a non-VSP provider, he or she is responsible for paying the complete bill at the time of service and applying for reimbursement for the benefits (less applicable copayments) according to the summary of benefits in the table that follows.

For further information about what is covered and what is not covered by the plan, participants should contact VSP by calling 1-800-877-7195, or by visiting the VSP web site (www.vsp.com).

Leidos Benefits Summary Plan Description

Summary of Benefits

BENEFIT	FREQUENCY	VSP NETWORK DOCTOR	NON-VSP PROVIDER
Vision Exam	Once every calendar year	\$20 copay then plan pays 100% for exam services	\$20 copay then plan pays up to \$45 for exam services
Lenses	Once every calendar year	Plan pays 100% for single vision, lined bifocal, lined trifocal lenses and standard progressive lenses. Lens options that enhance appearance, durability and function of glasses are available with an average of 20% - 25% discount	After \$20 copay, plan reimburses up to: \$30 for single vision \$50 for lined bifocal or standard progressive lenses \$65 for lined trifocal
Frames	Once every calendar year	Plan covers frames up to \$150; participants may upgrade frames by paying the difference in cost; 20% discount on any out-of-pocket costs	After \$20 copay, plan reimburses up to \$70
Contacts (in lieu of lenses and frames)	Once every calendar year	Plan pays up to \$150 allowance; 15% discount on contact lens exam. Contact lens fitting and evaluation covered in full after a copay not to exceed \$60	Plan reimburses up to \$105*
Medically necessary contact lenses (in lieu of lenses and a frame)	Once every calendar year	Plan pays 100% if contact lenses are required for certain medical conditions that prevent a participant from wearing eyeglasses; Medically necessary contact lenses must be approved by VSP	Reimbursed up to \$210
Laser Vision Correction		Plan pays \$100 per eye up to a \$200 lifetime maximum, plus plan provides discounts averaging 15% on charges not to exceed: Custom LASIK: \$2,300 per eye LASIK: \$1,800 per eye PRK: \$1,500 per eye	Plan reimburses \$100 per eye up to a \$200 maximum; no discounts available

* Applied both to contact lens fitting and evaluation and to contacts.

Leidos Benefits Summary Plan Description

Plan Design

The vision plan through [VSP \(www.vsp.com\)](http://www.vsp.com) offers participants the flexibility to receive services from a VSP network doctor or a non-VSP provider. No referrals or identification cards are needed to see a VSP doctor.

VSP Network Doctors

Vision care services and eyewear may be obtained from any licensed optometrist, ophthalmologist or dispensing optician. However, the plan generally pays maximum benefits and offers additional discounts when participants receive services and eyewear from [VSP \(www.vsp.com\)](http://www.vsp.com) network doctors.

Participants pay only a copayment to a VSP doctor for services. VSP will pay the VSP doctor directly according to the plan's agreement with the doctor.

VSP doctors offer additional savings including a 20% discount on additional pairs of prescription glasses (lenses and frame) and sunglasses. Services must be received within 12 months of a participant's last covered eye exam and provided by the same VSP doctor who conducted the exam. Participants can also save 15% off the cost of a contact lens exam when they receive contact lens services from a VSP doctor. (This discount does not apply to the purchase of contacts.)

Scheduling an Appointment with a VSP Network Doctor

When calling to schedule an appointment with a VSP doctor, participants should identify themselves as a VSP member.

To locate a VSP doctor near a participant's home or office:

- Visit the VSP Web site at [VSP \(www.vsp.com\)](http://www.vsp.com) to search for a doctor by name or location.
- Call VSP's Member Services at 1-800-877-7195. VSP's automated service allows participants to search for a doctor by Zip Code or name.

Non-VSP Providers

A participant receives the best value from the VSP benefit when he or she visits a VSP network doctor. If a participant obtains plan benefits from a non-VSP provider, he or she must pay the provider in full at the time of service. The participant will be reimbursed by VSP according to the reimbursement schedule listed in the Schedule of Benefits. Services obtained from non-VSP providers are subject to the same copayments and limitations as services obtained from VSP providers.

Leidos Benefits Summary Plan Description

Laser Surgery Discount

VSP has contracted with many laser surgery facilities and doctors, offering participants access to laser vision correction surgery for hundreds of dollars less than they might pay privately. Participants can visit [VSP's web site \(www.vsp.com\)](http://www.vsp.com) to learn more about the laser surgery program.

What VSP Covers

Benefits generally covered through [VSP \(www.vsp.com\)](http://www.vsp.com) include:

- Vision examination, including the test necessary to ensure visual wellness and to detect potential eye-related medical problems;
- Prescription of corrective lenses when indicated;
- Single vision, lined bifocal or lined trifocal lenses in glass or plastic;
- Standard progressive lenses
- A selection of frames to choose from, up to the plan allowance;
- Contact lenses in place of prescription glasses;
- Discounts and allowances on lenses and frames, contact lens exam and laser eye surgery;
- Type 2 diabetes follow-up services and contact lens exams (evaluation and fitting)

What VSP Does Not Cover

[VSP \(www.vsp.com\)](http://www.vsp.com) covers the participant's visual needs rather than optional extras or "cosmetic" materials. If a participant selects any of the following cosmetic options listed below, the participant will pay a negotiated VSP member price:

- Blended lenses;
- Oversize lenses;
- UV (ultraviolet protection) lenses;
- Progressive multifocal lenses;
- Coating of a lens or lenses;
- Laminating of a lens or lenses;
- Cosmetic lenses; and
- Optional cosmetic processes

In addition, services and eyewear that aren't covered include:

- Orthoptics or vision training and any associated supplemental testing;
- Planolenses (non-prescription lenses);
- Two pair of glasses in lieu of bifocals;

Leidos Benefits Summary Plan Description

- Replacement of lenses and frames under the plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Corrective vision treatment of an experimental nature;
- Costs for services and/or eyewear above benefit allowances;
- Services/eyewear not indicated as covered plan benefits.

Continuing Vision Insurance After Plan Coverage Ends

A federal law called the Consolidated Omnibus Budget Reconciliation Act (COBRA) enables a participant and his or her covered dependents to continue vision 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 vision insurance if their coverage stops due to the participant's death or entitlement to Medicare; divorce; legal separation; dissolution of registered domestic partnership; or when the child no longer qualifies as an **eligible dependent**. The participant must elect coverage according to the rules of the Leidos health care plans. Continuation is subject to federal law, regulations, and interpretations.

For more information about participants' rights under COBRA, the participant should refer to "**Continuing Health Care Coverage Through COBRA**" in the Plan Information section.

Participants should refer to the **VSP web site (www.vsp.com)** for additional information.

Filing Claims

For out-of-network reimbursement, the participant must pay the entire bill at the time of service and then send the following information to VSP:

- An itemized receipt listing the date of services and an itemized list of services received;
- The participant's name, Social Security Number, phone number and address;
- The group number (#12180678);
- The patient's name, date of birth, phone number and address; and
- The patient's relationship to the participant (such as "self," "spouse," "child," etc.).

Claims for reimbursement must be submitted within six months of the date of service. Participants should keep a copy of the information for their records and send the originals to:

Vision Service Plan (VSP)
Attention: Claims Services
P.O. Box 385018
Birmingham, AL 35238-5018

Participants should contact VSP with any questions about coverage at 1-800-877-7195.

Leidos Benefits Summary Plan Description

Employee Assistance Plan

You and your eligible dependents have access to the LifeMatters Employee Assistance Plan (EAP), which offers confidential, personal assessment and referral services through Empathia. The full cost of the program is paid for by Leidos.

Confidentiality

It's important that you and your household have access to confidential counseling and that your right to privacy is maintained. That's why your contact with Empathia, including counseling records and services, will be kept confidential in accordance with federal and state laws.

Empathia will not share information about your counseling with Leidos or anyone else without your written permission. The only exception is when the life or safety of an individual is seriously threatened, or if disclosure is required by law.

For more information, contact LifeMatters directly at 800-634-6433 or visit LifeMatters at www.mylifematters.com and enter the access code "Leidos1".

Covered Benefits

You and your dependents are each eligible for up to five visits per presenting problem per calendar year at no charge. If you or a dependent require extended mental health/substance abuse treatment, you may be eligible for benefits under your [medical plan](#).

EAP defines a "dependent" as any natural person (other than an employee) eligible to receive benefits under the Plan. In addition, with respect to EAP services, "dependent" shall also include any person residing with an employee on a full-time basis.

EAP counselors with Empathia can help you with the following:

- Relationship counseling (marital discord, parent-child issues, etc.)
- Emotional counseling (depression, anxiety, moodiness, etc.)
- Financial and legal service referral assistance
- Help in dealing with work-related stress
- Counseling on providing care for elderly parents
- Addiction counseling (alcohol, substance abuse, gambling, etc.)
- Work/Life resources and referral programs for childcare, education, eldercare, legal assistance and multitude of other community services

Leidos Benefits Summary Plan Description

Accessing LifeMatters

The LifeMatters EAP is available 24 hours a day, seven days a week. You may call Empathia at 800-634-6433, or you can access services online at www.mylifematters.com and enter the access code "Leidos1".

Claims Process

Claims Procedures

You may access EAP benefits by contacting Empathia directly either online or through the toll-free number to obtain an approval number; you are not required to file a claim for EAP services. If you wish to file a complaint about EAP approvals, claims, provider issues, service problems or any other aspect of the LifeMatters EAP, please call the toll free number 800-634-6433 and indicate you wish to file a complaint. The complaint will be investigated and a response to you will be processed within 30 days of receipt of the complaint.

Leidos Benefits Summary Plan Description

Flexible Spending Accounts

Leidos offers eligible participants the opportunity to save money by paying for eligible health care and/or dependent day care expenses on a pre-tax basis through the [Health Care Flexible Spending Account](#) and the [Dependent \(Day\) Care Flexible Spending Account](#). A participant may make contributions to one or both Flexible Spending Accounts, which can reduce his or her tax liability. Participation in a Flexible Spending Account program is voluntary.

The Leidos Flexible Spending Accounts are administered by [HealthEquity](#). Participants may log on to [HealthEquity](#) to submit verification, order additional health care debit cards, file a claim, check claim status or account balance information.

To learn more about the Flexible Spending Accounts, visit:

- [Health Care Flexible Spending Account](#)
- [Dependent \(Day\) Care Flexible Spending Account](#)
- [Important Rules About Flexible Spending Accounts](#)

Health Care Flexible Spending Account

Leidos offers two types of Health Care FSAs:

- Limited Purpose Health Care FSA (HSA Compatible)
- Health Care FSA

Limited Purpose Health Care FSA (HSA-Compatible)	Health Care FSA
<ul style="list-style-type: none">• Use it when you have an HSA	<ul style="list-style-type: none">• Use it when you are not enrolled in a Healthy Focus plan and are not enrolled in any other High Deductible Medical Plan with an HSA
<ul style="list-style-type: none">• For eligible dental and vision expenses	<ul style="list-style-type: none">• For eligible medical, prescription drug, dental and vision expenses
<ul style="list-style-type: none">• For medical and prescription drug expenses after you meet the deductible (Contact HealthEquity if you meet the deductible to find out what you will need to provide to begin using your account for eligible medical and prescription drug expenses)	

Leidos Benefits Summary Plan Description

A participant can set aside between \$100 and \$2,650 each year — on a pre-tax basis — to pay for eligible medical, dental, and vision care expenses, including:

- Eligible services not covered by a medical, dental or vision plan (except for cosmetic procedures);
- Annual deductibles;
- Copayments; and
- Out-of-pocket expenses.

See list of [eligible](#) and [ineligible](#) health care expenses later in this section.

Once enrolled in the Health Care Flexible Spending Account, a participant may not change the amount he or she contributes to the account, unless the participant experiences a qualified status change. See "[Changing Coverage \(Qualified Status Changes\)](#)" in the Participating in the Plans section for more information about qualified status changes.

Important: Participants must make an annual election each year. Health Care Flexible Spending Account elections cannot automatically roll over into the next plan year.

Carry-over Feature

Employees are able to carry-over up to \$500 of unused Limited Purpose Health Care FSA or Health Care FSA balance remaining at the end of the year into the next plan year. These funds will be added to the Participant's Health Care FSA or Limited Purpose Health Care FSA balance in the subsequent Plan Year. Participants who elect to contribute to a Health Savings Account (HSA) for the next Plan Year, may carry over up to \$500 of unused FSA funds to a Limited Purpose Health Care FSA balance in the subsequent Plan Year. Any remaining balances in excess of the \$500 carry-over feature at the end of the Plan year will be forfeited.

Eligible Health Care Expenses

Generally, any health care expense that the IRS allows as a deduction on income tax returns is eligible for reimbursement, provided it is not reimbursed from any other source. This includes expenses incurred for anyone a participant is entitled to claim as a dependent on his or her tax return, regardless of whether that dependent is covered under Leidos' medical, dental or vision plans. **Please note that neither participant insurance premiums nor expenses for registered domestic partners are eligible for reimbursement under the Health Care Flexible Spending Account.**

Leidos Benefits Summary Plan Description

You may be reimbursed for your own expenses as well as those for your qualified dependents. A dependent means an individual who qualifies as a dependent under a Company-sponsored health plan. This generally includes your spouse and your children up to age 26. For this purpose, "children" means your natural children, your stepchildren, your legally adopted children, and children placed with you for adoption. (Expenses for a domestic partner or children of a domestic partner are generally not eligible for reimbursement unless the person qualifies as your dependent for federal tax purposes). Your dependents do not need to be enrolled in a Company-sponsored health plan for you to receive reimbursement of their eligible health-related expenses. Only expenses incurred while you are participating in the Health Care FSA are eligible for reimbursement.

Health-related expenses that qualify for reimbursement are defined by the IRS (details can be found in IRS Publication 502, which provides general guidance as to whether expenses qualify as medical care under Section 213). Keep in mind that eligible expenses may change if the tax laws are revised. The health care expenses below are examples of covered expenses when not reimbursed by another plan, insurance policy or Medicare. This list is meant to provide only a summary of eligible expenses. For a more comprehensive list, visit the [HealthEquity](#) website:

- Acupuncture;
- Alcohol/substance abuse treatments;
- Ambulance services;
- Artificial limbs;
- Artificial teeth;
- Birth control pills and devices prescribed by a physician;
- Braillebooks and magazines;
- Capital expense — amount paid for home-installed special equipment, or for improvements, if their main purpose is medical care for the participant, the participant's spouse, or the participant's dependent;
- Car — the cost of special hand controls and other special equipment installed in a car for the use of a person with a disability;
- Contact lenses/eyeglasses;
- Copayments (under insurance plan);
- Crutches and canes (prescribed);
- Deductibles (under insurance plan);
- Fees for physical and mental health services provided by:
 - Chiropractors;
 - Chiropractors;
 - Christian Science practitioners;
 - Dentists;

Leidos Benefits Summary Plan Description

- Ophthalmologists;
- Optometrists;
- Osteopaths;
- Podiatrists;
- Psychiatrists;

- Psychologists;
- Surgeons
- Fertility enhancement;
- Guide dogs for the blind;
- Health institute — treatment that is prescribed by a physician and the physician issues a statement that the treatment is necessary to alleviate a physical or mental defect or illness;
- Hearing aids and diagnostic services;
- Hospital services;
- Laboratory fees;
- Laser eye surgery;
- Lead-based paint removal;
- Learning disability treatment and special schools;
- Legal fees to authorize treatment for mental illness;
- Lodging/meals at hospitals or while away from home for treatment;
- Medical conference — amounts paid for admission and transportation to a medical conference if the conference concerns the chronic illness of a participant or the participant's spouse or dependent;
- Medical equipment (prescribed);
- Medical information plan — amounts paid to a plan that keeps a participant's medical information so that it can be retrieved from a computer data bank for needed medical care;
- Nursing services;
- Operations/surgery, including abortions;
- Orthopedic shoes (excess cost of regular shoes);
- Over-the-counter medications (with Rx);
- Some over-the-counter items available without RX;
- Oxygen;
- Prescription drugs;

Leidos Benefits Summary Plan Description

- Psychoanalysis;
- Routine physical exams and immunizations;
- Smoking cessation programs;
- Special schools for the mentally and/or physically handicapped;
- Sterilization/vasectomy;
- Telephone and television equipment for the deaf;
- Therapy (physical, psychiatric, occupational);
- Transplants;
- Transportation to or from medical treatment;
- Weight-loss programs (only for treatment of a medical condition, not for general well-being);
- Wheelchair; and
- X-rays.

Ineligible Health Care Expenses

Some expenses are not eligible for reimbursement from the Health Care Flexible Spending Account. Below are examples of ineligible health care expenses. This list is meant to provide only a summary of ineligible expenses:

- Bottled water;
- Care of a normal and healthy baby by a nurse;
- Cosmetic dentistry, including teeth bleaching;
- Cosmetic medical procedures, such as face lifts;
- Dance lessons;
- Diaper services;
- Electric toothbrushes, even if recommended by a dentist;
- Funeral and burial expenses;
- Household help;
- Insurance premiums;
- Medical coverage premiums;
- Marriage counseling fees;
- Maternity clothes;
- Special foods, even if required for allergies;
- Swimming lessons;

Leidos Benefits Summary Plan Description

- Toothpaste and other sundries;
- Trips or vacations for general health improvement;
- Vitamins, supplements or tonics (unless specifically directed to use by a medical provider to treat a specific medical condition); and
- Weight-loss programs for general well-being.

Flexible Spending Account Reimbursement

Participants have three options in which to receive reimbursement from their **flexible spending account**:

- **Health Care Debit Card (not available for dependent day care)** — Participants can use their HealthEquity health care debit card at select pharmacies, healthcare providers and general merchandise stores that have an IRS-approved inventory and checkout system. In most instances, the card transaction will be automatically verified at checkout. With this verification, participants may have to submit a receipt to HealthEquity after the transaction. Participant is required to keep each receipt for tax purposes and in the event it is needed for verification.
- **Request Reimbursement** — Participants will be able to claim funds from their flexible spending account by requesting reimbursement on the HealthEquity website. As part of the online process, they can upload the backup documentation and associate them directly to the claim. Most claims are processed within a few days after they are received and payments are sent shortly thereafter. Participants will receive a check in the mail if they do not set up their direct deposit information with HealthEquity.

The participant can fax or mail their claim form, by downloading the Health Care Flexible Spending Account [claim form](#) to 1-801-999-7829 or mailing it to:

HealthEquity
Attn: HealthEquity Claims
15 W. Scenic Pointe Dr. Suite 100 Draper, UT 84020

- **Pay Provider Online** — Participants can pay many of their eligible healthcare expenses directly from their flexible spending account without filling out paper claims forms. Just enter the provider's name and other requested information with the backup documentation and payment will be sent directly to the provider.

Participants in the [Health Care Flexible Spending Account](#) can be reimbursed for the full amount they contribute during the year at any time during the year, even if they do not currently have that much money in their account.

If participants have concerns about how a claim has been administered, or wish to appeal a claims decision, information on relevant procedures is available in the Plan Information section.

If You Leave the Company

If you leave the Company during the year, any contributions you are making will stop and you have until April 30 of the following plan year to submit claims for reimbursement for any remaining balance. You will not be reimbursed for any eligible expenses incurred after your date of termination (or end of plan participation, if later). However, you may be able to continue your Health Care Flexible Spending Account coverage under COBRA on an after-tax basis.

Electing COBRA Coverage

When your participation in your Health Care Flexible Spending Account ends due to one of the qualifying events listed below, you may have limited rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA) to continue your account until the end of the calendar year in which your participation ends.

- You leave the Company (for reasons other than gross misconduct);
- Your coverage stops because you no longer meet the eligibility requirements;
- You die;
- You fail to return to work at the end of your leave under FMLA.

If you have funds remaining in your Health Care Flexible Spending Account, the COBRA administrator will provide you with a COBRA election form for continued coverage. To elect COBRA continuation coverage, you must complete and return the form to the COBRA administrator within 60 days after your coverage ends or within 60 days after you receive the form (whichever is later). If you elect COBRA coverage, the effective date of the coverage is the date of the qualifying event. You will have an additional 45 days following your election of COBRA coverage to pay any outstanding premiums.

You can continue the coverage until the end of the calendar year, as long as:

- You continue to make contributions for coverage within 30 days of the due date, and
- The Company is still offering the Plan to its employees.

You will have to pay 100% of the monthly contribution plus a 2% administrative charge for coverage under COBRA. Your contributions will be made on an after-tax basis.

Dependent (Day) Care Flexible Spending Account

A participant can set aside money on a pre-tax basis to pay for eligible dependent day care expenses for qualified dependents. These expenses must be necessary in order for a participant (and spouse, if married) to work. The amount that can be set aside each year is a minimum of \$100 up to:

- \$5,000* if the participant is single, or married and filing tax returns jointly;
- A total amount of \$5,000* together if the participant's spouse has a dependent care Flexible Spending Account through his or her company; or
- \$2,500* if the participant is married but files separate tax returns

* These are the maximum contributions allowed for dependent care expenses under current IRS rules.

Important: Participants must make an annual election each year. Dependent (Day) Care Flexible Spending Account elections cannot automatically roll over into the next plan year.

If a participant or spouse earns less than \$5,000, the combined amount that the participant and spouse can contribute may not exceed the amount of the lower salary.

If a participant is married but has a spouse who is a full-time student or is disabled, the IRS considers the spouse's earned income to be:

- \$250 a month if the participant has one qualified dependent; and
- \$500 a month if the participant has two or more qualified dependents.

Under the Dependent (Day) Care Flexible Spending Account, a qualified dependent is:

- A child under age 13 whom the participant claims as a dependent on his or her federal income tax return;
- A participant's spouse who is physically or mentally incapable of self-care; or
- Any other dependent that is physically or mentally incapable of self-care, whom the participant claims as a dependent on his or her federal income tax return, and who normally spends at least eight hours in the participant's home each day.

Once enrolled in the Dependent (Day) Care Flexible Spending Account, a participant generally may not change the amount he or she contributes to the account, unless the participant experiences a qualified status change. See "[Changing Coverage \(Qualified Status Changes\)](#)" in the Participating in the Plan section for more information about qualified status changes.

In addition, a participant may change the amount he or she contributes when there is a change in providers, a change in child care or adult care costs or a general change in his or her care situation.

Leidos Benefits Summary Plan Description

Eligible Dependent (Day) Care Expenses

Generally, any dependent care expense that the IRS allows as a deduction on income tax returns is eligible for reimbursement, provided it is not reimbursed from any other source. This includes expenses incurred for anyone a participant is entitled to claim as a dependent on his or her tax return, regardless of whether that dependent is covered under Leidos' medical, dental or vision plans. **Please note that expenses for registered domestic partners and dependent children of registered domestic partners are not eligible for reimbursement under the Dependent (Day) Care Flexible Spending Account.**

Below are examples of eligible dependent care expenses. This list is meant to **provide only a summary of eligible expenses:**

- Care at a licensed nursery school, day camp, or day care center;
- Services from individuals who provide dependent care in or outside a participant's home, unless the provider is the participant's spouse, own child under age 19, or any other dependent;
- After-school care for children under age 13;
- Household services related to the care of an elderly or disabled adult who lives with a participant; and
- Any other services that qualify as dependent care expenses under IRS regulations.

Important: For a detailed list of eligible dependent care expenses, please refer to IRS publication 503, (called "Child and Dependent Care Expenses") available from your local IRS office, or go to the [IRS web site \(www.irs.gov\)](http://www.irs.gov).

Ineligible Dependent (Day) Care Expenses

Below are examples of ineligible dependent care expenses. This list is meant to **provide only a summary of eligible expenses:**

- Expenses for food, clothing or education (unless incidental to the care);
- Registrations fees;
- Expenses for overnight camp;
- Expenses for transportation between a participant's house and the place that provides day care services, or the cost of transportation for a care provider;
- Expenses for dependent care when either the participant or his or her spouse is not working or is not looking for work;
- Charges for convalescent or nursing home care for a parent or a disabled spouse;
- Expenses paid to the spouse, a participant's own children under age 19, or any other dependents; and
- Expenses for which a federal child-care tax credit would be taken.

Important: For a detailed list of eligible dependent care expenses, please refer to IRS publication 503, (called "Child and Dependent Care Expenses") available from your local IRS office, or go to the [IRS web site \(www.irs.gov\)](http://www.irs.gov).

Leidos Benefits Summary Plan Description

Child Care Credit

Another way to reduce dependent care expenses is to take a tax credit when filing an income tax return. However, a participant may not contribute to a Dependent (Day) Care Flexible Spending Account and take the tax credit for any expenses reimbursed through the Dependent (Day) Care Flexible Spending Account.

With the tax credit, a participant can claim a deduction for a percentage of eligible dependent care expenses (the same expenses as defined for the Dependent (Day) Care Flexible Spending Account). The tax credit may be taken only on expenses up to \$3,000 for one dependent and up to \$6,000 for two or more dependents.

The tax credit percentage applied to eligible expenses decreases as a participant's adjusted gross income rises. Generally, if a participant's family income is greater than \$24,000 per year, the Dependent (Day) Care Flexible Spending Account will save more in taxes than the child care income tax credit. However, the advantages of the Flexible Spending Account or the tax credit depend on a participant's overall tax situation and should be discussed with a tax adviser.

Dependent (Day) Care Flexible Spending Account Reimbursement

Participants must pay for [eligible dependent day care expenses](#), save the receipts, and then file a claim for reimbursement from their accounts.

- **Request Reimbursement** — Participants will be able to claim funds from their flexible spending account by requesting reimbursement on the HealthEquity website. As part of the online process, they can upload the backup documentation and associate them directly to the claim. Most claims are processed within a few days after they are received and payments are sent shortly thereafter. Participant will receive a check in the mail if they do not set up their direct deposit information with HealthEquity.

The participant can fax or mail their claim form, by downloading the [Dependent Care Flexible Spending claim form](#) and faxing the completed form to 1-801-999-7829 or mailing it to:

HealthEquity

Attn: HealthEquity Claims

15 W. Scenic Pointe Dr. Suite 100 Draper, UT 84020

- **Pay Provider Online** — Participants can pay many of their eligible dependent day care expenses directly from their flexible spending account without filling out paper claims forms. Just enter the provider's name and other requested information with the backup documentation and payment will be sent directly to the provider.

Unlike with the Health Care Flexible Spending Account, a participant may receive reimbursement only up to the balance available in his or her account at the time the claim is filed.

Leidos Benefits Summary Plan Description

If participants have concerns about how a claim has been administered, or wish to appeal a claims decision, information on relevant procedures is available in the Plan Information section of the complete SPD.

If You Leave the Company

If you leave the Company during the year, any contributions you are making will stop and you have until April 30 of the following plan year to submit claims for reimbursement for any remaining balance. You will not be reimbursed for any eligible expenses incurred after your date of termination.

Important Rules About Flexible Spending Accounts

- **Must enroll annually** — Participants must enroll during each Open Enrollment period in order to participate each calendar year.
- **Use it or lose it** — Estimate annual dependent (day) care expenses carefully!
Any money put aside in a Dependent (Day) Care Flexible Spending Account must be used for eligible [dependent care expenses](#) incurred between January 1 and December 31 (or during the period of plan participation). The deadline to submit claims for the previous year's expenses is April 30th of the following. Any money left in the account after April 30th will be forfeited.
- **Carry-Over Provision** – IRS regulations specify that an employer may choose to provide a carry-over of unused funds to the next plan year. Starting in 2018, Leidos will allow active participants to carry over up to \$500 of unused funds to be reimbursed for qualified medical expenses incurred in the following Plan Year. Any unused funds in excess of the carryover will be forfeited after the April 30th deadline to submit claims for the previous Plan Year.
- **No double dipping** — Health care expenses reimbursed through the [Health Care Flexible Spending Account](#) and dependent care expenses reimbursed through the [Dependent \(Day\) Care Flexible Spending Account](#) cannot also be deducted on federal income tax returns.
- **No transferring of funds** — Transfers of funds from the Health Care Flexible Spending Account to the Dependent (Day) Care Flexible Spending Account and vice versa are not permitted.
- **Credit Balance at End of Coverage Period** – Claims received by the Plan Administrator on or after the earlier of (a) 90 days after termination of employment, or (b) April 30 following the end of the Plan Year for expenses incurred during the prior Plan Year, will be considered untimely and not eligible for reimbursement under the Plan. If any balance remains credited to the Participant's Health Care FSA after all reimbursements are made for that Plan Year, such balance in excess of \$500 is not carried over to reimburse the Participant for Qualifying Medical Care Expenses incurred during the subsequent Plan Year, and is not available to the Participant in any other form or manner. Instead such balance remains the property of Leidos and the Participant forfeits all rights with respect to such balance.

Leidos Benefits Summary Plan Description

- **Continuation of Coverage**—Participants who would lose coverage under the Health Care F S A as a result of a qualifying life event can elect, within a stated election period, continuation of coverage of benefits previously received under the Health Care FSA. If a participant timely elects continuation of coverage under COBRA, the benefits elected will be available for the time period prescribed by law (i.e., the end of the Plan Year). In addition, the Plan allows participants to carry-over up to \$500 of any amount remaining in their Health Care FSA as of the end of the calendar year in which the individual became eligible for continuation of coverage. Such carry-over amount may be used to pay or reimburse medical expenses incurred during the maximum duration of the COBRA continuation period (i.e., 18, 29, or 36 months, as applicable). Any unused amount of more than \$500 remaining in the Health Care FSA at the end of the calendar year in which the participant became eligible for continuation of coverage will be forfeited.

Leidos Benefits Summary Plan Description

Life and Accidental Death and Dismemberment (AD&D) Insurance Plans

Leidos offers several types of financial protection for participants and their families if they were to die or be injured in an accident, including:

- **Basic Term Life Insurance;**
- **Group Universal Life (GUL) Insurance;**
- **Basic Accidental Death and Dismemberment (AD&D) Insurance;**
- **Voluntary Accidental Death and Dismemberment (VAD&D) Insurance; and**
- **Business Travel Accident Insurance.**

Prudential insures the Basic Life Insurance and the Group Universal Life (GUL) Insurance plans. CIGNA Group Insurance insures the Accidental Death and Dismemberment plans, and the plans are underwritten by the Life Insurance Company of North America.

Basic Term Life Insurance

Basic Term Life Insurance may provide a benefit to employees and their eligible dependents if any were to die while the employee was working for Leidos.

- **Evidence of Coverage**

How Basic Term Life Insurance Works

Eligible employees automatically receive Basic Term Life Insurance coverage for themselves and their eligible dependents, including their spouse or registered domestic partner and their dependent children*.

Leidos pays the full cost of Basic Term Life Insurance coverage.

*To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.

Leidos Benefits Summary Plan Description

Employee Coverage

The amount of coverage that an employee may receive is based on his or her classification, as

Employee Coverage	
CLASS	BASIC TERM LIFE INSURANCE BENEFIT
Class 1 — All regular full-time employees working at least 30 hours per week and regular part-time employees working 12 – 29 hours per week and who are benefits eligible	1 times annual compensation*, rounded to the next higher multiple of \$1,000 prior to calculating your amount of insurance, to a maximum of \$1 million (Benefits for part-time employees will be based on
Class 5 — All eligible employees waiving Basic Term Life Insurance coverage amounts over \$50,000	\$50,000

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the work performed as of the date of loss. It does not include earnings received as bonuses, overtime pay or other extra compensation.

Basic Term Life Insurance benefit amounts over \$50,000 are subject to income tax. The value of an employee's life insurance coverage over \$50,000 will be added each year to his or her W-2 form as taxable income. This is called "imputed income."

The employee may choose to waive any coverage over \$50,000 at any time. However, if he or she waives this excess coverage and later wants to reinstate it, the employee may have to provide evidence of insurability to Prudential.

Employees Ages 70+

When an employee reaches age 70, the total amount of the employee's Basic Term Life Insurance benefit will be reduced by 35%. The amount lost due to age reductions is not eligible for port or conversion.

Dependent Basic Life Coverage

Coverage for an employee's eligible dependents equals \$2,000 per person. Under the Basic Term Life Insurance plan, eligible dependents may include the employee's spouse or registered domestic partner, natural child(ren), , legally adopted child(ren), child(ren) placed with the employee for adoption prior to legal adoption*, and the employee's stepchild(ren)** and Domestic Partner's child(ren)**.

See "[Eligibility](#)" in the Participating in the Plans section for more information about eligibility requirements.

Leidos Benefits Summary Plan Description

*A child placed with an employee for adoption prior to legal adoption is considered a Qualified Dependent from the date of placement for adoption.

**To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.

Additional Benefits

Basic Term Life Insurance also pays additional benefits, including:

- **Accelerated Benefits** — If an employee or his or her spouse or registered domestic partner becomes terminally ill and is not expected to live for more than 12 months, he or she may request an accelerated benefit equal to a maximum of 50% of his or her combined life insurance benefit (Basic Life Term Insurance, Optional Dependent Life Insurance, and Group Universal Life (GUL) Insurance. The maximum accelerated benefit amount for Basic Life Insurance is \$125,000.

Any remaining benefit amount will be paid to the employee's, spouse's or registered domestic partner's **designated beneficiary** upon his or her death.

Extraterritorial Information

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52844.**

Limitations and Exclusions

Benefits for **part-time employees** will be calculated using their pay for a standard number of hours worked per week.

Leidos Benefits Summary Plan Description

Group Universal Life (GUL) Insurance

Employees can purchase an added measure of protection for themselves through Prudential. Group Universal Life (GUL) Insurance provides benefits that go beyond term life insurance. GUL helps protect your family and builds a secure financial future.

Coverage Options

Group Universal Life (GUL) insurance pays a benefit if you die while covered. If you participate, you have the option to purchase either:

- Life insurance only, called GUL insurance; or
- GUL insurance and contribute to a cash accumulation fund that earns tax-deferred interest at a guaranteed minimum rate.

Employees can purchase GUL in amounts equal to 1, 2, 3, 4, 5, 6, 7, or 8 times their annual compensation, to a maximum of \$4 million. Any coverage purchased through GUL is in addition to Basic Term Life Insurance coverage.

Employees pay the full cost of coverage of Group Universal Life Insurance, which is purchased on an after-tax basis.

Delay in Effective Date

Your coverage under GUL will be delayed if you do not meet the Active Work Requirement on the day your insurance would otherwise begin. Instead, it will begin on the day that you meet the requirement. The same delay rule will apply to any change in your insurance if you do not meet the Active Work Requirement on the day on which that change would take effect.

Active Work Requirement is a requirement that you be actively at work at Leidos, or at any other place that Leidos requires you to go. You are considered actively at work during normal vacation if you were actively at work on your last regular scheduled workday.

Cash Accumulation Fund

In addition to providing a life insurance benefit for your loved ones, the GUL features a Cash Accumulation Fund that allows you to earn interest on a tax-deferred basis.

You can:

- **Earn guaranteed interest** - The Cash Accumulation Fund has a guaranteed interest rate that will never be less than 4 percent.
- **Keep it even after your employment with Leidos ends** - Insurance can continue at the full coverage amount up to age 100, on a direct-billed basis.
- **Enjoy tax benefits** - Earnings and interest credited on contributions to the Cash Accumulation Fund are tax-deferred. The death benefit (typically the face amount of insurance plus the Cash Accumulation Fund) is generally income tax-free to beneficiaries.

Leidos Benefits Summary Plan Description

- **Access funds easily** - You can take loans or make withdrawals from the cash accumulation fund at any time and for any reason. You can also use the Cash Accumulation Fund to pay premiums or purchase fully paid up coverage.
- **Qualify for special benefits if you become disabled or terminally ill** - Our Waiver of Premium provision for qualifying disabled employees and the Accelerated Benefit Option for terminally ill employees provide extra support when it's needed most.

If you elect to cancel coverage or withdraw from your Cash Accumulation Fund, you must complete the Owner Transaction Form.

Withdrawals

You can make a full or partial withdrawal from your cash accumulation fund for any reason. You can make up to 12 cash withdrawals per year. You can withdraw a minimum of \$200 (or your total balance, if your total balance is less than \$200). If you make a cash withdrawal, the cash accumulation fund will be reduced by the amount of that withdrawal.

The maximum partial withdrawal you can make is equal to your fund balance less any loan, loan interest and unpaid cost of premium due. If you make a partial withdrawal request for an amount greater than this, it will be treated as a full cash withdrawal.

Under current tax laws, the interest earned on your cash accumulation fund is not taxed until you withdraw more than your "cost basis." Generally, the cost basis is equal to your contributions made (including cost of insurance premium and contributions to your cash accumulation fund), less any untaxed portion of amounts previously withdrawn. Tax laws may change from time to time, so consult your tax advisor for information on taxability. To make a withdrawal, submit a written request to the Program Manager.

Loans

You may borrow up to the current value of your cash accumulation fund, subject to plan limitations. The minimum loan amount allowed under the plan is \$200. The maximum loan amount is 90% of your cash accumulation fund minus the cost of premium for one month of insurance. You will be charged up to 2% more than the interest rate earned. You may take one loan per year and only one loan can be in effect at any time.

You may repay all or part of your loan with interest by making payments directly to the Program Manager. You cannot repay a loan through payroll deductions.

Evidence of Insurability

When an employee enrolls for Group Universal Life (GUL) Insurance, he or she will be required to provide [evidence of insurability \(EOI\)](#) if he or she:

- Elects coverage in excess of (the lesser of) three times annual compensation or \$500,000 when first eligible to enroll;

Leidos Benefits Summary Plan Description

- Elects to increase coverage by more than one benefit level or any amount exceeding three times annual compensation during Open Enrollment or within 31 days of a qualified life event; or
- Elects to enroll for coverage after having waived coverage when first eligible

If the elected amount requires EOI, Prudential will either mail or email the required form and instructions for completion. Prudential may request that the employee complete a brief medical questionnaire. He or she may need to provide additional information.

Any evidence of insurability must be satisfactory to the plan's underwriter before coverage can be approved. The plan's underwriter uses standard underwriting rules and procedures for reviewing applications and has sole authority to approve or reject any application on the basis of health. Group Universal Life (GUL) Insurance coverage will be provided at the existing level while the decision on the covered person's evidence of insurability is pending.

Additional Benefits

Group Universal Life Insurance also pays additional benefits, including:

- **Accelerated Benefits** — If an employee becomes terminally ill and is not expected to live for more than 12 months, he or she may request an accelerated benefit equal to a maximum of 50% of his or her combined life insurance benefit (Basic Life Term Insurance and Group Universal Life (GUL) Insurance). The maximum accelerated benefit amount for Group Universal Life (GUL) Insurance is \$250,000.

Any remaining benefit amount will be paid to the employee's, spouse's or registered domestic partner's **designated beneficiary** upon his or her death.

Extraterritorial Information

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52844.**

Limitations and Exclusions

Group Universal Life (GUL) insurance will not be payable if the employee commits suicide within the first two years of being covered.

Benefits for **part-time employees** will be calculated using their pay for a standard number of hours worked per week.

Leidos Benefits Summary Plan Description

Optional Dependent Life Insurance

If employees elect Group Universal Life (GUL) Insurance, they can also elect to purchase Dependent Life Insurance for their [eligible dependents](#).

In no case may covered employees also be covered as dependents. Therefore, if you are married to another Leidos employee, you cannot be covered as both an employee and a dependent for Optional Life insurance (which includes Group Universal Life insurance).

In addition, your eligible dependent child(ren) can be covered by only one employee — so either you or your spouse (or domestic partner) may cover each dependent child.

- [Evidence of Coverage](#)

Spouse Life Insurance

Employees can purchase Spouse Life Insurance for their spouse or [registered domestic partner](#)*. Coverage is available for:

- \$10,000;
- \$25,000;
- \$50,000**;
- \$100,000**;
- \$150,000**;
- \$200,000**
- \$250,000**

** If you elect coverage to exceed the Guaranteed Issue, your spouse/domestic partner will be subject to EOI. Refer to [Evidence of Insurability](#) for more information.

Child Life Insurance

Employees can purchase Child Life Insurance for their eligible children, including their registered domestic partner's children*.

Coverage is available for:

- \$5,000;
- \$10,000
- \$25,000

*To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.

Leidos Benefits Summary Plan Description

Requirements for Dependent Coverage

On the date life insurance would otherwise be effective, if an eligible spouse, registered domestic partner or dependent child is:

- **an inpatient in a hospital, hospice, rehabilitation center, convalescence center, custodial care facility, or**
- **confined to his or her home under the care of a physician**

Then life insurance will become effective on the date he or she is no longer an inpatient in these facilities or confined at home.

Evidence of Insurability

When an employee enrolls for Optional Dependent Life Insurance, he or she will be required to provide **evidence of insurability (EOI)** if he or she:

- Elects Spouse Life coverage in excess of \$25,000 for his or her spouse or registered domestic partner when first eligible to enroll;
- Elects more than one level increase to Spouse Life coverage during a qualified life event or Open Enrollment

If the elected amount requires EOI, Prudential will either mail or email the required form and instructions for completion. Prudential may request that the spouse/domestic partner complete a brief medical questionnaire.

Any evidence of insurability must be satisfactory to the plan's underwriter before coverage can be approved. The plan's underwriter uses standard underwriting rules and procedures for reviewing applications and has sole authority to approve or reject any application on the basis of health. Dependent Life Insurance coverage will be provided at the existing level while the decision on the participant's evidence of insurability is pending.

Additional Benefits

Spouse Life Insurance also pays additional benefits, including:

- **Accelerated Benefits** — If an employee's spouse or registered domestic partner becomes terminally ill and is not expected to live for more than 12 months, he or she may request an accelerated benefit equal to a maximum of 50% of his or her Spouse Life Insurance benefit. The maximum accelerated benefit amount is \$250,000.

Any remaining benefit amount will be paid to the employee upon the spouse or registered domestic partner's death. (The employee is automatically the beneficiary for any covered dependent). For a covered person to qualify for an accelerated benefit, a doctor must certify his or her condition.

Leidos Benefits Summary Plan Description

Extraterritorial Information

IMPORTANT INFORMATION FOR RESIDENTS OF CERTAIN STATES: There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate. Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. **Your Access Code is 52844.**

Limitations and Exclusions

Spouse Life Insurance will not be payable if the spouse or registered domestic partner commits suicide within the first two years of being covered.

Leidos Benefits Summary Plan Description

Basic Accidental Death and Dismemberment (AD&D) Insurance

Basic AD&D insurance provides additional benefits to employees if they were to die or suffer dismemberment in an accident while employed by Leidos in an eligible fringe package.

How Basic AD&D Insurance Works

Eligible employees automatically receive coverage equal to one times their annual compensation, rounded to the next higher \$1,000. This is known as the "principal sum." The maximum Basic AD&D Insurance benefit is \$250,000.

Leidos pays the full cost of Basic AD&D Insurance.

- **Evidence of Coverage**

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the work performed as of the date of loss. It does not include earnings received as bonuses, overtime pay or other extra compensation.

Annual Compensation includes: A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid. **Commissions** will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

In the event of an employee's death, benefits will be paid to the employee's **beneficiary**. If an employee accidentally suffers dismemberment, the benefits will be paid directly to the employee. The chart below shows the benefit payments under the Basic AD&D Insurance plan:

Schedule of Benefits	
Basic Accidental Death and Dismemberment (AD&D) Insurance	
FOR THE LOSS OF:*	THE EMPLOYEE WILL RECEIVE:
<ul style="list-style-type: none">• Life• Two or more members• Loss of sight in both eyes• Loss of one hand or one foot and sight in one eye• Both upper and lower limbs (quadriplegia)**• Speech and hearing in both ears	100% of the principal sum

Leidos Benefits Summary Plan Description

<ul style="list-style-type: none"> • One member • Both lower limbs (paraplegia)** • Upper and lower limbs on one side of the body (hemiplegia)** • Loss of sight in one eye • Speech • Hearing in both ears 	50% of the principal sum
<ul style="list-style-type: none"> • Thumb and index finger of the same hand • All four fingers of the same hand • Loss of all toes of the same foot 	25% of the principal sum

*An employee's loss must occur within 365 days of the date of the accident. "Member" means hand, foot or eye. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total, permanent and irrevocable loss by natural, surgical or artificial means. "Loss of speech" means total, permanent and irrevocable loss of audible communication. "Loss of hearing" means total and permanent loss of hearing in both ears which cannot be corrected by any means. "Loss of a thumb and index finger" means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

** These injuries - or paralysees - mean the loss of use, without severance, of a limb. Such a loss must be determined by a doctor to be complete and not reversible.

Additional Benefits

Basic AD&D Insurance also pays additional benefits, including:

- **Monthly Coma Benefit** — If an employee is in a coma for at least 31 consecutive days as a result of an accident, a monthly coma benefit of 1% of the **principal sum** will be paid. This benefit will be paid until the employee's recovery, the 11th month of payment, or the employee's death, whichever is earliest.

If the employee dies while in a coma or remains comatose after 11 months of benefit payments, the plan will pay a lump sum to the employee's **beneficiary** equal to the principal sum.

- **Seat Belt(s) and Airbag Benefit** — If an employee dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile and he or she was wearing a seat belt, CIGNA will pay a seat belt benefit to the **designated beneficiary**.

The seat belt benefit will be at least \$1,000, to a maximum of 25% of the employee's benefit or \$25,000, whichever is less. An employee's beneficiary will receive the seat belt benefit if:

- The automobile the employee was driving/riding in was equipped with seat belts;
- The seat belt(s) was in actual use and properly fastened at the time of the covered accident; and

Leidos Benefits Summary Plan Description

- The position of the seat belt(s) was certified in the official report of the covered accident or by the investigating officer. A copy of the police accident report must be submitted with the claim. If certification is not available but it is clear that the employee was properly wearing a seat belt, CIGNA will pay the additional benefit. If, however, certification is not available and it is not certain that the employee was wearing a seat belt, then the benefit will be fixed at \$1,000.

Additionally, CIGNA will pay an additional 10% of the employee's benefit, to a maximum of \$12,500, if a seat belt benefit is payable to him or her, and he or she was positioned in a seat that was protected by a properly functioning, original, factory-installed supplemental restraint system (airbag) that inflates on impact.

Verification of the proper inflation of the supplemental restraint system at the time of impact must be part of the official accident report or be certified, in writing, by the investigating officers.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highway of any state or country. Automobiles include but are not limited to sedans, station wagons, sport utility vehicles, Jeeps, pickups, vans, campers or motor homes. Automobiles do not include mobile homes or motor vehicles used for mass or public transportation.

No benefit will be paid if the accident causing the employee's death occurred as a result of participation in a race, or a speed or endurance test.

- **Exposure** - If a covered person suffers a covered loss which results directly and independently of all other causes from unavoidable exposure to the elements following a covered accident, the accidental death and dismemberment benefit will be payable if a covered person suffers a covered loss which results directly and independently of all other causes
- **Disappearance** - If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the covered person was riding in the course of a trip which would otherwise be covered, it will be presumed that the covered person's death resulted directly and independently of all other causes and the principal sum will be paid.
- **Accidental Burn and Disfigurement Benefit** - If a covered person suffers a covered injury that leaves him/her disfigured, and that covered injury resulted directly and independently of all other causes from a covered accident, and the disfigurement satisfies the following conditions, then an accidental burn and disfigurement benefit will be paid.
 1. reconstructive or cosmetic surgery is required to restore the employee's physical abilities or correct Disfigurement, and must be performed within twelve months of the covered accident;

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2. a Physician must determine that the burn satisfies all of the following:
 - a. involves the minimum percentage shown below;
 - b. be classified as shown below; and
 - c. results in disfigurement or loss of physical abilities.

75-100% Body Disfigurement 100% of the Principal Sum

50-74% Body Disfigurement 50% of the Principal Sum

25-49% Body Disfigurement 10% of the Principal Sum

Burn Classification Third Degree

For purposes of this benefit: **Disfigurement or Disfigured** means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- **Carjacking Benefits**

If the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a carjacking of an automobile that the employee was operating, getting into or out of, or riding in as a passenger. A carjacking benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of \$25,000

Verification of the carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

- **Felonious Assault and Violent Crime Benefit**

If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The covered accident must occur while the covered person is on the business or premises of the Employer.

To qualify for benefit payment, the covered accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

The insurance company will pay a hospital stay benefit, subject to the following conditions and exclusions, when the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

1. the covered person is covered for hospital stay benefits under this Policy;
2. the hospital stay begins within 30 days of the violent crime/felonious assault;
3. the hospital stay is at the direction and under the care of a Physician;

Leidos Benefits Summary Plan Description

4. the covered person provides proof satisfactory to Cigna that his/her hospital stay was necessitated to treat covered injuries sustained in a covered accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the covered person's insurance is in effect.

A felonious assault/violent crime benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of \$25,000 as well as a hospital stay benefit of \$100 per day to a maximum benefit period of 365 days per hospital stay, per covered accident

- **Terrorism Benefits** — If a covered person suffers a covered loss caused directly and independently of all other causes while the victim of a Terrorist Act the amount payable is the Principal Sum multiplied by the percentage of the covered loss.

"Act of terrorism" refers to a hostile or violent act carried out by a group of persons having political, military or territorial goals, but who are not operating on behalf of a sovereign state. Their purpose is to compel an act or omission by any other person or any government entity.

- **War Risk Benefits** — If an employee suffers a loss of life or dismemberment due to war or an act of war, whether declared or undeclared, and such loss occurs within 365 days of the covered accident, benefits are payable. For more information about these benefits and any provisions, refer to the plan's certificate of coverage.

War risk benefits do not apply if the loss occurs in the United States or in any nation in which the employee is a citizen.

- **Brain Damage** — If a participant becomes brain damaged within 30 days and as a result of a covered accident, the plan will pay 100% of the principal sum. The participant must be hospitalized for treatment of the brain damage at least 7 of the first 30 days of the injury, and the brain damage must continue for at least 12 months.

If, after 12 months of continuous brain damage, a physician determines that the participant is permanently and totally disabled due to the brain damage, benefits will be paid in a lump sum at the beginning of the 13th month following the original date of the injury.

- **Rehabilitation** — If a participant suffers a covered loss due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of \$10,000, for covered rehabilitative expenses. Rehabilitative expenses must be incurred within two years of the covered accident.
- **Home Alterations and Vehicle Modifications** — If a participant suffers a covered loss, other than a loss of life, due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of \$10,000, for home alterations and vehicle modifications to accommodate the participant's injury.

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- **CIGNA Secure Travel**— Cigna Secure Travel is a comprehensive worldwide travel assistance program including pre-trip planning, assistance while traveling and emergency assistance. All of the program services are available when the covered person is traveling 100 miles or more from home. Services for medically necessary transport, return of dependent children, return of a traveling companion, visit of a family member/friend and repatriation of remains are covered by the program. Expenses for local ambulance or medical care are not covered under the program.

Limitations and Exclusions

Basic AD&D Insurance will not pay benefits for death or dismemberment resulting directly or indirectly from:

1. Intentionally self-inflicted Injury, suicide or any attempt thereof while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface as follows:
 - a. being flown by the covered person or in which the covered person is a member of the crew;
 - b. being used for crop dusting, spraying or seeding, giving and receiving flying instruction, fire-fighting, sky writing, sky diving or hang-gliding, racing, stunt or acrobatic flying; or
 - c. an ultra-light or glider;
 - d. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. Travel in any aircraft owned, leased or controlled by Leidos, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Leidos if the Aircraft may be used as Leidos wishes for more than 10 straight days, or more than 15 days in any year;
8. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;

Leidos Benefits Summary Plan Description

10. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Only one amount, the largest to which the employee is entitled, will be payable for all losses resulting from one covered accident.

Leidos Benefits Summary Plan Description

Voluntary Accidental Death and Dismemberment (VAD&D) Insurance Coverage

Employees can purchase additional accidental death and dismemberment insurance for themselves and their eligible dependents which:

- Pays a benefit to an employee's **designated beneficiary(ies)** if he or she dies in an accident
- Pays a benefit to an employee if the employee suffers a covered loss in an accident
- Pays a benefit to the employee if the employee's covered dependent(s) die or suffer a covered loss as a result of an accident.

Any coverage purchased through VAD&D Insurance is in addition to **Basic AD&D Insurance** coverage.

How Voluntary Accidental Death and Dismemberment (VAD&D) Insurance Works

There are two types of coverage under VAD&D Insurance:

- Employee coverage, which covers the employee only; and
- Family coverage, which covers the employee, the employee's spouse or registered domestic partner and/or their dependent children.

Employees pay the full cost of coverage of any VAD&D Insurance, which they purchase on a pre-tax basis.

Employee Coverage

Employees can purchase VAD&D Insurance in dollar increments of a factor times compensation benefit. Employees will be able to elect a coverage amount that best fits their needs in increments beginning at .5 time annual compensation, and increase in whole increments to 10 times annual compensation to a maximum of \$1,000,000.

- **Evidence of Coverage**

Important: "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the work performed as of the date of loss. It does not include earnings received as bonuses, overtime pay or other extra compensation.

Annual Compensation includes: A change in the amount of Annual Compensation is effective on the date of the change, if the Employer gives the Insurance Company written notice of the change and the required premium is paid. **Commissions** will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months.

Leidos Benefits Summary Plan Description

Dependent Coverage

Coverage for each dependent is equal to a percentage of an employee's VAD&D Insurance coverage amount as follows:

Dependent Coverage		
ELIGIBLE DEPENDENTS	PERCENTAGE OF EMPLOYEE COVERAGE	MAXIMUM DEPENDENT COVERAGE
SPOUSE OR REGISTERED DOMESTIC PARTNER ONLY (no eligible children)	60%	\$500,000
SPOUSE OR REGISTERED DOMESTIC PARTNER AND CHILD(REN)* <ul style="list-style-type: none"> • Spouse or Registered Domestic Partner • Each Child 	50%	\$500,000
CHILD ONLY (No eligible spouse or domestic partner)	10%	\$50,000
	25%	\$50,000

*To qualify for this benefit, a stepchild or registered domestic partner's child must reside with the Leidos employee.

Benefits Payments

Schedule of Benefits	
Voluntary Accidental Death and Dismemberment (VAD&D) Insurance	
FOR THE LOSS OF:*	THE EMPLOYEE WILL RECEIVE:
<ul style="list-style-type: none"> • Life • Two or more members • Both upper and lower limbs (quadriplegia)** • Loss of one hand or one foot and sight in one eye • Loss of sight in both eyes • Speech and hearing in both ears 	100% of the principal sum

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FOR THE LOSS OF:*	THE EMPLOYEE WILL RECEIVE:
<ul style="list-style-type: none"> • One member • Both lower limbs (paraplegia)** • Upper and lower limbs on one side of the body (hemiplegia)** • Loss of sight in one eye • Speech • Hearing in both ears 	50% of the principal sum
<ul style="list-style-type: none"> • Thumb and index finger of the same hand • All four fingers of the same hand • Loss of all toes on the same foot 	25% of the principal sum

*A covered person's loss must occur within 365 days of the date of the accident. "Member" means hand, foot or eye. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total, permanent and irrevocable loss by natural, surgical or artificial means. "Loss of speech" means total, permanent and irrevocable loss of audible communication. "Loss of hearing" means total and permanent loss of hearing in both ears which cannot be corrected by any means. "Loss of a thumb and index finger" means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

** These injuries - or paralyzes - mean the loss of use, without severance, of a limb. Such a loss must be determined by a doctor to be complete and not reversible.

Only one amount, the largest to which the covered person is entitled, will be payable for all losses resulting from one covered accident.

Additional Benefits

VAD&D Insurance also pays additional benefits, including:

- **Monthly Coma Benefit** — If a covered person is in a coma for at least 31 consecutive days as a result of an accident, a monthly coma benefit of 1% of the principal sum will be paid. This benefit will be paid until the covered person's recovery, the 11th month of payment, or the covered person's death, whichever is earliest.

If the covered person dies while in a coma or remains comatose after 11 months of benefit payments, the plan will pay a lump sum to the covered person's beneficiary equal to the principal sum.

Leidos Benefits Summary Plan Description

- **Seat Belt(s) and Airbag Benefit** — If a covered person dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile and he or she was wearing a seat belt, CIGNA will pay a seat belt benefit to the designated beneficiary. The benefit will be at least \$1,000, to a maximum of 25% of the covered person's benefit or \$25,000, whichever is less. A covered person's beneficiary will receive the seat belt benefit if:
 - the automobile the covered person was driving/riding in was equipped with seat belt;
 - The seat belt(s) was in actual use and properly fastened at the time of the covered accident; and;
 - The position of the seat belt(s) was certified in the official report of the covered accident or by the investigating officer. A copy of the police accident report must be submitted with the claim. If certification is not available but it is clear that the covered person was properly wearing a seat belt, CIGNA will pay the additional benefit. If, however, certification is not available and it is not certain that the covered person was wearing a seat belt, then the benefit will be fixed at \$1,000.

In the case of a child, "seat belt" means a child restraint — as required by state law and approved by the National Highway Traffic Safety Administration — that is properly secured at the time of the accident and is being used as recommended by its manufacturer for children of like age and weight.

Additionally, the insurance provider will pay an additional 10% of the covered person's benefit, to a maximum of \$12,500, if a seat belt benefit is payable to him or her, and he or she was positioned in a seat that was protected by a properly functioning, original, factory-installed supplemental restraint system (airbag) that inflates on impact.

Verification of the proper inflation of the supplemental restraint system at the time of impact must be part of the official accident report or be certified, in writing, by the investigating officers.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highway of any state or country. Automobiles include but are not limited to sedans, station wagons, sport utility vehicles, Jeep, pickups, vans, campers or motor homes. Automobiles do not include mobile homes or motor vehicles used for mass or public transportation.

No benefit will be paid if the accident causing the covered person's death occurred as a result of participation in a race, or a speed or endurance test.

- **Common Accident Benefit** — If a covered employee and his or her covered spouse or registered domestic partner die as a result of a common accident, the spouse's or registered domestic partner's benefit amount will increase to 100% of the employee's principal sum, to a maximum of \$500,000. "Common accident" means the same or separate accidents occurring within the same 24-hour period.

Leidos Benefits Summary Plan Description

- **Special Education Benefit** — If an employee elects family coverage, VAD&D Insurance will pay an additional benefit for education assistance, as follows:
 - For an employee's covered spouse or registered domestic partner: The plan will pay an additional 10% of the employee's principal sum, to a maximum of \$10,000, for up to three years when the spouse or registered domestic partner enrolls in any accredited school within one year of the employee's death. Enrolling in school must be for the purpose of retraining or refreshing skills needed for employment. The spouse or registered domestic partner must incur expenses that must be paid directly to, or approved and certified by, the same school.
 - For an employee's covered dependent children: The plan will pay an additional 10% of the employee's principal sum, to a maximum of \$10,000, for up to four consecutive years when the child enrolls as a full-time student before age 25. The school must be a college, university, or other institute of higher education. The expenses of higher education should be related to tuition, fees, books, room and board, and transportation, and must be paid directly to, or approved and certified by, the same school.

If the employee does not have a qualifying dependent for the Education and Training Benefit, \$1,000 will be paid to the employee's beneficiary.

- **Child Care Center Benefit** — If a covered employee dies as the result of a covered accident, the plan will pay child care center benefits for each covered dependent under age 13 equal to 10% of the employee's benefit amount, to a maximum of \$5,000 a year. The plan will pay benefits for five consecutive years, or until the child turns age 13, whichever happens first. To receive benefits, the covered child must be enrolled in a child care center on the date of the covered person's death or must enroll within 365 days after the covered person's date of death.

If, at the time of the accident, coverage for a dependent child is in force but there is no dependent who qualifies, the plan will pay a benefit of \$1,500 to the covered person's beneficiary.

"Child care center" means a facility that is licensed; is operated according to law, including laws and regulations applicable to child care facilities; and provides care and supervision for children in a group setting on a regular daily basis. It does not include hospitals, the child's home or care provided during normal school hours while a child is attending grades one through twelve.

- **Increased Dependent Child Dismemberment Benefits** — If a covered employee's covered child suffers a covered accidental injury, the plan will pay double the benefit amount, to a maximum of \$100,000. If the child subsequently dies within 365 days of the same covered accident, the loss of life benefit will not be reduced by the dismemberment benefit received under the increased dependent dismemberment benefit.

If a covered child sustains more than one covered loss from a single covered accident, the plan will pay double the benefit amount only for the largest amount to which the child is entitled.

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- **Exposure** - If a covered person suffers a covered loss which results directly and independently of all other causes from unavoidable exposure to the elements following a covered accident, the accidental death and dismemberment benefit will be payable if a covered person suffers a covered loss which results directly and independently of all other causes
- **Disappearance** - If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the covered person was riding in the course of a trip which would otherwise be covered, it will be presumed that the covered person's death resulted directly and independently of all other causes and the principal sum will be paid.
- **Insurance Continuation Expense Benefit**

The insurance provider will pay 3% of the Employee's Principal Sum, up to a \$3,000 Maximum Benefit per year for up to a Maximum Benefit Period of 3 years, if a surviving covered Spouse or Registered Domestic Partner or a surviving covered Dependent Child elects to continue group medical and dental insurance provided by the Employer of an Employee who died, subject to all of the following conditions and exclusions:

 1. the covered Employee's death results directly and independently of all other causes from a Covered Accident;
 2. the covered Employee is survived by a covered Spouse or covered Dependent Child who were insured under this Policy on the date the Employee died;
 3. the covered Spouse or covered Dependent Child is also covered under a medical or dental plan sponsored by the Employer at the time of the covered Employee's death;
 4. the covered Spouse or covered Dependent Child notifies Us of his election, within 60 days of the covered Employee's death, to continue his existing coverage under group insurance plans sponsored by the Subscriber as permitted by state or federal continuation law.

This benefit, payable annually, equals premiums required to continue insurance described above, as long as the total of Insurance Continuation Benefits paid for a surviving Spouse or Registered Domestic Partner and/or Dependent Child does not exceed the Maximum Benefit. The benefit will be paid at the end of each year during which medical and dental insurance is continued, if this insurance provider receives a request for reimbursement and proof of premiums paid during that year. Benefits will continue to be paid until the earliest of the following dates:

1. the date a surviving Spouse or Registered Domestic Partner and/or surviving Dependent Child is no longer eligible to continue medical and dental insurance coverage;
2. the date Insurance Continuation Expense Benefits paid total the Maximum Benefit; and
3. the end of the Maximum Benefit Period.

Leidos Benefits Summary Plan Description

Benefits are payable to the surviving covered Spouse or Registered Domestic Partner, or the person who actually paid the premium on the surviving covered Spouse's or Registered Domestic Partner's or Dependent Child's behalf, if other than the surviving covered Spouse or Registered Domestic Partner.

- **Accidental Burn and Disfigurement Benefit** - If a covered person suffers a covered injury that leaves him/her disfigured, and that covered injury resulted directly and independently of all other causes from a covered accident, and the disfigurement satisfies the following conditions, then an accidental burn and disfigurement benefit will be paid.
 1. reconstructive or cosmetic surgery is required to restore the employee's physical abilities or correct Disfigurement, and must be performed within twelve months of the covered accident;
 2. a Physician must determine that the burn satisfies all of the following:
 - a. involves the minimum percentage shown below;
 - b. be classified as shown below; and
 - c. results in disfigurement or loss of physical abilities.

75-100% Body Disfigurement	100% of the Principal Sum
50-74% Body Disfigurement	50% of the Principal Sum
25-49% Body Disfigurement	10% of the Principal Sum
Burn Classification	Third Degree

For purposes of this benefit: **Disfigurement or Disfigured** means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- **Carjacking Benefits**

If the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a carjacking of an automobile that the employee was operating, getting into or out of, or riding in as a passenger. A carjacking benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of \$25,000

Verification of the carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

- **Felonious Assault and Violent Crime Benefit**

If a covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The covered accident must occur while the covered person is on the business or premises of the Employer.

Leidos Benefits Summary Plan Description

To qualify for benefit payment, the covered accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

The insurance company will pay a hospital stay benefit, subject to the following conditions and exclusions, when the covered person suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

1. the covered person is covered for hospital stay benefits under this Policy;
2. the hospital stay begins within 30 days of the violent crime/felonious assault;
3. the hospital stay is at the direction and under the care of a Physician;
4. the covered person provides proof satisfactory to Cigna that his/her hospital stay was necessitated to treat covered injuries sustained in a covered accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the covered person's insurance is in effect.

A felonious assault/violent crime benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of \$25,000 as well as a hospital stay benefit of \$100 per day to a maximum benefit period of 365 days per hospital stay, per covered accident

- **Terrorism Benefits** — If a covered person suffers a covered loss caused directly and independently of all other causes while the victim of a Terrorist Act the amount payable is the Principal Sum multiplied by the percentage applicable to the covered loss.

"Act of terrorism" refers to a hostile or violent act carried out by a group of persons having political, military or territorial goals, but who are not operating on behalf of a sovereign state. Their purpose is to compel an act or omission by any other person or any government entity.

- **CIGNA Secure Travel** — Cigna Secure Travel is a comprehensive worldwide travel assistance program including pre-trip planning, assistance while traveling and emergency assistance. All of the program services are available when the covered person is traveling 100 miles or more from home. Services for medically necessary transport, return of dependent children, return of a traveling companion, visit of a family member/friend and repatriation of remains are covered by the program. Expenses for local ambulance or medical care are not covered under the program.
- **Brain Damage** — If a covered person becomes brain damaged within 30 days and as a result of a covered accident, the plan will pay 100% of the principal sum. The covered person must be hospitalized for treatment of the brain damage at least 7 of the first 30 days of the injury, and the brain damage must continue for at least 12 months.

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If, after 12 months of continuous brain damage, a physician determines that the covered person is permanently and totally disabled due to the brain damage, benefits will be paid in a lump sum at the beginning of the 13th month following the original date of the injury.

- **Rehabilitation** — If a covered person suffers a covered loss due to an accident, the plan will pay a benefit equal to 20% of the principal sum, to a maximum of \$10,000, for covered rehabilitative expenses. Rehabilitative expenses must be incurred within two years of the covered accident.
- **Bereavement/Trauma Counseling** — If a covered person suffers a covered loss, the plan will pay a benefit for bereavement and trauma counseling equal to \$150 per session for a maximum of 10 sessions. The covered person and/or his or her immediate family members are eligible.
- **Home Alterations and Vehicle Modifications** — If a covered person suffers a covered loss, other than a loss of life, due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of \$10,000, for home alterations and vehicle modifications to accommodate the covered person's injury.

Limitations and Exclusions

VAD&D Insurance will not pay benefits if a loss results, directly or indirectly, from or is caused by:

1. Intentionally self-inflicted Injury, suicide or any attempt thereat while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface as follows:
 - a. being flown by the covered person or in which the covered person is a member of the crew;
 - b. being used for crop dusting, spraying or seeding, giving and receiving flying instruction, fire-fighting, sky writing, sky diving or hang-gliding, racing, stunt or acrobatic flying; or
 - c. an ultra-light or glider;
 - d. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. Travel in any aircraft owned, leased or controlled by Leidos, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Leidos if the Aircraft may be used as Leidos wishes for more than 10 straight days, or more than 15 days in any year;
8. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;

Leidos Benefits Summary Plan Description

9. A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Leidos Benefits Summary Plan Description

Business Travel Accident Insurance

Business Travel Accident Insurance provides additional coverage for eligible employees traveling on Leidos-related business. Any benefits paid are in addition to [Basic Term Life Insurance](#) and [Basic AD&D Insurance benefits](#).

How Business Travel Accident Insurance Works

Employees automatically receive coverage equal to three times their annual compensation, to a maximum of \$500,000. This is known as the "principal sum."

Leidos pays the full cost of coverage.

- Important:** "Annual compensation" means an employee's annual wage or salary as reported by his or her employer for the worked performed as of the date of loss. It does not include earnings received as bonuses, overtime pay and other extracompensation. Commissions will be averaged for the 12 months just prior to the date the covered loss occurs, or the months employed, if less than 12 months

In the event of an employee's death while traveling on [Leidos-related business](#), benefits will be paid to the designated beneficiary. If an employee accidentally suffers dismemberment, the benefits will be paid directly to the employee. The chart below shows the benefit payments under the Business Travel Accident Insurance plan:

Schedule of Benefits	
Business Travel Accident Insurance	
FOR THE LOSS OF:*	THE EMPLOYEE WILL RECEIVE:
<ul style="list-style-type: none">LifeTwo or more membersBoth upper and lower limbs (quadriplegia)**Loss of one hand or one foot and sight in one eyeLoss of sight in both eyesSpeech and hearing in both ears	100% of the principal sum
<ul style="list-style-type: none">One memberBoth lower limbs (paraplegia)**Upper and lower limbs on one side of the body (hemiplegia)**Loss of sight in one eyeSpeechHearing in both ears	50% of the principal sum

Leidos Benefits Summary Plan Description

FOR THE LOSS OF:*	THE EMPLOYEE WILL RECEIVE:
<ul style="list-style-type: none"> • Thumb and index finger of the same hand • All four fingers of the same hand • Loss of all toes of the same foot 	25% of the principal sum

*An employee's loss must occur within 365 days of the date of the accident. "Member" means hand, foot or eye. "Loss of a hand or foot" means complete severance through or above the wrist or ankle joint. "Loss of sight" means total, permanent and irrevocable loss by natural, surgical or artificial means. "Loss of speech" means total, permanent and irrevocable loss of audible communication. "Loss of hearing" means total and permanent loss of hearing in both ears which cannot be corrected by any means. "Loss of a thumb and index finger" means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

**These injuries — or paralyzes — mean the loss of use, without severance, of a limb. Such a loss must be determined by a doctor to be complete and not reversible.

Defining Leidos-Related Travel

"Leidos-related travel" means that the employee is traveling on a required business trip away from where he or she is permanently assigned to work. Coverage will begin from the start of a planned trip. The employee may leave from his or her place of work, home or another location. Coverage ends upon the employee's return to his or her place of work or home, whichever occurs first. These benefits are subject to the conditions, limitations and exclusions of the policy.

Business-related travel does not include any commuting travel or time the employee is regularly commuting directly from his or her place of work to home, or vice versa.

Additional Benefits

Business Travel Accident Insurance also pays additional benefits, including:

- **Monthly Coma Benefit** — If an employee is in a coma for at least 31 consecutive days as a result of an accident, a monthly coma benefit of 1% of the principal sum will be paid. This benefit will be paid until the employee's recovery, the 11th month of payment, or the employee's death, whichever is earliest.

If the employee dies while in a coma or remains comatose after 11 months of benefit payments, the plan will pay a lump sum to the employee's beneficiary equal to the principal sum.

- **Seat Belt(s) and Airbag Benefit** — If an employee dies as a direct result of injuries sustained in a covered accident while driving or riding in an automobile and he or she was wearing a seat belt, CIGNA will pay a seat belt benefit to the designated beneficiary.

The benefit will be at least \$1,000, to a maximum of 25% of the covered person's benefit or \$25,000, whichever is less. An employee's beneficiary will receive the seat belt benefit if:

- The automobile the employee was driving/riding in was equipped with seat belts;

Leidos Benefits Summary Plan Description

- The seat belt(s) was in actual use and properly fastened at the time of the covered accident; and
- The position of the seat belt(s) was certified in the official report of the covered accident or by the investigating officer. A copy of the police accident report must be submitted with the claim. If certification is not available but it is clear that the employee was properly wearing a seat belt, CIGNA will pay the additional benefit. If, however, certification is not available and it is not certain that the employee was wearing a seat belt, then the benefit will be fixed at \$1,000.

Additionally, CIGNA will pay an additional 10% of the employee's benefit, to a maximum of \$12,500, if a seat belt benefit is payable to him or her, and he or she was positioned in a seat that was protected by a properly functioning, original, factory-installed supplemental restraint system (airbag) that inflates on impact.

Verification of the proper inflation of the supplemental restraint system at the time of impact must be part of the official accident report or be certified, in writing, by the investigating officers.

"Automobile" means a self-propelled, private passenger motor vehicle with four or more wheels that is of a type both designed and required to be licensed for use on the highway of any state or country. Automobiles include but are not limited to sedans, station wagons, sport utility vehicles, Jeeps, pickups, vans, campers or motor homes. Automobiles do not include mobile homes or motor vehicles used for mass or public transportation.

No benefit will be paid if the accident causing the employee's death occurred as a result of participation in a race, or a speed or endurance test.

- **Exposure** - If a covered person suffers a covered loss which results directly and independently of all other causes from unavoidable exposure to the elements following a covered accident, the principal sum will be paid.
- **Disappearance** - If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the employee was riding in the course of a trip which would otherwise be covered, it will be presumed that the employee's death resulted directly and independently of all other causes and the principal sum will be paid.
- **Brain Damage** — If a covered person becomes brain damaged within 30 days and as a result of a covered accident, the plan will pay 100% of the principal sum. The covered person must be hospitalized for treatment of the brain damage at least 7 of the first 30 days of the injury, and the brain damage must continue for at least 12 months.

If, after 12 months of continuous brain damage, a physician determines that the covered person is permanently and totally disabled due to the brain damage, benefits will be paid in a lump sum at the beginning of the 13th month following the original date of the injury.

Leidos Benefits Summary Plan Description

- **Rehabilitation** — If a covered person suffers a covered loss due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of \$10,000, for covered rehabilitative expenses. Rehabilitative expenses must be incurred within two years of the covered accident.
- **Home Alterations and Vehicle Modifications** — If a covered person suffers a covered loss, other than a loss of life, due to an accident, the plan will pay a benefit equal to 10% of the principal sum, to a maximum of \$10,000, for home alterations and vehicle modifications to accommodate the participant's injury.

- **Accidental Burn and Disfigurement Benefit**

If a covered person suffers a covered injury that leaves him/her disfigured, and that covered injury resulted directly and independently of all other causes from a covered accident, and the disfigurement satisfies the following conditions, then an accidental burn and disfigurement benefit will be paid.

1. reconstructive or cosmetic surgery is required to restore the employee's physical abilities or correct Disfigurement, and must be performed within twelve months of the covered accident;
2. a Physician must determine that the burn satisfies all of the following:
 - a. involves the minimum percentage shown below;
 - b. be classified as shown below; and
 - c. results in disfigurement or loss of physical abilities.

75-100% Body Disfigurement 100% of the Principal Sum

50-74% Body Disfigurement 50% of the Principal Sum

25-49% Body Disfigurement 10% of the Principal Sum

Burn Classification Third Degree

For purposes of this benefit: **Disfigurement or Disfigured** means spoiled or deformed appearance that can be corrected by means of reconstructive or cosmetic surgery.

- **Carjacking Benefit**

If the covered employee suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a carjacking of an automobile that the employee was operating, getting into or out of, or riding in as a passenger. A carjacking benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of \$25,000

Verification of the Carjacking must be made part of an official police report within 24 hours of the Carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within 24 hours or as soon as reasonably possible.

Leidos Benefits Summary Plan Description

- **Felonious Assault and Violent Crime Benefit**

If a covered employee suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid. The covered accident must occur while the covered employee is on the business or premises of the Employer.

To qualify for benefit payment, the covered accident must occur during any of the following:

1. actual or attempted robbery or holdup;
2. actual or attempted kidnapping;
3. any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

The insurance company will pay a hospital stay benefit, subject to the following conditions and exclusions, when the covered employee suffers a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a violent crime or felonious assault if all of the following conditions are met:

1. the covered employee is covered for hospital stay benefits under this Policy;
2. the hospital stay begins within 30 days of the violent crime/felonious assault;
3. the hospital stay is at the direction and under the care of a Physician;
4. the covered employee provides proof satisfactory to Cigna that his/her hospital stay was necessitated to treat covered injuries sustained in a covered accident caused solely by a violent crime or felonious assault;
5. the Hospital Stay begins while the covered employee's insurance is in effect.

A felonious assault/violent crime benefit of 10% multiplied by the percentage of the principal sum applicable to the covered loss will be paid, up to a maximum of \$25,000 as well as a hospital stay benefit of \$100 per day to a maximum benefit period of 365 days per hospital stay, per covered accident.

- **War Risk Benefits** — If an employee suffers a loss of life or dismemberment due to war or an act of war, whether declared or undeclared, and such loss occurs within 365 days of the covered accident, benefits are payable. For more information about these benefits and any provisions, refer to the plan's certificate of coverage.

War risk coverage does not apply if the loss occurs in the United States or in any nation in which the covered employee is a citizen.

- **CIGNA Secure Travel** — Cigna Secure Travel is a comprehensive worldwide travel assistance program including pre-trip planning, assistance while traveling and emergency assistance. All of the program services are available when the covered person is traveling 100 miles or more from home. Services for medically necessary transport, return of dependent children, return of a traveling companion, visit of a family member/friend and repatriation of remains are covered by the program. Expenses for local ambulance or medical care are not covered under the program.

Leidos Benefits Summary Plan Description

- **Personal Deviation** — If an employee suffers a loss of life or dismemberment due to an accident while outside the employee's city of permanent assignment which occurs seven days before or seven days after a scheduled business trip, and such loss occurs within 365 days of the covered accident, benefits are payable. For more information about these benefits and any provisions, refer to the plan's certificate of coverage.

Limitations and Exclusions

Business Travel Accident Insurance will not pay benefits resulting from:

1. Intentionally self-inflicted Injury, suicide or any attempt while sane or insane;
2. Commission or attempt to commit a felony or an assault;
3. Commission of or active participation in a riot or insurrection;
4. Declared or undeclared war or act of war;
5. Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface as follows:
 - a. being flown by the covered person or in which the covered person is a member of the crew;
 - b. being used for crop dusting, spraying or seeding, giving and receiving flying instruction, fire-fighting, sky writing, sky diving or hang-glider, racing, stunt or acrobatic flying; or
 - c. an ultra-light or glider;
 - d. designed for flight above or beyond the earth's atmosphere;
6. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
7. Travel in any aircraft owned, leased or controlled by Leidos, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Leidos if the Aircraft may be used as Leidos wishes for more than 10 straight days, or more than 15 days in any year;
8. Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
9. A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Only one amount, the largest to which the employee is entitled, will be payable for all losses resulting from one covered accident.

Leidos Benefits Summary Plan Description

The total amount the plan will pay as the result of any one accident is \$20 million. If multiple employees are involved in a single accident and their claims for benefits total more than \$20 million, the employee's benefit will be determined using the following formula: \$2 million divided by the total amount claimed by all employees. The result of applying this formula will be a percentage, and the employee's benefit will be this percentage of the amount he or she originally claimed.

Naming a Beneficiary for Life and AD&D Insurance

An employee can name any person or persons* as beneficiary(ies) for his or her [Basic Term Life Insurance](#), [Group Universal Life \(GUL\) Insurance](#), [Basic AD&D Insurance](#), [VAD&D Insurance](#) and [Business Travel Accident Insurance](#) by accessing the Leidos Human Resources System, Workday. If the employee wishes to name a minor (under age 18 in most states) or a trust as beneficiary, the employee should obtain legal advice, since special rules may apply.

The beneficiary the employee designates for these coverages may be different for each plan Leidos offers. The employee may change his or her beneficiary (ies) at any time via Workday.

If you fail to designate your beneficiaries with Leidos, your benefits will be paid based on the preferential beneficiary designation clause at the time of a claim. This means that any amount of insurance for which there is no beneficiary at your death will be payable to the first of the following:

- Your surviving spouse
- Your surviving child(ren), in equal shares or if none
- Your surviving parents, in equal shares or if none
- Your surviving siblings, in equal shares or if none
- Your estate

The employee is automatically the beneficiary for any covered dependents.

*Community Property Laws – If you are married and reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin) and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Continuing Life and AD&D Insurance After Coverage Ends

When an employee leaves Leidos or transfers to an ineligible class, he or she may be able to continue his or her life and AD&D coverage through individual policies.

Basic Term Life Insurance

An employee may port or convert his or her Basic Term Life Insurance coverage to an individual life insurance policy issued by Prudential Insurance Company of America*. The employee must make this election within 31 days of losing coverage under the Leidos group plan. No medical examination or other evidence of insurability will be required for conversion. However, evidence of insurability is required for portability. The employee pays the cost of coverage directly to the insurer.

*Portability is not available if coverage ends due to retirement or disability or for Basic Dependent Life coverage.

Group Universal Life (GUL) Insurance

An employee may **continue** his or her Group Universal Life (GUL) Insurance coverage by making an election within 31 days after the date of leaving employment with Leidos. No medical examination or other evidence of insurability is required for continuation of Group Universal Life (GUL) Insurance.

Optional Dependent Life Insurance

An employee may port or convert his or her spouse's or registered domestic partner's coverage, as well as any child life coverage, to individual policies. An employee must port his or her life insurance in order for any dependents to be eligible to port. The exceptions to this rule are death of employee or divorce.

In the event of the employee's death, both the spouse life and child life can be ported. In the event of divorce, the spouse life can be ported.

Spouses or Registered domestic partners may continue Spouse Life coverage up to the amount he or she was eligible for prior to losing coverage.

In addition, a dependent age 26 years or older who loses eligibility for Child Life Insurance may continue all or a portion of his or her coverage. He or she must submit an application within 31 days of losing coverage under the Leidos group plan.

Leidos Benefits Summary Plan Description

To continue Dependent Life Insurance, you must complete an application and apply within 31 days of your coverage termination. To obtain an application, please contact Prudential at 1-800-778-3827. Please provide the contract number 52844 when calling. If you are using a telecommunications device for the hearing impaired (TDD), please call 1-800-496-1214. Representatives are available to assist you Monday through Friday between 8:00 a.m. and 8:00 p.m.

Separate certificates of insurance will be issued for an employee's spouse or registered domestic partner and/or dependents. The employee and/or dependent pay the full cost of any continued coverage directly to The Prudential Insurance Company of America.

Basic AD&D Insurance and VAD&D Insurance

If an employee is age 69 or younger, his or her **Basic AD&D Insurance** and **VAD&D Insurance**, as well as the policies covering the employee's dependents, can be converted to an individual policy through Life Insurance Company of North America. The employee pays the full cost of coverage directly to Life Insurance Company of North America.

Leidos Benefits Summary Plan Description

Life Insurance Continuation (Portability)/Conversion

The information on this page will help you determine which life insurance plans you can continue (port) and which ones are eligible for conversion only. On the [matrix](#) below select the scenario that most closely describes your situation and read the options that are available to you.

Continuation/Conversion Matrix

Life Insurance Continuation/Conversion Matrix					
Reason Coverage Ends	Group Term Life	Group Universal Life	Optional Dependent Life	Basic AD&D	Voluntary AD&D
	Portability*	Continuation*	Portability	Conversion	Conversion
Employee Terminates Employment	Yes, to age 80 [^]	Yes, to age 100	Yes, to age 80	Yes, to age 70	Yes, to age 70
Employee loses eligibility and is no longer in an eligible class under the group policy	Yes, to age 80 [^]	Yes, to age 100	Yes, to age 80	Yes, to age 70	Yes, to age 70
Spouse no longer eligible due to divorce/legal separation	N/A	N/A	Yes, to age 80	N/A	Yes, to age 70
Spouse loses coverage to due to employee reaching age 70	N/A	N/A	N/A	N/A	Yes, to age 70
Child loses coverage due to ineligibility (No longer a dependent child of the employee)	No	N/A	Yes, able to convert policy	N/A	Yes
Employee loses a portion of coverage and still in an eligible class under the group policy due to:					
- Reduction in hours	No	No	No	No	No
- Age Reduction Schedule (35% at age 70)	No	No	No	No	No
* If you are losing coverage due to retirement or disability, you will be offered the option to convert your basic life coverage.					
[^] Coverage is limited to age 80					
** Conversion option is also available for GUL plan. For more information, contact Prudential at 1-877-889-2070					

Leidos Benefits Summary Plan Description

Important Information

1. The cost to convert/continue the life insurance products is based on the insurance company's standard group rates and will differ from the rate employees currently pay
2. An insured will remit premiums directly to CIGNA
3. An insured cannot port and convert the same group policy
4. Ported insurance is a group term policy issued by CIGNA
5. Converted insurance is an individual whole life policy and is used to continue coverage for individuals who lose a portion or all coverage under the active group policy
6. Age Restrictions
 - A. Ported life insurance terminates at age of 80
 - B. Converted AD&D insurance terminates at age 70
7. Conversion and/or portability application must be submitted in writing within 31 days of the date coverage ends
 - A. Employee portion of application should be completed and submitted to the address indicated on the form by the individual seeking coverage
 - B. The insurance company or one of its service providers will contact Leidos for the employer data
 - C. The insurance company will issue new policy(ies), which becomes effective 31 days after active coverage ends
 - D. Evidence of Insurability (EOI) is not required if life insurance is converted/continued within the specified time period. However, EOI is required to port Employee Basic Life Insurance.

Conversion/Continuation Forms

- **[Group Term Life Conversion Form](#)**
This form should be completed if employee would like to convert all or a portion of the terminating coverage to an individual policy (subject to conversion amount limitations).
- **[Group Term Life Portability Form](#)**
This form should be completed if an employee would like to convert all or a portion of the terminating coverage to an individual policy (subject to conversion amount limitations).
- **[Accidental Death and Dismemberment \(AD&D\) Conversion Form](#)**
This form should be completed if employee would like to convert all or a portion of the terminating coverage to an individual policy (subject to conversion amount limitations).

Leidos Benefits Summary Plan Description

Filing Claims

If an employee or a covered dependent dies or is seriously injured, the appropriate insurance company should be notified immediately.

Submit Basic Life, Dependent Life and Group Universal Life (GUL) Insurance claims to:

The Prudential Insurance Company of America

P.O. Box 8517
Philadelphia, PA 19176
1-888-257-0412 (phone)
1-888-227-6764 (fax)

Submit Accidental Death & Dismemberment claims to:

Life Insurance Company of North America

Life Claims
P.O. Box 22326 Pittsburg,
PA 15222-0326 1-800-
238-2125 (phone) 1-412-
402-3506 (fax)

After receiving notification, the insurer will process the claim for payment of benefits. All claims for benefits must be made by filing a properly completed form. If the claim is for a death benefit, a death certificate must be furnished along with the claim form.

If a covered person has concerns about how a claim has been administered or wishes to appeal a claims decision, information on relevant procedures is available in "[Claims Appeal and Review Procedures Under ERISA](#)" in the Plan Information section.

Leidos Benefits Summary Plan Description

Disability Program

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

- [Short-Term Disability](#) (STD) benefits; and
- [Long-Term Disability](#) (LTD) benefits.

Important: Please note that this summary is not a legally binding summary plan description for disability plans insured by organizations other than Leidos, such as the Hawaii and New York state plans. See the plan documents for those plans for more detailed information.

Short-Term Disability (STD)

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

- [Disability Sick Leave](#) (DSL)
- [Voluntary Short-Term Disability Insurance](#) (VSDI)
- [Leidos Private California Short-Term Disability Insurance](#) (Leidos CASDI)
- [Other State-Mandated Short-Term Disability Plans](#), including:
 - [California State Disability Insurance](#)*
 - [Hawaii Short-Term Disability](#)
 - [New Jersey Temporary Disability Insurance](#)
 - [New York Voluntary Disability Plan](#)
 - [Puerto Rico Temporary Disability Insurance](#)
 - [Rhode Island State Temporary Disability Insurance](#)

* All Leidos employees living in California, excluding those working at Varec & BD Systems are automatically covered by Leidos' Private California Short Term Disability program (Leidos CASDI). Leidos employees working for certain subsidiaries in California locations are covered by the State of California SDI program. If you are unsure of which plan you participate in, contact the Leidos Payroll Help Desk.

Leidos Benefits Summary Plan Description

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

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

- **Active Pay Status** — is defined as 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 LWOP, or receiving disability benefits (DSL, SDI, VSDI, or LTD).
- **Claims Administrator** — The organization that is accountable for receiving the participant's application, determining which benefits are payable and ensuring that payments are made:
 - For DSL, VSDI and Leidos' private CASDI, [Sedgwick CMS](#) administers the plans.
 - For the Hawaii state disability plan, Life Insurance Company of North America administers the plan.
 - For the New Jersey, New York, Rhode Island, and Puerto Rico state disability plans, the respective states administer the plans.
- **Hospital Confinement** — "Hospital Confinement", is defined as any 24 hour period of time, or any part thereof, for which a Claimant is properly charged a full day's rate for room and board as a registered bed patient in a hospital, or in a nursing home. Emergency Room Visit, Outpatient Surgery and 23-Hour Hospital Stay is excluded.
- **Physician** – Includes physicians and surgeons holding an M.D. or D.O. degree, psychologists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by state law and acting within the scope of their practice as defined by state law. For Disability related to normal pregnancy or childbirth, medical certification may be provided by a midwife or nurse practitioner.
- **Psychologist** – is defined as a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two (2) years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.
- **Qualified Disability** — A disability that has been certified by a physician or other health care provider, based on objective medical evidence, and subsequently reviewed and approved by the claims administrator. Each plan may have different definitions as to what types of conditions are disabling (for example, some state plans differ from the private insurance plans). Keep in mind that not all disabilities will be approved.

Leidos Benefits Summary Plan Description

In general, under most short-term disability plans, a person is considered disabled when he or she:

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

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

- **Recurring Disability** — Recurring Disability shall mean two or more intervals of Disability, due to the same cause or condition, separated by less than 31 days of continuous active work with the Company, shall be considered the same Disability. A new waiting period will not be required. For purposes of calculating the Claimant's amount of benefits under the Plan, regular wages as of the date of the original onset of Disability shall be used.
- **Regular Wages**
 - With respect to Regular, Full-time Employees, regular wages shall mean the scheduled base salary amount of Compensation excluding overtime, shift differential pay, bonuses, commissions, and stock transactions in effect during the last completed payroll period immediately prior to the date of commencement of the Employee's Disability.
 - With respect to all Part-time Employees, regular wages shall mean the average weekly Compensation paid by the Company excluding overtime, shift differential pay, bonuses, commissions, and stock transactions during the previously completed 12-week period prior to the date of commencement of the Employee's Disability.

Important: For all plans (except DSL and VSDI), this document provides only a summary of general plan provisions. Separate documents are available from the plan administrators, which serve as the legal documents that govern those plans.

Leidos Benefits Summary Plan Description

Overview of the Short-Term Disability (STD) Plans

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

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

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

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

The STD Program components are outlined below:

STD Program Components				
PLAN	WHO IS COVERED?	WHO PAYS FOR COVERAGE?	WHEN DOES IT BEGIN?	HOW LONG DOES IT LAST?
<u>DSL</u>	Those in benefit-eligible fringe packages	Leidos	On the 8th calendar day, except when hospitalized	For a maximum of 180 days or upon exhaustion of benefits in accordance with plan limits
<u>VSDI</u>	Only those who enroll	The participant	On the 8th calendar day, except when hospitalized	Until the end of the qualified disability, to a maximum of 180 days
<u>Leidos CASDI</u>	California employees who are eligible and automatically enrolled in this plan	The participant	On the 8th calendar day of disability	Until the end of the 52nd week of a qualified disability; or after the participant has exhausted his or her 52-week benefit amount, if part-time

Leidos Benefits Summary Plan Description

PLAN	WHO IS COVERED?	WHO PAYS FOR COVERAGE?	WHEN DOES IT BEGIN?	HOW LONG DOES IT LAST?
OTHER STATE LAWS	Employees in California who are not eligible for the Leidos CASDI program; all employees in Hawaii, New Jersey, New York, Puerto Rico and Rhode Island	Varies by state; usually both the participant and the employer	Varies by state	Varies by state

How Short Term Disability Works

How to File a Claim

If a participant becomes disabled, as defined by the Disability Program, he or she will need to take some specific steps to apply for benefits:

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

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

Leidos Benefits Summary Plan Description

How STD Benefits Are Paid

After a participant is certified as having a qualified disability, he or she receives STD benefits based on the length of his or her disability, his or her elected coverage (VSDI), DSL balance and any state benefits.

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

- **Weeks 1:** 7 calendar day waiting period unless hospitalized as **defined**;
- **Weeks 2 – 10:** Up to 100% of weekly wages to a maximum plan benefit;
- **Weeks 11 – 19:** Up to 80% of weekly wages to a maximum plan benefit;
- **Weeks 20 – 26*:** Up to 66 2/3% of weekly wages to a maximum plan benefit.

*If hospitalized as **defined**, the participant will receive:

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

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

- Disability benefits will be paid bi-weekly through Leidos' payroll system;
- The benefit amount will be reduced proportionately if a benefit is payable for less than a full week;
- Benefits are paid through the participant's bi-weekly paychecks, through direct deposit, if applicable, as long as the check is processed as part of the regular payroll cycle; Most payments are taxable (depending on the plan) and payroll deductions will continue to be made for medical, dental, vision, the Group Universal Life (GUL) Insurance Plan, and the Voluntary AD&D Insurance Plan.
- Participants on part time disability will have a one pay period delay in receiving their benefit payment.

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

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

Leidos Benefits Summary Plan Description

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

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

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

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

Pregnancy

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

Confidentiality

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

STD Claims Management

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

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

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

Leidos Benefits Summary Plan Description

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

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

Coordination among the STD Plans

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

- Social Security benefits (except family Social Security benefits) for any period of time during which disability benefits are paid. Once disability benefits begin, however, they will not be further reduced by any statutory increase in Social Security benefits. If the receipt of Social Security retirement benefits commenced prior to the Participant's Disability such benefits will not be offset
- Any benefits based on wages payable to the participant under any worker's compensation law;
- Disability benefits payable to the participant under any employer-sponsored group policy other than the Leidos disability plans;
- Disability benefits payable under any federal or state law;
- Any salary, income or sick pay from any employer or from self-employment.
- Retirement benefits, paid or due from a LEIDOS sponsored Pension Plan or Savings Plan offset net disability dollar for dollar paid during the disability. Any plan, fund or other arrangement, by whatever name called, providing disability benefits pursuant to any Compulsory Benefit Act or law of any government.
- Any government retirement or disability plan that is initiated or increased as a result of a Participant's Disability.
- Some portion of income or wages earned during rehabilitation employment; (refer to the individual plan's SPD or evidence of coverage for more information (excluding [DSL](#), [VSDI](#) and [Leidos CASDI](#)); and

Leidos Benefits Summary Plan Description

- Any financial settlement, award, benefit or other monetary recovery the participant receives — through litigation or otherwise — attributable in whole or in part to the negligence, the wrongful act or any other civil or criminal incident that resulted, in whole or in part, in the disease, illness, incapacity or injury that substantiates the disability claim. (This offset can be made for the entire amount of the third party recovery, regardless of whether it is attributable to lost wages, incurred medical expenses or punitive damages.)

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

When STD Benefits End

Returning to Work

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

When STD Benefit Payments End

STD benefits generally end when the participant:

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

For more information about when benefits end for all disability plans (excluding [DSL](#), [VSDI](#) and [Leidos CASDI](#)), refer to the plan's SPD or evidence of coverage.

Leidos Benefits Summary Plan Description

If the Participant Becomes Disabled Again

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

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

For more information about what happens when a participant becomes disabled again, refer to the plan's SPD or evidence of coverage (excluding [DSL](#), [VSDI](#) and [Leidos CASDI](#)).

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

Other plans, such as the state-mandated plans, have different maximum benefit durations.

What the STD Plans Generally Do Not Cover

The STD plans will not pay benefits for qualified disabilities that:

- Are not disabling (i.e., do not prevent the employee from doing his or her job);
- Were incurred during, or as a result of, engaging in a criminal act;
- Were incurred while on layoff or leave of absence (FMLA and similar protected leaves), severance, military leave, or any other status where the participant was not engaged in active employment with Leidos;
- Were incurred while on full time or part time long term disability,
- Were incurred while the employee was on unauthorized absence, or was not an employee;
- Were incurred as a result of service in any armed force, except as required by law.

Under the [DSL](#) and [VSDI](#) plans, benefits will also not be paid for qualified disabilities that:

- Are intentionally self-inflicted;
- Are incurred because the participant was not receiving care or following the prescribed treatment plan that is:
 - From a health care provider who's training and clinical experience are suitable for treating the disease, illness, incapacity or injury;

Leidos Benefits Summary Plan Description

- 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; and
- For the purpose of maximizing medical improvement; and
- Are filed more than 60 days after the qualified disability began.

For all plans, excluding the DSL, VSDI and Leidos CASDI plans, refer to the SPD or evidence of coverage provided by each plan's administrator for more information.

Disability Sick Leave (DSL)

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

A participant receives DSL hours on the first day of hire or transfer date into a benefit-eligible status. Thereafter, a participant receives DSL hours on his or her anniversary date. A participant receives up to 10 days (or 80 hours) of DSL each year. Participants can accumulate up to 1,560 hours, or 195 days, of DSL. Unused DSL hours are not payable upon termination. Employees scheduled to work less than 40 hours per week will receive a prorated number of DSL hours equivalent to two times their scheduled workweek on their DSL anniversary date.

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

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

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

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

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

Leidos Benefits Summary Plan Description

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

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

DSL benefits will terminate on the earliest of the following:

- On the end date of the pay period which marks the termination of employment;
- On the end date of the pay period in which an employee ceases to be eligible; or
- On the date of termination of the plan

DSL Benefit Limitations

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

- The participant is not an employee as defined in the plan;
- The participant is not in an employment status that is eligible for DSL;
- The disability leave is not supported by objective medical evidence from a treating physician or other health care provider and approved by the claims administrator;
- The participant has reached the 180 day maximum period under the claim;
- The participant is confined, pursuant to commitment, court order, or certification, in an institution, or other place, as a dipsomaniac, drug addict or sexual psychopath;
- The participant receives benefits or is eligible for benefits payable under any Unemployment Compensation Act of the United States or of any state during any period of disability leave;
- The participant receives wages from Leidos (excluding Paid Time Off pay) for any day. However, DSL benefits will be paid for any seven-day week or partial week, in an amount that does not exceed the participant's maximum weekly DSL benefit amount and which, when added to the wages received, does not exceed the participant's weekly wage, exclusive of the wages paid for overtime immediately prior to the commencement of the participant's qualified disability;
- The participant, for any day of unemployment or disability, receives or is entitled to receive benefits or cash payments for:
 - Temporary or permanent disability under a workers' compensation or employer liability law of this state or any other state, or of the federal government; or
 - A maintenance allowance, except when certain conditions are met;

Leidos Benefits Summary Plan Description

If the cash payments for temporary or permanent disability or a maintenance allowance, combined with permanent disability benefits, are less than the amount of the DSL benefit the participant would have received, the participant will be entitled to receive DSL disability benefits, reduced by the amount of such cash payments, if otherwise eligible; or

- The participant:
 - Is incarcerated in any federal, state, or municipal penal institution, jail, medical facility, public or private hospital, or in any other place because of a criminal conviction of a federal, state or municipal law or ordinance; or
 - Commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.
 - For any period of disability the participant records uncompensated time, overtime, bereavement, jury duty, voting, or holiday on his or her timecard.

Voluntary Short-Term Disability Insurance (VSDI)

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

VSDI benefits begin:

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

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

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

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

Leidos Benefits Summary Plan Description

VSDI Schedule

PERIOD OF DISABILITY	TOTAL PAY (From all Sources)	VSDI (Integrated with state plan, if applicable)	DSL PORTION
WEEK 1	0 (7 day waiting period)	0 (7 day waiting period)	0 (7 day waiting period)
WEEKS 2 – 10	100% of regular weekly wages	80% (to a maximum weekly benefit of \$4808)	20%, as available
WEEKS 11 – 19	80% of regular weekly wages	80% (to a maximum weekly benefit of \$3846)	20%, as available
WEEKS 20 – 26*	66 2/3% of regular weekly wages	80% (to a maximum weekly benefit of \$3202)	20%, as available

* Not to exceed 180 days

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

Example VSDI Schedule

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

* Not to exceed 180 days

** Based on DSL balance

Leidos Benefits Summary Plan Description

If hospitalized as **defined**, the participant will receive:

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

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

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

VSDI Benefit Limitations

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

- The participant is not an employee as defined in the plan;
- The participant is on long term disability on a full time or part time basis.
- The participant's disability is not supported by objective medical evidence provided by a physician or other health care provider stating a diagnosis, the medical facts within the physicians' or health care providers' knowledge, a conclusion with respect to the disability and an opinion with respect to the probable duration of the disability, and is not approved by the plan administrator;
- The disability leave exceeds the maximum duration of 180 days;
- The participant is confined, pursuant to commitment, court order, or certification, in an institution, or other place, as a dipsomaniac, drug addict, or sexual psychopath;
- The participant is eligible for benefits payable under any Unemployment Compensation Act of the United States or of any state;
- The participant receives wages from Leidos (excluding Paid Time Off pay), or any employer. However, VSDI benefits will be paid for any seven-day week or partial week, in an amount that does not exceed the participant's maximum weekly VSDI benefit amount and which, when added to the wages received, does not exceed the participant's weekly wage, exclusive of the wages paid for overtime immediately prior to the beginning of the participant's qualified disability;
- The participant, for any day of unemployment and disability, receives or is entitled to receive benefits or cash payments for:
 - Temporary or permanent disability benefit under a workers' compensation or employer liability law of this state or any other state, or of the federal government; or
 - A maintenance allowance, except when certain conditions are met;

If the cash payments of temporary or permanent disability or a maintenance allowances, combined with permanent disability benefits, are less than the amount of VSDI benefits the participant would have received, the participant will be entitled to receive, if otherwise eligible, VSDI benefits, reduced by the amount of the cash payments;

Leidos Benefits Summary Plan Description

- The participant:
 - Is incarcerated in any federal, state, or municipal penal institution, jail, medical facility, public or private hospital, or in any other place because of a criminal conviction of a federal, state or municipal law or ordinance;
 - Commits a crime and is disabled due to an illness or injury, caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction.
 - Commits an intentional self-inflicted injury while sane or insane.
 - Has an illness or injury due to any act of war, declared or undeclared, or insurrection, except while traveling overseas on Company business.
 - Has an illness or injury for which the Participant is not under the continuous care and treatment of a duly qualified licensed Physician.
 - 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.
 - For any period of disability the participant records uncompensated time, overtime, bereavement, jury duty, voting, or holiday on his or her timecard; or
- The employee is not actively at work on the day the coverage would have otherwise began.

Leidos Private California Short-Term Disability Insurance (Leidos CA VPDI)

Employees who work for a covered California Leidos organization are automatically enrolled in a special short-term disability insurance plan, the Leidos Private California State Disability Plan (Leidos CA V P D I). This excludes employees working for subsidiaries who are covered by the State of California SDI program.

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

Participants pay for coverage through contributions that are no higher than the contribution rate for the California State Disability Insurance Plan. These rates are established each year by the California Employment Development Department. For the 2019 plan year the contribution rate has been set at 1.0% percent of taxable wages. The maximum salary subject to this contribution is \$118,371. The maximum contribution is \$1,183.71 in 2019.

If a participant is enrolled in Leidos CA VPDI and is unable to work due to a qualified disability, the plan pays benefits equal to 55% of a participant's regular base wages. The current weekly maximum is \$1,252 per week (as of January 1, 2019). The weekly benefit maximum is set each year by the State of California. This is a calendar-day plan, so each day's benefit during a qualified disability is one-seventh of a participant's weekly benefit.

Leidos Benefits Summary Plan Description

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

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

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

If you have any questions about this Voluntary Plan or wish to withdraw from the Leidos Private CA VPDI plan contact Leidos Employee Services at 855-553-4367, option 3.

Leidos CA VPDI Benefit Limitations

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

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

Leidos Benefits Summary Plan Description

- Certification is not required if the participant submits evidence of receipts of temporary or permanent benefits under a workers' compensation law for any day for which he or she is entitled to receive disability benefits reduced by such temporary or permanent worker's compensation benefits;
- The participant is receiving unemployment benefits;
- The participant is receiving wages or regular wages from any employer, except that benefits will be paid for any week or partial week not to exceed the maximum weekly benefit amount which, when added to the wages or regular wages, does not exceed the participant's weekly regular wages prior to the beginning of the disability;
- The participant is confined by court order or certification as a dipsomaniac, drug addict or sexual psychopath;
- The participant has knowingly made a false statement or representation in order to receive any benefits under this plan;
- The participant is incarcerated because of a criminal conviction or he or she commits a crime and becomes disabled due to an illness or injury in any way caused by, or arising out of the commission of, arrest, investigation, or prosecution of any crime that results in a felony conviction; or
- The participant is receiving or is entitled to receive benefits or cash payments for temporary disability, vocational rehabilitation maintenance allowance or permanent disability benefits under workers' compensation law. However, if these benefits are less than the amount the participant would otherwise receive as benefits under this plan, he or she will be entitled to receive disability benefits reduced by the amount of these workers' compensation payments.

Benefits will be limited to the state plan rate for disabilities occurring during the extended coverage period following the beginning of a layoff without pay or a leave of absence without pay.

Other State-Mandated Short-Term Disability Plans

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

- California State Disability Insurance*;
- Hawaii Short-Term Disability;
- New Jersey Temporary Disability Insurance;
- New York Voluntary Disability Plan;
- Puerto Rico Temporary Disability Insurance; and
- Rhode Island State Temporary Disability Insurance.

Leidos Benefits Summary Plan Description

* Leidos employees working for certain subsidiaries in California locations are covered by the State of California SDI program. All other Leidos employees living in California are covered by the Leidos Private California Short Term Disability program. If you are unsure of which plan you participate in, contact Leidos Corporate Payroll Help Desk

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

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

Contact Information for State-Mandated Plans

For more detailed information about these state-mandated plans, contact a Human Resources representative or the following plan contacts below.

Contact Information for State-Mandated Plans

State Mandated Short-Term Disability	Contact Information
California State Disability Insurance	Employment Development Department 800 Capitol Mall Sacramento, California 95814 916-653-0707
Hawaii Short-Term Disability	ESIS P.O. Box 1639 7 Waterfront Plaza, Suite 400 Honolulu, HI 96806 800-779-6249 or 808-543-8303 ESIS 500 Ala Moana Blvd. Honolulu, Hawaii 96813 800-779-6249 or 808-543-8303 Life Insurance Company of North America 1601 Chestnut Street Philadelphia, Pennsylvania 19192-2235 800-732-1603

Leidos Benefits Summary Plan Description

New Jersey Temporary Disability Insurance	Division of Disability Insurance Service Department of Labor CN387 Trenton, New Jersey 08625 609-292-2681
New York Voluntary Disability Insurance	Disability Benefits Bureau Workers Compensation Bureau 180 Livingston Street Brooklyn, New York 11248-0005 800-353-3092
Puerto Rico Temporary Disability Insurance	Bureau of Employment Security Disability Insurance Program 505 Ave Munoz Rivera San Juan, Puerto Rico 00918-3514 797- 625-7900 or 787-754-5824
Rhode Island State Temporary Disability Insurance	Dept. of Labor and Training Temporary Disability Insurance 1511 Pontiac Avenue Cranston, Rhode Island 02920-4407 401-462-8740

Voluntary Long-Term Disability (LTD)

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

The LTD plan provides a monthly benefit of up to 60% percent of an employee's base monthly salary not to exceed \$14,500 per month. Employees enrolled in LTD pay 100 percent of the cost on an after-tax basis thereby providing a tax-free benefit when received.

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

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

- **Qualified Disability** — One where a participant cannot perform his or her own occupation in the first two years of disability. After two years of disability, a qualified disability is one where a participant is unable to perform any occupation that he or she is reasonably qualified to hold. Refer to the LTD evidence of coverage, issued by Life Insurance Company of North America (LINA), a CIGNA company, for more information on criteria for "own occupation" versus "any occupation."

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

- **Claims Administrator** — [Life Insurance Company of North America](#) (LINA), a CIGNA company.
- **Claims Fiduciary** — [Life Insurance Company of North America](#) (LINA), a CIGNA company.

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

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

Leidos Benefits Summary Plan Description

Overview of LTD Benefits

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

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

The following maximum benefit periods apply:

LTD Benefit Period

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

How LTD Works

What to Do in Case of a Long-Term Disability

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

To assist the employee in transitioning from short term to long term disability claim with CIGNA, 45 days prior to STD maximum duration:

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

Definition of Disability/Disabled

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

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

Leidos Benefits Summary Plan Description

How LTD Benefits Are Paid

If the participant is receiving benefits from the [LTD plan](#):

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

LTD Limitations and Exclusions

LTD benefits are provided based on certain maximums and exclusions. For more information, participants can also refer to "[What the LTD Plan Does Not Cover](#)."

Pre-Existing Conditions

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

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

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

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

Leidos Benefits Summary Plan Description

Benefit Maximums for Certain Conditions

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

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

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

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

The Plan Determines Eligibility and Certifies Disability

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

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

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

Confidentiality

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

LTD Claims Management

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

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

Continuation of Insurance

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

If a participant's active service ends due to an employer-approved unpaid leave of absence, insurance for that participant will continue for up to 24 months if the required premium is paid. If a participant's active service ends due to family medical leave of absence, insurance for that participant will continue for up to 12 weeks if the required premium is paid.

Rehabilitation During a Period of Disability

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

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

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

Leidos Benefits Summary Plan Description

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

Work Incentive Benefits

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

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

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

Survivor Benefit

The plan will pay a Survivor Benefit if a participant dies while monthly benefits are payable. The participant must have been continuously disabled for the survivor benefit waiting period before the first benefit is payable. These benefits will be payable for the maximum benefit period for Survivor Benefits.

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

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

Coordination With Other Benefits

Social Security Disability Benefits

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

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

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

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

Other LTD Benefits

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

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

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

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

When LTD Benefits End

Returning to Work

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

When LTD Benefit Payments End

LTD benefits end:

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

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

If a Participant Becomes Disabled Again

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

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

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

What the LTD Plan Does Not Cover

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

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

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

- Is incarcerated in a penal or corrections institution;
- Is not receiving appropriate care under a licensed physician;
- Fails to cooperate with the plan in the administration of the claim, such as providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due;
- Refuses to participate in rehabilitation efforts as required by the plan; or
- Refuses to participate in a Transitional Work Arrangement or other modified work arrangement.

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

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

Conversion Privilege

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

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

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

Leidos Benefits Summary Plan Description

Plan Information

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

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

Employee Retirement Income Security Act of 1974 (ERISA)

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

ERISA Rights Statement

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

Receive Information About Plan and Benefits

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

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

Continuation of Group Health Plan Coverage

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

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Participants' Rights

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

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

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

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

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

Assistance with Questions

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

Qualified Medical Child Support Orders (QMCSOs)

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

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Children’s Health Insurance Program (CHIP)

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

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

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

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

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

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

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ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005 Rev. Jan 2017	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075

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

For more information on special enrollment rights, contact either:

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

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

Claims Appeal and Review Procedures Under ERISA

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

- [Disability Plan Claims](#)
- [Non-Disability Welfare Plan Claims](#)

Please note: Participants enrolled in an [HMO](#) or a [CIGNA International Medical Plan](#) should also review the applicable medical plan documentation.

Disability Plan Claims

Claim Review

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

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

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

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

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

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

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

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

If a Claim Is Denied

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

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

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

Claims Appeal Procedure If a Claim Is Denied

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

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

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

Leidos Benefits Summary Plan Description

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

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

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

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

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

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

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

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

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

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

Non-Disability Welfare Plan Claims

Definitions

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

Leidos Benefits Summary Plan Description

Filing an Initial Claim

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

Insufficient Claims

Improperly Filed Pre-service Claims

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

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

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

Incomplete Urgent Care Claims

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

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

Leidos Benefits Summary Plan Description

Notice of Benefit Determination

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

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

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

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

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

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

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

Appeal of Adverse Decision

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

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

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

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

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

Important: Second Level of Appeal

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

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

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

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

Notice of Decision on Appeal

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

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

A Participant's Right to Information

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

Information is "relevant" information if it:

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

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

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

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

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

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

Certificates of Creditable Coverage

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

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

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

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Disclosure of Protected Information

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

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

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

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

Adding New Dependents

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

Continuing Health Care Coverage through COBRA

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

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

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Who Is Eligible for COBRA

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

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

When COBRA Coverage Will End

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

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

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

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

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

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

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

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

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

Privacy Notice

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

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

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

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

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

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

How the Plan May Use or Disclose Your Health Information

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

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

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

How the Plan May Share Your Health Information with Leidos

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

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

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

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

Other Allowable Uses or Disclosures of Your Health Information

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

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

Other Allowable Uses or Disclosures of Your Health Information

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

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Other Allowable Uses or Disclosures of Your Health Information

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

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

Your Individual Rights

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

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

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

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

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

Right to Receive Confidential Communications of Your Health Information

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

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

Right to Inspect and Copy Your Health Information

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

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

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

Leidos Benefits Summary Plan Description

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

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

Right to Amend Your Health Information that Is Inaccurate or Incomplete

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

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

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

Right to Receive an Accounting of Disclosures of Your Health Information

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

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

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

Leidos Benefits Summary Plan Description

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

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

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

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

Changes to the Information in this Notice

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

Complaints

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

Leidos

Attn: HIPAA Compliancy Department

11955 Freedom Dr.

Reston, VA 20190

Leidos Benefits Summary Plan Description

Contact

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

Health Plan Regulations

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

Breast Reconstruction Following a Mastectomy

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

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

Hospitalization in Connection with Childbirth

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

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

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

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

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

Leidos Benefits Summary Plan Description

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

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

Additional Information Regarding Coordination of Benefits

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

- [Releasing and Obtaining Information](#)
- [Subrogation](#)
- [Recovery of Overpayment](#)

Releasing and Obtaining Information

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

Subrogation

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

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

Leidos Benefits Summary Plan Description

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

Recovery of Overpayment

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

Leidos Benefits Summary Plan Description

Administrative Information

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

For a comprehensive contact information list, go to [Contact Information](#).

Medical Plans

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

Leidos Benefits Summary Plan Description

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

Leidos Benefits Summary Plan Description

Dental PPO Plan

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

Leidos Benefits Summary Plan Description

Vision Plans

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

Leidos Benefits Summary Plan Description

Life and AD&D Insurance Plans

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

Leidos Benefits Summary Plan Description

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

Leidos Benefits Summary Plan Description

Business Travel Accident Insurance

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

Leidos Benefits Summary Plan Description

Short-Term Disability Plan

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

Leidos Benefits Summary Plan Description

Long-Term Disability Plan

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

Leidos Benefits Summary Plan Description

Flexible Spending Accounts

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