NORTHROP GRUMMAN

Summary Plan Description

Northrop Grumman Health Plan

2026

Your Northrop Grumman Health Plan

At Northrop Grumman, our Health Plan is our shared commitment to your physical and financial health. The Health Plan is designed to offer you extensive benefit choices at competitive rates; the flexibility in choosing those benefits you want and need based on your personal situation; and the plans and services that help you make the most out of the benefit elections you make each year.

Information about the specific benefits, programs and services offered to eligible Northrop Grumman employees is described in this Summary Plan Description (SPD). Below is an overview of what is covered in this SPD:

- Plan provisions governing your health and welfare benefits – including eligibility, coverage levels and Plan guidelines;
- Health care coverage (medical, prescription drug, dental and vision plans);
- Tax-advantaged accounts (flexible spending accounts, health savings accounts), short- and long-term disability and life and accident insurance; and
- Additional benefits designed to assist you in the personal and professional areas of your life

Familiarize yourself with the SPD, as it should be your primary reference guide for, and will help you make the most out of, the Health Plan.

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Your Total Rewards

The total rewards you receive from Northrop Grumman are so much more than the dollar amount of your paycheck. It's your paycheck plus all the benefits, perks and services that you receive as a valued Northrop Grumman employee.

Explore the *Total Rewards Gateway* at **totalrewards.northropgrumman.com** to learn more about the benefits and opportunities available to you and your family.

If you log in to ***Total Rewards Gateway*,** you'll get access to more personalized information about your pay, benefits and services.

About this SPD

This Summary Plan Description (SPD) describes the main provisions of the Northrop Grumman Health Plan (also referred to as the "Health Plan" or "Plan") offered by Northrop Grumman Corporation ("Northrop Grumman" or "the Company"). The Plan is a component plan under the Northrop Grumman Corporation Group Benefits Plan.

Northrop Grumman reserves the right to amend, modify or terminate any and all parts of this Plan at any time and for any reason (subject to any relevant collective bargaining agreements). This summary is not a contract for, nor a guarantee of, present or continued employment between you and Northrop Grumman.

The information contained in this SPD is effective January 1, 2026.

Note: The benefits described in this SPD are offered to certain hourly and salaried employees of Northrop Grumman. This version of the SPD describes the benefits available for eligible Northrop Grumman employees and their dependents.

This SPD provides information about the Northrop Grumman Health Plan. Several medical and dental benefits, and all short-term disability, health reimbursement account and flexible spending account benefits provided under the Plan are provided on a "self-insured" basis. Other medical and dental benefits, and all vision, life, accidental death and dismemberment, business travel accident, group legal, voluntary hospital indemnity, voluntary critical illness, voluntary accident, Employee Assistance Program, and long-term disability benefits provided under the Plan are provided on an "insured" basis. For "insured benefits," premium payments are paid to an insurance company and the insurance company assumes financial responsibility for claims under the Plan. For "self-insured" benefits, no insurance company assumes financial responsibility for claims under the Plan. An insurance company may be hired to process claims under the Plan, but approved claims are paid out of the funds deposited to the trust maintained for the Plan (see **Specific Plan Facts** section for information about the trustee). Northrop Grumman and employee contributions are deposited in the trust and are used to pay benefits.

The self-insured benefits and some of the insured benefits provided under the Plan are described in detail in this document. Full details on the insured benefits provided under the Plan are described in detail in the coverage certificate or subscriber contract through which those benefits are provided. Those separate subscriber contracts are considered part of and must be read together with this summary plan description. This SPD contains the Plan rules regarding eligibility, participation, costs, and administration and other important information regarding the Plan that applies to all benefits, whether self-insured or insured.

Other than the dependent day care flexible spending account, the Plan benefits described in this document are subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). There are other benefits provided under the Plan not described in this document that are not subject to ERISA. Descriptions of those benefits can be found in annual enrollment materials and other benefit communications.

Questions?

If you have questions not answered in this SPD, contact the Northrop Grumman Benefits Center (NGBC).

Hours:

8:30 a.m. to midnight ET, Monday – Friday
(except most New York Stock Exchange holidays)

Phone:

U.S.: 800-894-4194

International: Dial the AT&T out-of-country access number, then 800-894-4194

TTY: 711

Information provided to you by the NGBC is for informational purposes only and is not, and should not be considered, part of the Northrop Grumman Health Plan or this guide and cannot modify the Plan or this guide. Accordingly, the terms of the Northrop Grumman Health Plan will govern, even if inconsistent with information provided by the NGBC.

Your Health Plan Resources

FIDELITY NETBENEFITS® AND THE NGBC

To learn more about the Health Plan and access your personalized benefits information, log on to *Fidelity NetBenefits* at **netbenefits.com/northropgrumman** or call the NGBC at 800-894-4194.

***Fidelity NetBenefits*: Your One-Stop Resources to Manage Your Benefits**

Fidelity NetBenefits is the place to manage your personalized benefits, including your Northrop Grumman savings and retirement plans, health and insurance plans and health savings accounts. Through the site, you're able to:

- Review your plan elections or make benefit changes
- View benefit plan information, such as Summaries of Benefits and Coverage, Summary Annual Reports, etc.
- Use the ALEX® benefits tool to help you choose your "best-fit" medical and/or dental plan based on your personal information

When you first access the site, you'll need to set up a user name and password. The same password is used when calling the NGBC. If you already have a Fidelity account, use your existing name and password.

Northrop Grumman Benefits Center

Benefits Center service representatives are available to assist you Monday through Friday (except for most New York Stock Exchange holidays) from 8:30 a.m. to midnight Eastern time (for most services). If you are calling from outside the United States, dial the AT&T out-of-country access number, then dial 800-894-4194. TTY service is available at 711.

Eligibility and Participation

This section contains basic information about your Northrop Grumman Health Plan — including: **Eligibility**, **How the Plan Works,** and **Enrolling In Your Benefits**.

For additional information or special requirements that apply to specific benefits, see the separate descriptions of each benefit in this SPD (for example, you can refer to the medical, long-term disability (LTD), flexible spending accounts (FSAs) or life and accident insurance sections for information specific to each of those benefits).

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the Plan if you meet all the requirements below:

- You are regularly scheduled to work 20 or more hours per week; and
- You are a United States citizen or legal resident; and
- You are either:
  - A non-represented hourly or salaried employee of a Northrop Grumman business unit that participates in the Plan, or
  - An eligible employee of a participating represented group that has bargained to participate in the Plan and you meet the eligibility requirements under the terms of the bargaining agreement.

Note: If you satisfy the eligibility requirements above, review the specific benefit descriptions that follow to determine whether you are eligible for the particular benefits described in each section. Some groups of employees are not eligible for all benefits under the Plan.

If you are a union employee, your eligibility for the Plan, participation in the Plan, and benefits available to you under the Plan are always subject to the terms of your collective bargaining agreement.

Questions?

If you have questions about eligibility for coverage under the Northrop Grumman Health Plan, call the Northrop Grumman Benefits Center (NGBC). Benefits Center service representatives are available to answer your questions.

Hours:

8:30 a.m. to midnight ET, Monday – Friday
(except most New York Stock Exchange holidays)

Phone:

U.S.: 800-894-4194

International: Dial the AT&T out-of-country access number, then 800-894-4194

TTY: 711

You are not eligible to participate in the Plan if you are:

- Classified by Northrop Grumman as an employee that is not benefits eligible, including a temporary employee, intern, or casual employee
- Employed at a Northrop Grumman entity that is not a participating employer in the Plan
- Classified by Northrop Grumman as an independent contractor
- A non-resident alien
- Covered by a non-participating bargaining unit
- Covered by certain contracts (refer to your human resources representative for details)
- A person hired by an outside agency (called a “job shopper” or “leased employee”)
- Not reported on Northrop Grumman payroll records as an employee

Note: If you fall into any of the categories listed above, you will not be eligible for coverage under the Northrop Grumman Health Plan unless and until you are later classified by Northrop Grumman as an eligible employee.

Dependent Eligibility

If you enroll in the Northrop Grumman Health Plan, you may be able to enroll or cover your eligible dependents as described below. It is your responsibility to make sure that the dependent you enroll meets the eligibility requirements and provide proof of their eligibility for the coverage (e.g., a marriage or birth certificate) when requested.

If, at any time after you enroll, your covered dependent no longer meets the eligibility requirements (e.g., divorce of a spouse, loss of legal guardianship appointment, or any other event that results in a loss of eligibility), you must notify the NGBC at 800-894-4194 immediately to terminate his or her coverage. If you or your dependent do not notify the NGBC in a timely manner, your dependent may lose their Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation rights, as described in the **COBRA Continuation Of Coverage** section.

By enrolling any person in the Northrop Grumman Health Plan, you state, represent, and agree to all of the following:

- You understand the eligibility requirements set forth below
- The person you enroll meets the eligibility requirements set forth below
- If the person ceases to meet the eligibility requirements you will immediately notify the plan administrator by calling the NGBC at 800-894-4194
- You understand that the plan administrator reserves the right to require you, as a condition of eligibility and at any time, to provide proof of eligibility of any person you enroll and you agree to provide the required proof within the time specified by the plan administrator
- You understand that meeting the eligibility requirements and providing required proof of eligibility are material conditions of enrollment and continued coverage under the Northrop Grumman Health Plan
- You understand that enrolling a person who does not meet the eligibility requirements, failing to notify the plan administrator immediately if a person ceases to meet the eligibility requirements, or refusing or failing to provide required proof of eligibility constitutes fraud or an intentional misrepresentation of material fact and is prohibited by the Northrop Grumman Health Plan
- If you refuse or fail to timely provide required proof of eligibility for a person, the plan administrator will cancel that person's coverage as of the date of enrollment or such other date as the plan administrator determines, in its sole discretion, to be appropriate

Note: If you enroll a person who does not meet the eligibility requirements, or if you fail to notify the plan administrator immediately if a person ceases to meet the eligibility requirements, or if you refuse or fail to timely provide required proof of eligibility for a person, you may be financially and legally responsible for all health care expenses incurred during the period of ineligibility and you may be subject to disciplinary action, including but not limited to termination of your and your dependents' coverage under the Plan, termination of your employment and criminal charges.

PROOF OF ELIGIBILITY

When you enroll your dependent(s) in the Northrop Grumman Health Plan, you will be required to provide documentation verifying their eligibility for coverage. You will receive detailed instructions from an independent, third-party administrator chosen to verify dependent eligibility. You may be asked to provide copies of legal documents, such as a government-issued marriage, birth or adoption certificate, domestic partnership affidavit or federal tax return.

If you do not promptly provide documentation sufficient to verify your covered dependent(s)' continued eligibility or if the administrator determines that any of the information you provide or provided regarding your covered dependents is untrue, incomplete or misleading, coverage for your dependent will end.

Additionally, you must provide the NGBC with the Social Security number for any dependents age 45 or older who are enrolled in your Northrop Grumman Health Plan medical coverage. If the NGBC does not have your covered dependent's Social Security number on file on their 45th birthday, coverage for your dependent will end. If you provide the NGBC with your covered dependent's Social Security number within 31 days of your covered dependent's 45th birthday, their medical coverage may be reinstated as of the date coverage was dropped. If you provide the NGBC with your covered dependent's Social Security number more than 31 days after your covered dependent's 45th birthday, their medical coverage may be reinstated as of the date their Social Security number is provided to the NGBC.

The following individuals are eligible as your dependents if they meet all of the stated requirements:

SPOUSE AND DOMESTIC PARTNER

Your Spouse

- This includes your common-law spouse only if common-law status is recognized in your state of legal residence. You will be required to submit a Declaration of Informal Marriage, an affidavit, marriage certificate, and/or other documents as required by the plan administrator.
- This does not include your divorced spouse, even if the separation agreement or divorce decree states that you must continue coverage. If the court orders you to provide coverage for your divorced spouse, you must arrange coverage on your own or through COBRA, as described in the **COBRA Continuation of Coverage** section.
- If your spouse works, please read **Special Provisions For Working Spouses (Or Eligible Domestic Partners)**
- If your spouse is retired, read **Special Provisions For Retired Spouses (Or Eligible Domestic Partners)**

Your Domestic Partner

- A domestic partner is an individual of the same sex or opposite sex who is your life partner and not your legal spouse. You and your domestic partner must meet all of the following requirements:
  - Be at least 18 years of age and not related to each other by blood by a degree of closeness that would prohibit marriage in your state of legal residence;
  - Not be married to anyone else and not be the domestic partner of anyone else;
  - Live together in the same permanent residence in an exclusive, emotionally committed, and financially responsible relationship similar to marriage for at least the last six months; and
  - Be each other's sole domestic partner and intend to remain so indefinitely.

  You will be required to submit a Domestic Partner Affidavit or other documents as required by the plan administrator.

OTHER ELIGIBLE DEPENDENTS

The following people are eligible for medical, dental and vision coverage as your dependents if they meet the requirements stated. To verify your dependent(s) eligibility, you will be required to provide proof of relationship (e.g., a copy of your dependent's birth certificate or adoption certification or a copy of the court order naming you as the child's legal guardian). For information on when their coverage ends, see **When Coverage Ends**. Different rules apply for purposes of optional life insurance coverage, optional accidental death and disability insurance, and group legal coverage for your dependents. Those rules are found in the **Life and Accident Insurance** or **Group Legal Plan** section.

Your Children

- Your biological child to the end of the month in which they turn age 26
- Your adopted child to the end of the month in which they turn age 26. A person is treated as your adopted child if:
  - You have legally adopted the person; OR
  - The person is lawfully placed with you for legal adoption.
- Your stepchild to the end of the month in which they turn age 26, but only while you are married to the child's biological or adoptive parent. A stepchild is the biological child or adopted child of your spouse but not of you.
- Your foster child to the end of the month in which they turn age 26. A foster child is a person who is placed with you:
  - By an authorized placement agency; OR
  - By judgment, decree, or other order of a court of competent jurisdiction.
- Your unmarried and disabled biological child, adopted child, stepchild, or foster child who is age 26 or older and meets **all** of the following requirements:
  - The child became disabled while the child was under the age of 26; and
  - You claim the child as a dependent on your federal tax return.

A Child for Whom You Are a Legal Guardian

- A child that you claim as a dependent on your federal tax return and for whom you, the Northrop Grumman employee, are the court-appointed legal guardian, up to the end of the month in which they turn age 26
- An unmarried and disabled child for whom you, the Northrop Grumman employee, are the court-appointed legal guardian, who is age 26 or older and meets **all** of the following requirements:
  - They became disabled when the child was under the age of 26; and
  - You claim the child as a dependent on your federal tax return.

Children of Your Domestic Partner

- The biological or adopted child of your domestic partner up to the end of the month in which they turn age 26

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A qualified medical child support order (QMCSO) is an order or judgment from a state court or administrative agency that satisfies certain requirements.

If you are subject to an order, the plan administrator notifies you and each affected child (or the child's representative) about the procedures that determine the validity of the order and how it will be implemented.

Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. After the plan administrator verifies that an order is a QMCSO, the plan administrator enrolls the child according to the terms of the order.

If a QMCSO requires the plan to provide coverage to your child, the plan administrator automatically may change your election under the plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of such judgment, decree or order if you desire, but only within 31 days of the event.

If the QMCSO requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child under the Northrop Grumman Health Plan if you provide proof to the plan administrator that such person actually provides the coverage for that child.

DISABILITY DEFINITION

Note: You will be required to submit an affidavit from the treating physician or other documents as required by the plan administrator to confirm a disability. The Plan considers a person to be disabled only if all of the following are true:

- they are unable to earn a living because of a mental or physical handicap;
- such mental or physical handicap is expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months; AND
- they are dependent on you for financial support.

Quantum Health, in its discretion, will make the determination as to whether a person is disabled under these criteria.

INELIGIBLE DEPENDENTS

Ineligible dependents include but are not limited to:

- The divorced spouse of an employee, even if the employee is required to provide coverage (COBRA coverage may be available on a temporary basis)
- The former domestic partner of an employee, once the partnership has been dissolved (COBRA-like coverage may be available on a temporary basis)
- Dependent children of an employee that exceed the maximum age (COBRA coverage may be available on a temporary basis)

SPECIAL PROVISIONS FOR WORKING SPOUSES (OR ELIGIBLE DOMESTIC PARTNERS)

If You Both Work for Northrop Grumman

If you and your spouse (or eligible domestic partner) work for Northrop Grumman, one spouse can cover both of you. Or, each spouse (or eligible domestic partner) can select separate coverage.

Only one parent may cover your eligible children for medical, dental, vision, life, and AD&D benefits (even if you are divorced or unmarried). You and your dependents **cannot** be covered twice under any plan (except for life insurance coverage, as noted below).

In the case of Life and AD&D coverage:

- You and your spouse (or eligible domestic partner) **cannot** both select employee plus family AD&D coverage. One spouse (or eligible domestic partner) may select optional employee AD&D coverage, and the other may select optional employee plus family AD&D coverage, but only one benefit would be paid in the event of the death of the spouse (or eligible domestic partner) who had chosen employee-only coverage.
- You and your spouse (or eligible domestic partner) **can** select optional spouse life insurance for one another, but only one of you may elect optional life insurance coverage for your eligible dependent children.

If Your Spouse (or Eligible Domestic Partner) Is Covered Under His or Her Own Employer's Plan

If you have a working spouse (or eligible domestic partner) who has enrolled in medical coverage through his or her own employer, you can enroll your spouse (or eligible domestic partner) in a Northrop Grumman medical plan option. However, claims for your spouse's (or eligible domestic partner's) medical care must first be submitted to his or her employer's plan because that plan is the primary payer. Then, once you

receive an explanation of benefits (EOB) from your spouse's (or eligible domestic partner's) plan (reflecting either the amount of payment or a denial), you can submit it along with your claim to your Northrop Grumman medical plan option claims administrator for reimbursement as a secondary payer.

For example, if your spouse's (or eligible domestic partner's) plan is an HMO but he or she goes to a non-HMO doctor, in most cases the claim would be denied by the HMO. However, you can submit both the claim and the EOB (which shows that your claim was denied by the HMO) to your Northrop Grumman medical plan option claims administrator for reimbursement, if eligible. Because the claim filing process may be time-consuming, your spouse (or eligible domestic partner) is strongly encouraged to obtain and utilize medical care through the plan provided by his or her employer.

SPECIAL PROVISIONS FOR RETIRED SPOUSES (OR ELIGIBLE DOMESTIC PARTNERS)

If you are an active employee and your spouse (or eligible domestic partner) is retired, special eligibility provisions apply.

If Your Spouse (or Eligible Domestic Partner) Is a Northrop Grumman Retiree

If your spouse (or eligible domestic partner) is a Northrop Grumman retiree, you have two options for your active employee medical coverage:

- You may cover your spouse (or eligible domestic partner) as your dependent under your active employee medical, dental, and/or vision plan options
- You can be covered under your active employee medical, dental, and vision plan options, and your spouse (or eligible domestic partner) can be covered under his or her retiree medical plan option, if eligible. (You may enroll your spouse (or eligible domestic partner) in your dental or vision plan option.)

If you are an active employee eligible for this Plan, you may not be covered as a dependent under your spouse's (or eligible domestic partner's) retiree medical plan option through Northrop Grumman.

If Your Spouse Is a Retiree of a Company Other Than Northrop Grumman

The chart below illustrates how your spouse's benefits are paid if:

- Your spouse is retired and enrolls in his or her company's retiree medical plan, if applicable, and
- You enroll your spouse as a dependent under an active employee medical plan option.

IF YOUR SPOUSE IS…	NORTHROP GRUMMAN'S ACTIVE MEDICAL PLAN OPTION PAYS…	YOUR SPOUSE'S RETIREE MEDICAL PLAN OPTION PAYS…	MEDICARE PAYS…
Under age 65 and not Medicare-eligible	First	Second	Not applicable
65 or over, or Medicare-eligible	First	Third	Second

Questions About Eligibility

If you have questions about eligibility for coverage under the Northrop Grumman Health Plan, call the NGBC at 800-894-4194.

HOW THE PLAN WORKS

Your Basic and Optional Benefits

The Northrop Grumman Health Plan includes two types of benefits: basic and optional. You automatically receive your "basic" benefits — you do not need to make any election to receive them. Northrop Grumman pays the full cost of your basic benefits. You can purchase additional benefits for yourself and your family. These are called "optional" benefits, and you need to make an election to receive them. You may also choose to set aside pre-tax dollars in the flexible spending accounts (FSAs) and/or a health savings account (HSA), if eligible.

BENEFIT OFFERING	NORTHROP GRUMMAN PAYS THE ENTIRE COST	NORTHROP GRUMMAN AND YOU SHARE THE COST	YOU PAY THE ENTIRE COST
BENEFIT TYPE	**BASIC**	**OPTIONAL**	
Medical / Prescription Drug		X	
Dental		X	
Vision			X
Flexible Spending Accounts			
• Health care FSA			X
• Dependent day care FSA			X
Health Savings Account*			X
NGCare/Employee Assistance Program	X		
Insurance Plans			
• Basic life insurance**	X		
• Basic accidental death and dismemberment insurance***	X		
• Business travel accident insurance	X		X
• Optional life insurance**			X
• Optional accidental death and dismemberment insurance***			
Disability **			
• Basic long-term disability insurance	X		
• Short-term disability insurance	X		
• Optional long-term disability insurance			X
Group Legal			X
Voluntary Benefits******			
• Critical Illness			X
• Hospital Indemnity			X
• Accident Insurance			X

**The Health Savings Account (HSA) is not part of the Northrop Grumman Health Plan. You own your HSA. Northrop Grumman may facilitate pre-tax payroll deductions to your HSA. Northrop Grumman may make a contribution to your HSA as part of the Well-being Incentive Program.*

***If you are an Independence, MO represented employee benefits will be effective after you complete your 120-day probation period.*

**** ABL represented employees are not eligible. If you are an Independence, MO represented employee benefits will be effective after you complete your 120-day probation period.*

*****Baltimore and Sunnyvale Represented employees are not eligible.*

Coverage Categories

Under the Northrop Grumman Health Plan, you can select the combination of coverage that fits your and your family's needs. If you select medical, dental, or vision coverage, you must select one of the following coverage categories based on the dependents you want to include in your coverage:

- You only
- You + child(ren)
- You + spouse (or eligible domestic partner)
- You + family (employee, child(ren), and spouse (or eligible domestic partner))

You may have a different coverage category for each benefit. For example, you can enroll yourself only in a medical plan option and enroll yourself and your entire family in a dental plan option.

If both you and your spouse (or eligible domestic partner) work for Northrop Grumman, special provisions may apply to the coverage category you are eligible to elect. See **Special Provisions for Working Spouses (or eligible domestic partners)** for details.

Your Cost for Coverage

Each optional benefit option has a cost associated with it. This is your per-pay-period cost to purchase that benefit. The cost for each benefit is based on:

- The option you choose. Generally, the higher the level of coverage you choose, the higher the cost
- Your coverage category for medical, dental, and vision
- For medical, your base annual pay (except for certain represented employees)
  - If you earn $100,000 or less annually, you pay a fixed amount
  - If you earn more than $100,000 annually, you pay a fixed employee contribution amount plus a percentage of your base salary over $100,000

In general, Northrop Grumman pays the majority of the cost for your medical and dental coverage. What you pay is the difference between the actual cost of coverage and Northrop Grumman's contribution to your coverage.

Paying for Coverage

Employees pay for their optional benefits through payroll deductions, both pre-tax and after-tax. Deductions are taken from each paycheck a participant receives during the plan year. The deductions in a particular paycheck represent the employee cost for the pay period to which the check applied. However, rates change with the first paycheck received in the new plan year.

Because of payroll system limitations, the total deducted for health and welfare benefits, including Health Care and/or Dependent Day Care Flexible Spending Accounts, over the year might be slightly more or less

than the total amount of the employee's election, but the total amount deducted is the employee's cost of coverage. The Plan does not refund or seek payment of those slight differences.

In the event an employee does not receive a paycheck or the paycheck does not cover the full required deductions (e.g., on unpaid time off; disciplinary suspension), Northrop Grumman may recoup the unpaid deductions in a future paycheck(s).

Northrop Grumman's contributions and your costs may change from plan year to plan year. Your annual enrollment materials will provide additional information about your cost for coverage under each option.

If you are on an unpaid leave of absence, you must pay the usual cost of coverage for your optional benefits. Failure to make timely monthly payments will result in loss of coverage. Payments are due on the first day of the month of coverage. If payment is not received within 31 days of the due date, coverage will terminate effective on the last day of the last month for which a payment was made. For example, payment for May coverage is due May 1, so if you fail to make the payment by May 31, your coverage will be terminated retroactive to April 30. Employees on unpaid leave who are being billed by our administrator and who return to work prior to the due date for their payments will have the outstanding payments transferred to payroll as arrears. These arrears will be collected in future paychecks.

If you believe there is a discrepancy between the amount you should be paying for your benefits and the amount that is being deducted from your paychecks or the amount you are being billed, you must notify the NGBC promptly.

PRE-TAX VS. AFTER-TAX BENEFITS

There are certain benefits you purchase on a pre-tax basis and others you purchase on an after-tax basis. When you purchase benefits on a pre-tax basis, you pay for your coverage before federal and Social Security taxes are deducted from your paycheck and, at most locations, before state and local taxes are withheld. In other words, you pay for these benefits with pre-tax money. This pre-tax payment method can lower your taxable income.

The pre-tax benefits are:

- Medical
- Dental
- Vision
- Health Care Flexible Spending Account (FSA)
- Dependent Day Care Flexible Spending Account (FSA)
- Contributions to a Health Savings Account (HSA)*

The after-tax benefits are:

- Optional long-term disability (LTD) insurance**
- Optional life insurance**
- Optional accidental death and dismemberment (AD&D) insurance**
- Group legal
- Voluntary Accident Insurance***
- Voluntary Critical Illness Insurance***
- Voluntary Hospital Indemnity Insurance***

**You own your HSA, and the HSA is not part of this Plan.*

*** If you are an Independence, MO represented employee benefits will be effective after you complete your 120-day probation period. ABL represented employees are not eligible for AD&D insurance.*

****Baltimore and Sunnyvale Represented employees are not eligible.*

When Coverage Ends

Coverage in the Northrop Grumman Health Plan ends when the first of these events occurs:

- You or your dependents are no longer eligible to participate in the Plan (see the following chart for examples of when eligibility would end and their corresponding coverage end dates)
- You fail to make a contribution or authorize a payroll deduction for coverage, if required
- You reach the end of a continuation period during a leave of absence
- The Northrop Grumman Health Plan terminates

Here are examples of when coverage would end:

IF YOU OR YOUR DEPENDENTS ARE NO LONGER ELIGIBLE FOR PARTICIPATION BECAUSE:	THEN COVERAGE WILL END:
Your employment ends due to a voluntary termination	On the day your employment ends (coverage may be continued as described in **COBRA Continuation of Coverage**)
Your employment ends due to a non-voluntary termination	As specified in the terms of the separation agreement or document, or on the last day of employment in the absence of a separation agreement (coverage may be continued as described in **COBRA Continuation Of Coverage**)
Your dependent child turns age 26 (unless the dependent child qualifies for a disability extension)	On the last day of the month in which the dependent turns age 26 (coverage may be continued as described in **COBRA Continuation Of Coverage**)
Your dependent covered by reason of a QMCSO is no longer required to be covered by the QMCSO	If the dependent was covered only by the QMCSO and if requested by the employee within 31 days of the date of the release, on the date on which coverage is no longer required by the QMCSO. If the dependent was covered at the time the QMCSO was issued, the dependent may be dropped at the next annual enrollment or qualified life event that allows a dependent to be dropped from coverage
Your spouse (or eligible domestic partner) loses eligibility due to a divorce (or the end of a domestic partnership)	On the effective date of the divorce (or end of the domestic partnership)
You fail to submit required documentation requested as a result of a dependent verification request	As of the date specified in the dependent audit notification If you provide the required documentation to the NGBC during the same plan year as when your dependent's coverage ended, the dependent's coverage will be reinstated as of the date you provide the required documentation (on a prospective basis only). Otherwise, you may re-enroll the dependent during any next Annual Enrollment period, with coverage effective the following January 1.

IF YOU OR YOUR DEPENDENTS ARE NO LONGER ELIGIBLE FOR PARTICIPATION BECAUSE:	THEN COVERAGE WILL END:
Your disabled dependent child over age 26 marries or ceases to be considered disabled by the Plan	On the date of the marriage or on the date the dependent ceases to be considered by the Plan to be disabled (coverage may be continued as described in **COBRA Continuation Of Coverage**)

Note: The plan administrator reserves the right to require you, as a condition of eligibility and at any time, to submit proof of eligibility of any person you enroll and you agree to provide the required proof within the time specified by the plan administrator.

You and your dependents may continue coverage under certain circumstances when coverage otherwise would end, as described in **COBRA Continuation of Coverage**.

ENROLLING IN YOUR PLAN BENEFITS

When You Can Enroll

You may select your optional benefits:

- When you are a new employee, and
- During annual enrollment.

Once you make your benefit selections, they remain in effect for the entire plan year. Generally, you cannot make changes to your benefits until the next annual enrollment. However, you may make certain changes as described here:

- **For your pre-tax benefits** (medical, dental, vision and flexible spending accounts): You may be able to make changes or choose new benefits during the plan year if you have a qualified life event. The effective date of the change will be the date of the qualified life event, not the date you report the qualified life event to the plan administrator or the date you make a new election. See **Qualified Life Events** for details.
- **For your after-tax benefits*** (optional life*, optional AD&D**, long-term disability insurance* and voluntary benefits***): You can make changes during the plan year as permitted by the terms of the insurance policy or certificate of coverage, but you may be required to present evidence of insurability.*
- For details, call the NGBC at 800-894-4194

Note: For group legal, you may change your election only during the annual enrollment period each year. If you establish a Fidelity HSA, you may adjust your contributions at any time, and the change will be effective as soon as administratively possible.

If you waive medical plan coverage during annual enrollment because you have coverage elsewhere and then you lose that other coverage, you may be able to enroll in Northrop Grumman medical coverage before the next annual enrollment period. See **Special Enrollment Periods Provided Under HIPAA** for details.

**If you are an Independence, MO represented employee, basic life, basic AD&D, STD, LTD, LTD buy-up, Optional Life, Spouse/Child life, Optional AD&D and Spouse/Child AD&D benefits will be effective after you complete your 120-day probation period.*
*** ABL represented employees are not eligible.*
**** Baltimore and Sunnyvale represented employees are not eligible for voluntary benefits.*

When You Can Enroll Your Dependents

For pre-tax benefits (medical, dental, vision): If you want to enroll your dependents in the pre-tax benefits, you must do so at the same time you select benefits for yourself (i.e., within 31 days of your date of hire or during annual enrollment).

You may also enroll dependents within 31 days of when they first become eligible for coverage as a result of a qualified life event (see **Qualified Life Events**). For example, if you get married or have a child, you may enroll your new spouse or child in your medical plan option. If you do not enroll your spouse or children when they first are eligible, you generally cannot enroll them until the next annual enrollment. You must take affirmative action to enroll a new spouse or child by completing all steps in the enrollment process. You are required to provide your dependents' Social Security Number(s).

For after-tax benefits (optional life and AD&D)*: You may enroll your dependents in **Optional Life Insurance** and **Accidental Death and Dismemberment (AD&D) Insurance** at any time, as permitted by

the insurance policies or certificates of coverage and subject to evidence of insurability, as applicable. Refer to those sections of this summary plan description for details.

**If you are an Independence, MO represented employee, Optional Life, Spouse/Child life, Optional AD&D and Spouse/Child AD&D benefits will be effective after you complete your 120-day probation period. ABL represented employees are not eligible for AD&D benefits.*

Keep in Mind

Your benefit elections remain in effect for the remainder of the plan year. You cannot make changes until the next annual enrollment unless you experience a qualified life event as described in **Qualified Life Events**.

Enrolling as a New Employee

On your date of hire, you automatically begin participating in company-provided basic benefits* as long as you are eligible for the Northrop Grumman Health Plan.

If you want to participate in any of the optional benefits, you must make an election and complete all steps of the enrollment process. You will receive instructions on how to find information about the specific plan options available to you, their costs, and how to make your benefit elections. You may be referred to *NetBenefits*® at **netbenefits.com/northropgrumman** to make your enrollment choices.

You must make your benefit elections within 31 days after your date of hire. The first day of this 31-day period is your hire date. Your elections become effective retroactive to your hire date, so coverage for you and any of your dependents you enroll begins on the first date of employment (subject to life insurance evidence of insurability requirements). If you do not make your benefit elections within the 31-day period, you automatically receive Northrop Grumman basic benefits only — you receive no optional benefits and your dependents are not covered. (However, you can choose or make changes to your **Optional Life Insurance, Accidental Death and Dismemberment (AD&D) Insurance**,** and **Long-Term Disability (LTD)** at any time,* subject to the provisions of those plans, including evidence of insurability and/or pre-existing condition exclusions. Refer to those sections of this summary plan description for details

The effective date of your coverage will be deferred if you are not in active service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date you return to active service and the date coverage would otherwise have become effective. You will be considered in active service on any day that is either of the following: (1) one of your employer's scheduled work days on which you are performing your regular duties on a full-time basis, either at one of your employer's usual places of business or at some other location to which your employer's business requires you to travel; or (2) a scheduled holiday, vacation day or period of employer-approved paid leave of absence, other than sick leave, only if you were in active service on the preceding scheduled workday.

**If you are an Independence, MO represented employee, basic life, basic AD&D, STD, LTD, LTD buy-up, Optional Life, Spouse/Child life, Optional AD&D and Spouse/Child AD&D benefits will be effective after you complete your 120-day probation period.*
***ABL represented employees are not eligible for AD&D benefits.*

Enrolling During Annual Enrollment

Each year you have an opportunity to reassess your benefit choices and make changes during annual enrollment. Your annual enrollment benefit elections are effective for the following plan year. Prior to annual enrollment, the plan administrator may provide you with general information about your benefits and instructions on how you can enroll. You will be referred to an enrollment website, where you will be able to view and download your personal information including your benefit options and their costs.

Generally, you need to enroll during annual enrollment if you want to make changes to your benefit elections. If you do not enroll, your current coverage (if available) will carry over to the following plan year, except for flexible spending account and health savings account elections. If you want to contribute to a flexible spending account or health savings account in the following year, you must make a new election. You will be advised if your current option is not available and whether a new election is necessary. You must complete all steps of the enrollment process in order for your election to become effective.

If You Are on an Unpaid Leave of Absence

If you are on an unpaid leave of absence during the annual enrollment period, you may enroll in or make changes to your medical, dental, vision, and/or group legal coverage (and your Health Care Flexible Spending Account if your leave is pursuant to the Family and Medical Leave Act ("FMLA")). You may also decrease your basic or optional life insurance,* optional AD&D insurance,* optional LTD insurance,* or voluntary benefits.** You may make these elections through the enrollment website or by calling the NGBC. If you wish to make changes to your flexible spending accounts (FSAs), or increase your basic or optional life insurance,* optional AD&D insurance,* optional LTD insurance coverage* or voluntary benefits,** you may do so only when you return to work on a regular basis (as a benefits-eligible employee) by calling the NGBC within 31 days of your return to work.

If your unpaid leave of absence begins after the end of the annual enrollment period and extends through the beginning of the following plan year (January 1), your benefit elections generally will be effective as follows:

- Your medical, dental, and/or vision coverage will take effect at the start of the plan year
- You must make new FSA elections when you return to work on a regular basis (except that if you are on an FMLA leave, the Health Care FSA election you made during Annual Enrollment will still be effective)
- If you enroll in optional life insurance, optional AD&D insurance,*** optional LTD insurance or voluntary benefits,** call the NGBC when you return to work to make new elections.

**If you are an Independence, MO represented employee, basic life, basic AD&D, STD, LTD, LTD buy-up, Optional Life, Spouse/Child life, Optional AD&D, Spouse/Child AD&D will be effective after you complete your 120-day probation period.*
***Baltimore and Sunnyvale represented employees are not eligible.*
****ABL represented employees are not eligible.*

If Your Address Changes

Your address is used in the administration of the Plan for purposes of determining the benefits for which you are eligible and for mailing important notices. It is your obligation to make sure that the plan administrator has your current address. If your address changes, you must update your address in Workday (or contact the HRSC) or your local human resources representative immediately to report the change.

If You Make an Election Mistake

If you make a mistake when making your benefit elections, you generally cannot correct the mistake until the next annual enrollment. The only exception is if there is clear and convincing evidence that you made an election in error (for example, you make a Dependent Day Care Flexible Spending Arrangement election rather than a Health Care Flexible Spending Arrangement election when you do not have children). The Plan Administrator or its designee shall have the sole discretion to determine whether there is clear and convincing evidence of a mistake. Mistakes regarding the scope of coverage or the tax treatment of an election are not correctable.

If You Move Out of Your Current Medical Plan Option Service Area

If you move out of the service area of your current medical plan option, you and your family may select new health care benefits based on your new home ZIP code within 31 days. (For example, if you are in an HMO, and you move to an area where that HMO is not offered.) When you move, you must update your address in Workday. After you change your address, you will receive the materials necessary to select benefits at your new location.

Qualified Life Events

After you select the benefits that you will pay for with pre-tax dollars for the plan year, you cannot make a change to those benefits until the next annual enrollment unless you experience a qualified life event.

Generally, a qualified life event is a change in your personal situation that results in the gain or loss of eligibility for a Northrop Grumman Health Plan option, your spouse's employer's plan, or your dependent's employer's plan.

Read this section for general information about how your pre-tax health and welfare benefits may be affected by personal and family-related events.

Qualified life events include:

- Change in marital status, including marriage, divorce, annulment, and death of spouse
- Change in number of dependents, including birth, adoption, placement for adoption, commencement of legal guardianship, and death of dependent
- Change in employment status (termination or commencement of employment) for you, your spouse, or your dependent
- Change in work schedule, including a reduction or increase in hours of employment for you, your spouse, or your dependent, a switch between part-time and full-time status, a strike or lockout, and beginning or returning from an unpaid leave of absence
- Inability of your dependent to meet the Plan's coverage requirements due to a change in age or other conditions of eligibility
- Change in residence or worksite for you, your spouse, or your dependent that results in a loss of coverage
- Your dependent becomes eligible for coverage under his or her employer's plan
- Enrollment by you, your spouse, or a dependent in Medicare or Medicaid
- Significant gain or loss in coverage (e.g., your spouse loses coverage in his or her employer's plan)
- A court judgment, decree, or order requiring coverage for your dependent child(ren)
- HIPAA special enrollment event
- Any other changes set forth in IRS regulations issued pursuant to Code section 125

Except for HIPAA special enrollment events, the benefit change you make must be on account of and consistent with the qualified life event. For example, if your dependent spouse who is enrolled in a Northrop Grumman medical plan option gains benefit coverage through their employer, you are allowed to discontinue their coverage (as well as your own coverage and that of your dependent child(ren)), but you are not allowed to change from one Northrop Grumman medical plan option to another.

When you make an election change, you are certifying that the qualified life event occurred and that you satisfy any other conditions required for you to make the election change you request. Additional conditions may be specified on *NetBenefits* at **netbenefits.com/northropgrumman** or when you call the NGBC. You may be required to provide evidence supporting your ability to make the election change.

Qualified Life Events Resulting in a Loss of Eligibility

If a qualified life event results in a loss of eligibility for the plan, you must immediately report the qualified life event through *NetBenefits* at **netbenefits.com/northropgrumman** or by calling the NGBC at 800-894-4194. If you do not report the qualified life event within 31 days after the qualified life event, any premiums you have paid will not be refunded and the Plan reserves the right to cancel coverage retroactive to the date of the qualified life event.

Other Qualified Life Events

For all other qualified life events, you may only make permissible changes within 31 days after the qualified life event. You may make such changes by accessing *NetBenefits* or by calling the NGBC at 800-494-4194. For information about qualified life events that affect domestic partner coverage, call the NGBC at 800-894-4194.

How Benefits Are Impacted By Common Qualified Life Events

The Northrop Grumman Health Plan is designed to allow you to adapt your coverage to certain changes in your personal needs and priorities, depending on the life events you experience and special situations throughout your career. The charts on the following pages provide general information about how your pre-tax and after-tax health and welfare benefits may be affected by personal and family-related events.

Where appropriate, they offer things to think about, actions you may wish to take and where you can find more information.

IF YOU GET MARRIED

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
Medical, **Dental** and **Vision**	**Within 31 days after the marriage, you can:** • Add your spouse and dependent child(ren), including stepchild(ren), to your coverage • Change your medical plan option • Remove your dependents from coverage under certain conditions • Stop coverage • Newly elect coverage
Health Care Flexible Spending Account	**Within 31 days after the marriage, you can:** • Increase or start contributions
Dependent Day Care Flexible Spending Account	**Within 31 days after the marriage, you can:** • Increase or start contributions if you acquire newly eligible dependents • Decrease or stop contributions if your new spouse is not employed or makes a Dependent Day Care FSA election under his or her plan

THINGS TO THINK ABOUT	IN THIS SPD, SEE…
Is your spouse a Northrop Grumman employee? You may choose to enroll your spouse as your dependent, or vice versa. Or, you may each enroll in coverage as a company employee.	• **Eligibility and Participation**
Is your spouse eligible for health benefits or insurance coverage from another source? If so, think about your and your spouse's enrollment choices.	• **Medical** • **Coordination of Benefits**
Does your spouse have any dependents? They may be eligible for Northrop Grumman benefits once you are married.	• **Eligibility and Participation**
Is your spouse contributing to a flexible spending account (FSA)? If so, you may want to adjust your own contributions.	• **Flexible Spending Accounts**
Do you need to increase the amount of your life and accident insurance coverage or change your beneficiary under these plans? If you're not already covered by optional life insurance, you may want to consider enrolling.	• **Eligibility and Participation** • **Optional Life Insurance** • **Beneficiary Designation**
What life insurance coverage does your spouse have? You may want to enroll your spouse and any eligible dependents for dependent coverage under the optional life insurance.	• **Eligibility and Participation** • **Optional Life Insurance**
Do you need to increase your long-term disability coverage? You may want to consider enrolling in optional LTD coverage to help provide income protection if you become disabled and unable to work for a long period of time.	• **Optional Long-Term Disability (LTD)**

IF YOU GET A DIVORCE OR AN ANNULMENT

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
Medical, **Dental** and **Vision**	**Within 31 days after the divorce or annulment, you must drop your ex-spouse and any former stepchild(ren) from coverage. You can also:** • Start coverage for yourself under certain conditions • Add your dependent child(ren) to your coverage under certain conditions
Health Care Flexible Spending Account	**Within 31 days after the divorce or annulment, you can:** • Increase or start contributions • Decrease or stop contributions Change must be consistent with the event. For example, if an employee currently has an FSA, it can be decreased or dropped because of loss of dependents.
Dependent Day Care Flexible Spending Account	**Within 31 days after the divorce or annulment, you can:** • Increase or start contributions • Decrease or stop contributions Change must be consistent with the event. For example, if an employee now has financial responsibility for child care, he or she can newly elect or increase contributions.

THINGS TO THINK ABOUT	IN THIS SPD, SEE…
Were you covered under your former spouse's (or eligible domestic partner's) health insurance? If so, you may want to enroll in the Northrop Grumman Medical, Dental and/or Vision Plans.	• **Eligibility and Participation** • **Medical**, **Dental** and **Vision Plans**
Do you have dependent children? If so, determine whether they'll be covered by your health care coverage or your former spouse's (or eligible domestic partner's) coverage. After a divorce or separation, your child(ren) might have court-ordered rights to health care coverage provided by you.	• **Eligibility and Participation** • **Qualified Medical Child Support Order** •
Was your former spouse contributing to a Dependent Day Care FSA? If so, limits on married couples' contributions no longer apply. You may want to adjust your contributions.	• **Dependent Day Care Flexible Spending Account**
Do you want to name someone other than your former spouse (or eligible domestic partner) as your beneficiary for your life and accident insurance? If your former spouse (or eligible domestic partner) was your beneficiary, he or she will continue as your beneficiary until you designate a different beneficiary.	• **Beneficiary Designation**
Do you or any of your family members need help through this difficult time? The Northrop Grumman Employee Assistance Program (EAP) can help you and your family.	• **NGCare/Employee Assistance Program**

IF YOU HAVE A BABY OR ADOPT A CHILD

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
Medical, **Dental** and **Vision**	**Within 31 days after the birth or adoption, you can:** • Add your new dependent child to your coverage • Change your medical plan option (Note: Changing your medical plan option will be effective on the child's birthdate. Check with your current insurance carrier before making a change as it may impact coverage for the birth.) • Add your spouse and dependents to your medical coverage • Start coverage for yourself and dependents • Drop coverage for yourself or any eligible children under certain conditions (e.g., your spouse adds you and dependents to his or her coverage.)
Health Care Flexible Spending Account	**Within 31 days after the birth or adoption, you can:** • Increase or start contributions
Dependent Day Care Flexible Spending Account	**Within 31 days after the birth or adoption, you can:** • Increase or start contributions • Decrease or stop contributions if there is a decrease in the cost of day care (e.g., one parent is now staying home)

THINGS TO THINK ABOUT	IN THIS SPD, SEE…
Is your spouse (or eligible domestic partner) a Northrop Grumman employee? If one spouse (or eligible domestic partner) is enrolled in benefits as a company employee, he or she can also enroll the child as a dependent with the same coverage. If each spouse (or eligible domestic partner) is enrolled as a company employee, either one—but not both—may cover the child.	• Dependent Children in **Eligibility and Participation** • **Medical**, **Dental** and **Vision Plans**
Does your spouse (or eligible domestic partner) have health benefits or insurance coverage from another source that could cover the child? If so, think about the most effective coverage choices for you (both in terms of the benefits available and your total cost for each coverage, that is, your annual premiums *plus* the cost you pay when you receive services).	• **Medical** • **If You Have Other Health Care Coverage: Non-Duplication of Benefits** in Medical Plans
How much time off will you and/or your spouse (or eligible domestic partner) need after the child's birth or adoption? Your unique situation will determine what time off is available to you to meet your needs.	• **Medical** • **COBRA Continuation Of Coverage** and FMLA
Who will care for the child if both you and your spouse return to work? The Northrop Grumman Employee Assistance Program (EAP) can help you find dependent day care in your area. In addition, a Dependent Day Care FSA (through Northrop Grumman and/or your spouse's employer) can reduce your taxes, making it easier for you to pay for Dependent Day Care.	• **NGCare/Employee Assistance Program** • **Dependent Day Care Flexible Spending Account**
Do you need to increase your life insurance coverage? If you're not already covered by optional life insurance, you may want to consider enrolling. If you are enrolled, you may wish to review your coverage amount.	• **Eligibility and Participation** • **Optional Life Insurance**
Do you need to increase your long-term disability coverage? You may want to consider enrolling in optional LTD coverage to help provide income protection if you become disabled and unable to work for a long period of time.	• **Optional Long-Term Disability (LTD)**

IF YOUR SPOUSE (OR ELIGIBLE DOMESTIC PARTNER) BECOMES ELIGIBLE FOR AND ELECTS COVERAGE THROUGH HIS OR HER EMPLOYER

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
Medical, **Dental** and **Vision**	**Within 31 days after your spouse (or eligible domestic partner) gains benefits, you can:** • Remove your spouse (or eligible domestic partner) from benefits • Remove your dependents from benefits under certain conditions • Stop coverage under certain conditions
Health Care Flexible Spending Account	**No changes allowed**
Dependent Day Care Flexible Spending Account	**No changes allowed**

IF YOUR SPOUSE (OR ELIGIBLE DOMESTIC PARTNER) LOSES ELIGIBILITY FOR BENEFITS

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
Medical, **Dental** and **Vision**	**Within 31 days after your spouse (or eligible domestic partner) loses benefits, you can:** • Start coverage for yourself if you lose coverage provided by your spouse's (or eligible domestic partner's) employer • Add coverage for your spouse (or eligible domestic partner) and/or child(ren)
Health Care Flexible Spending Account	**Within 31 days after your spouse loses eligibility for benefits, you can:** • Increase or start contributions if your spouse can no longer contribute
Dependent Day Care Flexible Spending Account	**Within 31 days after your spouse loses eligibility for benefits, you can:** • Increase or start contributions if your spouse can no longer contribute

IN THE CASE OF DEATH OF A DEPENDENT OR SPOUSE (OR ELIGIBLE DOMESTIC PARTNER)

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
All	There are many benefit changes that you may need to consider after the death of a dependent or spouse (or eligible domestic partner). Call the NGBC at 800-894-4194.

CHANGE IN HOME ADDRESS

BENEFIT OPTION	CHANGES YOU CAN OR MUST MAKE
Medical, **Dental**	A change in your home address can affect your eligibility for certain options. If you lose eligibility for your current medical and/or dental plan as a result of an address change, you will be able to make a new option election. If you change your home address, please make the updates in Workday. Until your address is updated, you will not be able to make any benefit changes.

WHAT HAPPENS TO YOUR BENEFITS IN SPECIAL SITUATIONS

This section describes how certain career changes affect each plan option, and what, if anything, you need to do. The situations described in this section are:

- **If You Take a Leave of Absence**
- **If You Transfer**
- **If Your Employment Ends**
- **If You Are Rehired or Recalled**

For information about what may happen to your benefits when you experience a personal life change, including marriage or the birth of a child, refer to **Qualified Life Events**.

If You Take a Leave of Absence

If you take a leave of absence from Northrop Grumman, how your benefits will be affected depends on the type of leave:

- **If You Take an Approved Medical or Occupational Leave of Absence**
- **If You Take a Personal or Educational Leave of Absence**
- **If You Take a Family Leave of Absence**
- **If You Take a Military Leave of Absence**

While you are on leave, you are required to continue to make contributions for your benefits. Your contributions will continue through automatic payroll deductions for as long as you are receiving a paycheck from Northrop Grumman. If your paychecks stop, your business unit will continue to pay its share of the premium for your benefits for so long as you are entitled to an employer contribution, but it is your responsibility to continue to pay your share of the cost. You automatically will receive an invoice from our administrator on a monthly basis. Failure to make required payments in a timely manner will result in loss of coverage.

REINSTATEMENT OF YOUR BENEFITS AFTER A LEAVE

If you take a leave of absence, your benefits generally will continue for a specified period as described below. If your benefits are terminated during the leave, they will be reinstated when you return to work, assuming that you continue to be eligible.

Generally, if you return from leave in the same plan year, your benefits in effect when you began your leave will be reinstated. Different rules apply to optional life insurance coverage. See **Life and Accident Insurance** for more information.

Note: Your plan year flexible spending account contributions will be reinstated, but the per-pay-period contributions will likely be higher than they were before your leave, since the plan year amount you are contributing will remain the same but be divided among fewer pay periods. If you return to work before the plan year has ended, and you make a new FSA contribution election when you return from leave, the new election amount cannot be less than the total of any reimbursements you have already received. If your leave is an FMLA leave and you declined to continue participation in the Health Care FSA during your FMLA leave, then when you return to work after your FMLA leave, you can elect to

reduce your FSA coverage at a level on a pro rata basis for the period during the FMLA leave for which no premiums were paid, less prior reimbursements.

If you return from leave in a following plan year, you may select new medical, dental, flexible spending accounts (FSAs), and/or vision benefits, if you are eligible. You may make changes to your FSAs, optional life insurance, optional accidental death and dismemberment (AD&D) insurance,* optional long-term disability (LTD) insurance or voluntary benefits,** when you return to work on a regular basis. (**Note:** If you return to work after a new plan year has begun, you must make a new FSA election if you wish to participate in the FSA. If your optional life insurance was terminated while you were on a leave of absence, you will have to submit Evidence of Insurability. See the **Life and Accident Insurance** section for details.)

* *ABL represented employees are not eligible for AD&D benefits.*
** *Baltimore and Sunnyvale represented employees are not eligible for voluntary benefits.*

IF YOU TAKE AN APPROVED MEDICAL OR OCCUPATIONAL LEAVE OF ABSENCE

If you take a leave of absence for medical reasons, including a work-related leave or Workers Compensation, your benefits may continue for a maximum of 12 months from your last day of work. (Note: A portion of this leave may be designated as FMLA leave.) If you are receiving a paycheck from Northrop Grumman, your regular contributions will continue. When you go on unpaid leave (i.e., you are not receiving a paycheck from Northrop Grumman), you will be required to make monthly contributions. Here is how each of your benefits will be affected:

BENEFIT OPTION	WHAT HAPPENS DURING A MEDICAL LEAVE OF ABSENCE
Medical, **Dental** and **Vision**	Coverage continues for the duration of your approved leave, up to the 12-month maximum, as long as you continue to pay your contributions; you can make changes during annual enrollment. COBRA may be elected when coverage ends.
Health Care Flexible Spending Account (FSA)	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis. If you are on an unpaid leave, your contributions stop. Once you no longer receive a paycheck, if you want to continue your FSA, you can choose to continue with after-tax contributions for the balance of the plan year or longer, if legally required. You can be reimbursed for eligible expenses incurred only during the time you made contributions. Expenses that you incur after the last day of the last pay period in which you made contributions are not eligible for reimbursement.
Dependent Day Care Flexible Spending Account	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis. If you are on unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred during the plan year.
Health Savings Account (HSA)*	Your pre-tax contributions continue as long as you are receiving a paycheck from Northrop Grumman.
Basic and Optional Long-Term Disability (LTD)**	Coverage continues for the duration of your approved leave, up to the 12-month maximum or until a long-term disability (LTD) benefit is approved, provided any required premiums are paid. If an LTD benefit is approved, benefit payments continue up to the limits of the LTD plan.
Short-Term Disability (STD)**	Coverage continues for the duration of your approved leave, up to six months.

BENEFIT OPTION	WHAT HAPPENS DURING A MEDICAL LEAVE OF ABSENCE
Basic Life Insurance**	Coverage continues for the duration of your approved leave, up to the 12-month maximum. When coverage ends, you may choose conversion or portability within 31 days.
Optional Life Insurance (employee, spouse, child)**	Coverage continues for the duration of your approved leave, up to the 12-month maximum, as long as you make required contributions. When coverage ends, you may choose conversion or portability within 31 days.
Basic Accidental Death and Dismemberment (AD&D)**	Coverage continues for the duration of your approved leave, up to the 12-month maximum. When coverage ends, you may choose portability within 31 days.
Optional Accidental Death and Dismemberment (AD&D)**	Coverage continues for the duration of your approved leave, up to the 12-month maximum, provided you make required contributions. When coverage ends, you may choose portability within 31 days.
Group Legal	Coverage continues for the duration of your approved leave up to the 12-month maximum, provided you make required contributions. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)***	Coverage continues for the duration of your approved leave up to the 12-month maximum, provided you make required contributions. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

**You own the HSA. The HSA is not part of the Northrop Grumman Health Plan.*
***Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*
****Baltimore and Sunnyvale represented employees are not eligible.*

IF YOU TAKE A PERSONAL OR EDUCATIONAL LEAVE OF ABSENCE*

If you are approved for a leave of absence for personal or educational reasons, your benefits may continue to the end of the month plus one month from the day that your leave begins. If you are receiving a paycheck from Northrop Grumman, your regular contributions will continue. When you go on unpaid leave, you will be required to make monthly contributions. Here is how your benefits will be affected:

BENEFIT OPTION	WHAT HAPPENS DURING A PERSONAL OR EDUCATIONAL LEAVE OF ABSENCE
Medical, **Dental** and **Vision**	Coverage continues to the end of the month plus one month from the day that your leave begins, provided you make any required contributions. When coverage ends, you may choose COBRA until you return to work (subject to the maximums and other rules explained in **COBRA Continuation of Coverage**).

BENEFIT OPTION	WHAT HAPPENS DURING A PERSONAL OR EDUCATIONAL LEAVE OF ABSENCE
Health Care Flexible Spending Account (FSA)	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis to the end of the month plus one month from the day that your leave begins. You may continue your FSA after that point by making after-tax contributions through COBRA for the remainder of the plan year. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred only during the time you made contributions. Expenses that you incur after the last day of the last pay period in which you made contributions are not eligible for reimbursement. Once you no longer receive a paycheck, if you wish to continue your FSA, you can choose to continue with after-tax contributions through COBRA for the remainder of the plan year.
Dependent Day Care Flexible Spending Account	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis to the end of the month plus one month from the day that your leave begins. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses during the plan year.
Health Savings Account (HSA)**	Your pre-tax contributions continue as long as you are receiving a paycheck from Northrop Grumman.
Basic Long-Term Disability (LTD)***	Coverage continues to the end of the month plus one month from the day your leave begins.
Optional Long-Term Disability (LTD)***	Coverage continues to the end of the month plus one month from the day that your leave begins, provided you make required contributions.
Short-Term Disability (STD)***	Coverage continues to the end of the month plus one month from the day your leave begins.
Basic Life Insurance***	Coverage continues to the end of the month plus one month from the day your leave begins. When coverage ends, you may choose conversion or portability within 31 days.
Optional Life Insurance* (employee, spouse, child)**	Coverage continues to the end of the month plus one month from the day that your leave begins, provided you make required contributions. When coverage ends, you may choose conversion or portability within 31 days.
Basic Accidental Death and Dismemberment (AD&D)***	Coverage continues to the end of the month plus one month from the day your leave begins. When coverage ends, you may choose portability within 31 days.
Optional Accidental Death and Dismemberment (AD&D)***	Coverage continues to the end of the month plus one month from the day your leave begins, provided you make required contributions. When coverage ends, you may choose portability within 31 days.

BENEFIT OPTION	WHAT HAPPENS DURING A PERSONAL OR EDUCATIONAL LEAVE OF ABSENCE
Group Legal	If you are receiving a paycheck from Northrop Grumman during your leave, coverage continues on an after-tax basis to the end of the month plus one month from the day that your leave begins. If you are on unpaid leave, coverage continues to the end of the month plus one month provided you make any required contributions. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)****	If you are receiving a paycheck from Northrop Grumman during your leave, coverage continues on an after-tax basis to the end of the month plus one month from the day that your leave begins. If you are on unpaid leave, coverage continues to the end of the month plus one month provided you make any required contributions. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

** Plymouth Teamsters, ABL, NRE, Baltimore, Bacchus and Independence, MO represented employees are not eligible to take a personal or educational leave of absence.*
*** You own the HSA. The HSA is not part of the Northrop Grumman Health Plan.*
**** Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*
***** Baltimore and Sunnyvale represented employees are not eligible.*

IF YOU TAKE A FAMILY LEAVE OF ABSENCE

If you take a leave of absence for family reasons — for example, to care for a sick family member — coverage continues to the end of the month plus four additional months from the day your leave begins. If you are receiving a paycheck from Northrop Grumman, your regular contributions will continue. When you go on unpaid leave, you will be required to make monthly contributions. Here is how your benefits will be affected:

BENEFIT OPTION	WHAT HAPPENS DURING A FAMILY LEAVE OF ABSENCE
Medical, **Dental** and **Vision**	Coverage continues to the end of the month plus four additional months from the day that your leave begins, provided you make any required contributions. When coverage ends, you may choose COBRA until you return to work (subject to the maximums and other rules explained in **COBRA Continuation of Coverage**).
Health Care Flexible Spending Account (FSA)	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis to the end of the month plus four additional months from the day your leave begins. You may continue your FSA after that point by making after-tax contributions for the remainder of the plan year, or longer, if legally required. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred only during the time you made contributions. Claims that you incur after the last day of the last pay period in which you made contributions are not eligible for reimbursement. Once you no longer receive a paycheck, if you wish to continue your FSA, you can continue with after-tax contributions for the remainder of the plan year or longer, if legally required.
Dependent Day Care Flexible Spending Account	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis to the end of the month plus four additional months from the day your leave begins. If you are on unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred during the balance of the plan year.
Health Savings Account (HSA)*	Your pre-tax contributions continue as long as you are receiving a paycheck from Northrop Grumman.
Basic Long-Term Disability (LTD)**	Coverage continues to the end of the month plus four additional months from the day your leave begins.
Optional Long-Term Disability (LTD)**	Coverage continues to the end of the month plus four additional months from the day your leave begins, provided you make required contributions.
Short-Term Disability (STD)**	Coverage continues to the end of the month plus four additional months from the day your leave begins.
Basic Life Insurance**	Coverage continues to the end of the month plus four additional months from the day your leave begins. When coverage ends, you may choose conversion or portability within 31 days.
Optional Life Insurance (employee, spouse, child)**	Coverage continues to the end of the month plus four additional months from the day your leave begins, provided you make required contributions. When coverage ends, you may choose conversion or portability within 31 days.

BENEFIT OPTION	WHAT HAPPENS DURING A FAMILY LEAVE OF ABSENCE
Basic Accidental Death and Dismemberment (AD&D)**	Coverage continues to the end of the month plus four additional months from the day your leave begins. When coverage ends, you may choose portability within 31 days.
Optional Accidental Death and Dismemberment (AD&D)**	Coverage continues to the end of the month plus four additional months from the day your leave begins, provided you make required contributions. When coverage ends, you may choose portability within 31 days.
Group Legal	Coverage continues to the end of the month plus four additional months from the day your leave begins provided you make the required payroll deductions or direct bill. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)***	Coverage continues to the end of the month plus four additional months from the day your leave begins provided you make required payroll deductions or direct bill. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

**You own the HSA. The HSA is not part of the Northrop Grumman Health Plan.*
***Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*
****Baltimore and Sunnyvale represented employees are not eligible.*

Note: You may also take Family and Medical Leave for up to 26 weeks if a covered family member is seriously injured or contracts a serious illness while on active military service. Benefits continue for the full period of the leave on the same terms described above.

IF YOU TAKE A MILITARY LEAVE OF ABSENCE

The Plan complies with specific plan and contract provisions, as well as federal and state laws regarding military leaves. If you take a military leave of absence, are called to active military duty, or are reassigned to another military duty station, here is how your benefits will be affected. If you are receiving a paycheck from Northrop Grumman, your regular contributions will continue except as described below. When you go on unpaid leave, you will be required to make monthly contributions as described below.

BENEFIT OPTION	WHAT HAPPENS DURING A MILITARY LEAVE OF ABSENCE
Medical, **Dental** and **Vision**	Coverage continues at no cost for the employee only, except for the TRICARE Supplement. You must make any required contributions for your covered family members. If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis. If you are on an unpaid leave, you will be direct billed for your share of the cost of your dependents' coverage.

BENEFIT OPTION	WHAT HAPPENS DURING A MILITARY LEAVE OF ABSENCE
Health Care Flexible Spending Account (FSA)	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred only during the time you made contributions. Claims that you incur after the last day of the last pay period in which you made contributions are not eligible for reimbursement. Once you no longer receive a paycheck, if you wish to continue your FSA, you can continue with after-tax contributions through COBRA for the remainder of the plan year. After the plan year ends, you may elect to continue participation in the FSA on an after-tax basis for up to 24 months from the date your leave began. If you are a member of the reserves and you are called to active duty for at least 180 days, you may withdraw, on a taxable basis, a portion or all of your Health Care FSA balance without penalty.*
Dependent Day Care Flexible Spending Account (FSA)	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred during the plan year.
Health Savings Account (HSA)**	If you are receiving a paycheck from Northrop Grumman during your leave, your contributions continue on a pre-tax basis. If you are on an unpaid leave, your pre-tax contributions to your HSA will stop.
Basic Long-Term Disability (LTD)***	Coverage stops on the day your leave begins.
Optional Long-Term Disability (LTD)***	Coverage stops on the day your leave begins.
Short-Term Disability (STD)***	Coverage continues.
Basic Life Insurance***	Coverage continues.
Optional Life Insurance*** (employee, spouse, child)	Coverage continues as long as you make required contributions.
Basic Accidental Death and Dismemberment (AD&D)***	Coverage stops on the day your leave begins. When coverage ends, you may choose portability within 31 days.
Optional Accidental Death and Dismemberment (AD&D)***	Coverage stops on the day your leave begins. When coverage ends, you may choose to portability within 31 days.
Group Legal	Your contributions continue as long as you are receiving a paycheck from Northrop Grumman. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.

BENEFIT OPTION	WHAT HAPPENS DURING A MILITARY LEAVE OF ABSENCE
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)****	Your contributions continue as long as you are receiving a paycheck from Northrop Grumman. You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

**To be eligible for a qualified reservist distribution, you must be a member of a reserve component and must be ordered or called to active duty either for a period of at least 180 days or for an indefinite period. Per IRS rules, you will have to submit a copy of your order or call to active duty. The qualified reservist distribution amount available to you is the amount you contributed to the health FSA as of the date of the qualified reservist distribution request, minus health FSA reimbursements you received as of that date. The Plan may not make a qualified reservist distribution with respect to amounts credited to your FSA that are attributable to prior plan years (i.e., any plan years prior to the plan year in which you were ordered or called to active duty).*

***You own the HSA. The HSA is not part of the Northrop Grumman Health Plan.*

****Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*

*****Baltimore and Sunnyvale Represented employees are not eligible.*

Note: If you are on a military leave of absence, coverage continues for a maximum of five years subject to the limitations noted above. For more information about a military leave of absence, contact American Family Life Assurance Company of Columbus (AFLAC), Northrop Grumman's leave of absence administrator, at 800-244-8017.

If You Transfer

If you transfer from one business unit of Northrop Grumman to another, how your benefits are affected depends on the type of transfer.

IF YOU TRANSFER FROM A BUSINESS UNIT THAT PARTICIPATES IN THE NORTHROP GRUMMAN HEALTH PLAN TO ANOTHER BUSINESS UNIT THAT PARTICIPATES IN THE NORTHROP GRUMMAN HEALTH PLAN

Here is how your benefits are affected:

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
Medical, **Dental** and **Vision**	Your coverage continues. However, if your current medical or dental option is not available, you must select a new option within 31 days of the transfer (otherwise, you will receive no medical or dental coverage). In addition, even if your current health plan options continue to be available, your contributions may change based on your new business unit's contribution structure.
All Other Benefits	Your coverage continues. If you move to a business unit that has a different STD benefit, you will be enrolled automatically in that STD benefit.

IF YOU TRANSFER FROM A BUSINESS UNIT THAT PARTICIPATES IN THE NORTHROP GRUMMAN HEALTH PLAN TO A BUSINESS UNIT THAT DOES NOT PARTICIPATE IN THE NORTHROP GRUMMAN HEALTH PLAN

Here is how your benefits are affected:

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
Medical, **Dental** and **Vision**	Coverage stops on your transfer date. You can select new coverage under your new benefit program, if available. If coverage is not available, you may be able to elect COBRA.
Health Care and Dependent Day Care Flexible Spending Account (FSAs)	Coverage stops on your transfer date. You can select new coverage under your new benefit program, if available. You have until March 31 following the end of the plan year to file claims for eligible expenses incurred during the plan year while covered under the Northrop Grumman Health Plan. If a health care flexible spending account is not available and you want to continue your previous FSA, you can continue with after-tax contributions through COBRA for the remainder of the plan year.
Health Savings Account (HSA)*	Your pre-tax contributions stop on your transfer date.

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
All Other Benefits**	Coverage stops on your transfer date. You may be eligible for basic and optional benefits under your new benefit program, if available. You can choose conversion or portability for your **Life Insurance** (basic and optional) and portability for your **Accidental Death and Dismemberment (AD&D) Insurance** (basic and optional), or port your optional life insurance, if such insurance is not replaced under the plan of the new business unit. You may be able to continue **Group Legal Plan** coverage by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.

**You own the HSA. The HSA is not part of the Northrop Grumman Health Plan.*
***If you are an Independence, MO represented employee, basic life, basic AD&D, STD, LTD, LTD buy-up, Optional Life, Spouse/Child life, Optional AD&D, Spouse/Child AD&D will be effective after you complete your 120-day probation period. ABL represented employees are not eligible for AD&D.*

IF YOU TRANSFER FROM A BUSINESS UNIT THAT DOES **NOT** PARTICIPATE IN THE NORTHROP GRUMMAN HEALTH PLAN TO A BUSINESS UNIT THAT DOES PARTICIPATE IN THE NORTHROP GRUMMAN HEALTH PLAN

You generally are treated as a new employee for purposes of the Northrop Grumman Health Plan. See **Enrolling as a New Employee** for details. However, if you were participating in a Health Care FSA prior to your transfer, your Health Care FSA election under this Plan will be limited to the IRS maximum allowed less the amounts you contributed to a Health Care FSA under the plan in which you were participating prior to the transfer. Likewise, if you were participating in a Dependent Day Care FSA prior to your transfer, the amount you may contribute to the Dependent Day Care FSA under this Plan for the remainder of the calendar year is your applicable limit for the calendar year (see **Flexible Spending Accounts** to determine your limit) less amounts you had previously contributed to a Dependent Day Care FSA in the calendar year of your transfer.

If Your Employment Ends

If your employment with Northrop Grumman ends, how your benefits will be affected depends on whether:

- **If You Voluntarily Quit or Are Discharged**
- **If Your Employment Ends Due to a Layoff/Reduction in Force**
- **If You Retire**
- **If You Die While Actively Employed**

IF YOU VOLUNTARILY QUIT OR ARE DISCHARGED

If your employment ends because you voluntarily quit, or you are discharged at a time when you are not eligible for retiree benefits, here is what happens to your benefits:

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
Medical, Dental, Vision, EAP	Coverage stops on your termination date. You can elect COBRA continuation no later than 60 days after the date you would lose coverage under the Northrop Grumman Health Plan or the date you receive a COBRA election notice, whichever is later.
Health Care Flexible Spending Account (FSA)	Your contributions stop on your termination date, and you can submit eligible expenses incurred through your termination date. You can select COBRA continuation coverage for the remainder of the plan year by electing coverage no later than 60 days after your termination date or the date you receive a COBRA continuation notice, whichever is later.
Dependent Day Care Flexible Spending Account (FSA)	Your contributions stop on your termination date. You can be reimbursed for eligible expenses incurred through the end of the plan year.
Basic and Optional Long-Term Disability (LTD)*	Coverage stops on your termination date.
Short-Term Disability (STD)*	Coverage stops on your termination date.
Basic Life Insurance*	Coverage stops on your termination date. You may choose conversion or portability within 31 days after your termination date.
Optional Life Insurance* (employee, spouse, child)	Coverage stops on your termination date. You may choose conversion or portability within 31 days after your termination date.
Basic Accidental Death and Dismemberment (AD&D)*	Coverage stops on your termination date. You may choose portability within 31 days after your termination date.
Optional Accidental Death and Dismemberment (AD&D)*	Coverage stops on your termination date. You may choose portability within 31 days after your termination date.
Group Legal	Coverage stops on your termination date. You may be able to continue coverage by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.
Health Savings Account (HSA)**	Your pre-tax contributions stop on your termination date.
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)***	Coverage stops on your termination date. You may be able to continue coverage by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

**Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*
***You own the HSA. The HSA is not part of the Northrop Grumman Health Plan. You may continue to make HSA contributions directly to the HSA custodian if you elect COBRA continuation coverage for your HDHP and have no other disqualifying coverage.*
****Baltimore and Sunnyvale represented employees are not eligible.*

If you are discharged, your coverage will end as specified in the separation agreement or document, or the last day of employment in the absence of a separation agreement (coverage may be continued as described in the **COBRA Continuation of Coverage**).

IF YOUR EMPLOYMENT ENDS DUE TO A LAYOFF/REDUCTION IN FORCE

If your employment ends due to a layoff/reduction in force, the following chart describes how your benefits may be affected.

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
Medical, **Dental**, **Vision, EAP**	Coverage continues to the end of the month plus one month from your termination date. You do not pay anything for this coverage. If you are eligible for Severance benefits, you may be able to continue your benefits at a subsidized rate for some or all of the severance period. When your subsidized coverage ends, you will automatically be billed at full COBRA continuation rates for the balance of the 18-month continuation period. The COBRA continuation period starts the day following your layoff date.
Health Care Flexible Spending Account (FSA)	Your contributions stop on your termination date, and you can submit eligible expenses incurred through your termination date. You can elect COBRA continuation coverage for the remainder of the plan year by electing coverage no later than 60 days after your termination date or the date you receive a COBRA continuation notice, whichever is later.
Dependent Day Care Flexible Spending Account (FSA)	Your contributions stop on your termination date. You can file claims for eligible expenses incurred during the plan year.
Basic and Optional Long-Term Disability (LTD)*	Coverage stops on your termination date.
Short-Term Disability (STD)*	Coverage stops on your termination date.
Basic Life Insurance*	Coverage stops on your termination date. You may choose conversion or portability within 31 days after your termination date.
Optional Life Insurance* (employee, spouse, child)	Coverage stops on your termination date. You may choose conversion or portability within 31 days after your termination date.
Basic Accidental Death and Dismemberment (AD&D)*	Coverage stops on your termination date. You may choose portability within 31 days after your termination date.
Optional Accidental Death and Dismemberment (AD&D)*	Coverage stops on your termination date. You may choose portability within 31 days after your termination date.
Group Legal	Coverage stops on your termination date. You may be able to continue coverage by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage date.
Health Savings Account (HSA)**	Your pre-tax contributions stop on your termination date.

Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)* **	Coverage stops on your termination date. You may be able to continue coverage by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

**Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*
***You own the HSA. The HSA is not part of the Northrop Grumman Health Plan. You may continue to make HSA contributions directly to the HSA custodian if you elect continuation coverage for your HDHP and have no other disqualifying coverage.*
****Baltimore and Sunnyvale represented employees are not eligible.*

IF YOU RETIRE

If your employment terminates at a time when you are eligible for retiree benefits and your termination of employment is coded as a retirement, here is what happens to your benefits:

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
Medical, **Dental, Vision**, **EAP**	Coverage continues to the end of the month in which you terminate employment. You can elect COBRA within 60 days of your termination date or enroll in a Northrop Grumman retiree medical plan, if eligible (call the NGBC for details and costs).
Health Care Flexible Spending Account (FSA)	Your contributions stop on your termination date, and you can submit eligible expenses incurred through your termination date. You can elect COBRA continuation coverage for the remainder of the plan year by electing coverage no later than 60 days after your termination date or the date you receive a COBRA continuation notice, whichever is later.
Dependent Day Care Flexible Spending Account (FSA)	Your pre-tax contributions stop on your termination date. You can file claims for eligible expenses incurred during the plan year.
Basic and Optional Long-Term Disability (LTD)*	Coverage stops on your termination date.
Short-Term Disability (STD)*	Coverage stops on your termination date.
Basic Life Insurance*	Coverage stops on your termination date. You may choose conversion or portability within 31 days after your termination date.
Optional Life Insurance* (employee, spouse, child)	Coverage stops on your termination date. You may choose conversion or portability within 31 days after your termination date.
Basic Accidental Death and Dismemberment (AD&D)*	Coverage stops on your termination date. You may choose portability within 31 days after your termination date.
Optional Accidental Death and Dismemberment (AD&D)*	Coverage stops on your termination date. You may choose portability within 31 days after your termination date.
Group Legal	Coverage stops on your termination date. You may be able to continue coverage by making payments directly to the carrier. You must contact MetLife Legal Plans within 30 days of your coverage end date.
Health Savings Account (HSA)**	Your pre-tax contributions stop on your termination date.
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)* **	Coverage stops on your termination date. You may be able to continue coverage by making payments directly to the carrier. You must contact MetLife within 31 days of your coverage end date.

**Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*
***You own the HSA. The HSA is not part of the Northrop Grumman Health Plan. You may continue to make HSA contributions directly to the HSA custodian if you elect COBRA continuation coverage for your HDHP and have no other disqualifying coverage.*

****Baltimore and Sunnyvale represented employees are not eligible.*

IF YOU DIE WHILE ACTIVELY EMPLOYED

If you die while actively employed,* here is what happens to your benefits:

BENEFIT OPTION	WHAT HAPPENS TO YOUR BENEFITS
Medical, **Dental**, **Vision and EAP**	Dependent coverage continues through COBRA at no charge to your eligible survivor(s) (spouse (or eligible domestic partner) and eligible dependent children) to the end of the month plus one year from the date of your death. At the end of the year, if you had met the age and service requirements to qualify for retiree medical at the time of death, your survivors will be eligible to participate in the Retiree Medical Plan, if eligible. Otherwise, your eligible dependents may continue benefits for the balance of the 36-month COBRA continuation period by paying the full COBRA rates.
Health Care Flexible Spending Account (FSA)	Contributions stop on the date of your death. Your dependents can file claims for eligible expenses incurred before your death. Your dependents also have the option to continue the FSA with after-tax contributions through COBRA for the remainder of the plan year.
Dependent Day Care Flexible Spending Account (FSA)	Contributions stop on the date of your death. Your dependents can file claims for eligible expenses incurred through the end of the plan year.
Basic and Optional Long-Term Disability (LTD)**	Coverage stops on the date of your death.
Short-Term Disability (STD)**	Coverage stops on the date of your death.
Basic and Optional Life Insurance (employee)**	Your beneficiary receives the amount of your basic life insurance and any optional life insurance you selected for yourself.
Optional Life Insurance (spouse, child)**	Coverage continues for 31 days from the date of your death, during which time your dependent(s) may choose conversion or portability.
Basic Accidental Death and Dismemberment (AD&D)**	If you die in an accident, your beneficiary receives the amount of your basic AD&D insurance; otherwise, coverage stops on the date of your death.
Optional Accidental Death and Dismemberment (AD&D)**	If you die in an accident, your beneficiary receives the amount of any optional AD&D insurance you selected. Coverage stops on the date of your death unless you chose family coverage. Your covered dependents may choose conversion or portability within 31 days from the date of your death.
Group Legal	Coverage stops on the date of your death.
Health Savings Account (HSA)***	Your pre-tax contributions stop on the date of your death.
Voluntary Benefits (Voluntary Critical Illness, Hospital Indemnity and Accident Insurance)******	Coverage stops on the date of your death.

**For purposes of this section, you will be considered "actively employed" if you are actively at work or you are on a temporary leave of absence during which you are paying for coverage at active-employee rates.*

***Independence, MO represented employees have a 120-day probation period. ABL represented employees are not eligible for AD&D.*

****You own the HSA. The HSA is not part of the Northrop Grumman Health Plan. In the event of your death, any amounts remaining in the HSA transfer to the beneficiary named in the HSA beneficiary designation form. (If a beneficiary is not named, the funds transfer according to the terms of the HSA trust or custodial account agreement).*

*****Baltimore and Sunnyvale represented employees are not eligible.*

If your death is due to a job-related accident or illness while you are actively employed, your spouse (or eligible domestic partner's) and/or qualifying dependent(s)'s medical coverage continues at no cost for at least the end of the month plus one year from the date of death. After that period, your spouse's (or eligible domestic partner's) coverage will continue up to the time he or she turns age 65, becomes eligible for Medicare, or remarries — whichever happens first. (If your spouse (or eligible domestic partner) is age 65 or older at the time of your death, coverage will continue to the end of the month plus one year from the date of your death.) Your qualifying dependent(s)'s coverage will continue at no cost for at least the end of the month plus one year from the date of death, and after that for as long as he or she continues to qualify as an eligible dependent. If you have met the minimum age and service requirements of the Northrop Grumman Retiree Medical Plan at the time of your death, your spouse (or eligible domestic partner) and/or qualifying dependent(s) may be eligible for benefits under the Northrop Grumman Retiree Medical Plan.

If You Are Rehired or Recalled

If you are rehired (after you were terminated) and you return to employment with Northrop Grumman, or you are recalled (after you were terminated for lack of work or a reduction in workforce) and you return to work, how your benefits are affected depends on when you return to work:

IF YOU ARE REHIRED OR RECALLED DURING THE SAME PLAN YEAR

In most cases, your prior benefit choices are reinstated on the date you return to work. However, optional life insurance will be subject to Evidence of Insurability. See **Life and Accident Insurance** for details. Please call the NGBC at 800-894-4194 to confirm your reinstatement is in place, or to verify or change your coverage. If you are rehired within 31 days of your termination, no changes are permitted unless you have a qualified life event.

IF YOU ARE REHIRED OR RECALLED IN A DIFFERENT PLAN YEAR

You are treated as a new employee for purposes of the Northrop Grumman Health Plan. See **Enrolling as a New Employee** for details. Your prior benefits will not automatically be reinstated.

Well-being

This section of your SPD includes information about well-being options available to you under the Northrop Grumman Health Plan. Read this section carefully for the information that applies to your specific health care coverage options.

MY WELL-BEING

We encourage your personal and professional well-being by supporting you in achieving your personal best. Taking advantage of the information, activities, and resources available to you can help you meet a wide range of personal needs and ultimately empower you and your family to take responsibility for your own physical, emotional, social and financial well-being.

Well-being Incentive Program*

This financial incentive encourages you to take advantage of free preventive health care and to get to know a doctor so you have a resource for medical assistance when the need arises. You and your spouse or eligible domestic partner may receive a reward of $500 each during the plan year, or $1,000 combined when you complete your annual physical or cancer screening or the well-being assessment through Quantum Health and biometric screening through Quest Diagnostics within certain communicated timeframes. Rewards will consist of either a monetary contribution into your Health Savings Account (HSA) account or in your paycheck as taxable income if you are not enrolled in an HSA-qualified plan, have not elected to have an HSA through Fidelity, or your HSA is not in good order. You must be an active employee in order to receive an incentive. If you terminate employment prior to Northrop Grumman's provision of the incentive, you will not receive the incentive, even if you completed your annual physical and well-being assessment prior to terminating employment.

**Baltimore and Sunnyvale Represented employees are not eligible.*

Annual Physical Incentive Program

Baltimore and Sunnyvale represented employees are eligible for this program. The Annual Physical Incentive encourages you to seek preventive care, which is the key to early detection of health problems. You and your eligible dependents are eligible to receive up to a $500 credit toward your medical premiums if you are enrolled in a Northrop Grumman medical plan and get an annual physical within certain communicated timeframes.

Vida Health Programs

Vida Health is a virtual program to help manage your health and well-being depending on your need. Whether you're focused on nutrition, weight loss, mental health or overall well-being, Vida Health can connect you with a health coach who will personalize a plan for you and then guide you every step of the way.

Vida Health helps manage chronic conditions such as diabetes, high blood pressure, heart health and COPD. Vida Health offers diabetes experts that help manage weight, stress, blood sugar levels and any lifestyle related changes that may adversely impact your health.

A health coach can also help build resilience, address burnout and manage life changes, including a smoking cessation program through Vida Health. The health coach can teach you the skills and techniques needed to successfully quit smoking.

The Vida Health programs are available to Anthem members age 18 and over at no additional cost.

To get started, download the Vida Health app and complete the registration process. You will be able to message your health coach and track your progress all within the app. If you have questions or need help with registration, please call Vida Health at 855-442-5885.

SWORD Health

You and your dependents 13 and older who are enrolled in an Anthem medical plan have access to a free virtual program through SWORD Health offering physical therapy for back, joint and muscle pain. You will be partnered with a licensed physical therapist who will design a personalized therapy program. To track your progress, you will receive a tablet and motion sensors and complete the program from the comfort of your home, or anywhere. To learn more, visit livehealthonline.com.

Medical

Access to comprehensive, high-quality medical care is a primary concern for many people. That's why Northrop Grumman offers medical coverage for you and your family through the Northrop Grumman Health Plan. The goal of the Plan is to provide you with access to affordable and quality health care when you need it. These benefits are designed to help you and your family maintain health and to protect you from major financial hardship in the event of illness or injury.

This section of your SPD includes information about the medical coverage options available to you under the Northrop Grumman Health Plan. Read this section carefully for the information that applies to your specific health care coverage options.

Note: The coverage certificates and subscriber contracts for Cigna Global Health Benefits® and the Health Maintenance Organization (HMO) options are considered part of and must be read together with this summary plan description.

MEDICAL PLAN OPTIONS

The Northrop Grumman Health Plan is designed to give you the flexibility to choose what you want to pay for medical care. The Plan offers you a choice of:

- **Three medical plans administered by Anthem**, including two IRS-qualified high-deductible health plans*
- **Regional HMO plan options**, if offered in your home ZIP code area
- **Cigna Global Medical** (if you work and live outside the United States or on a regular rotational assignment abroad)

The medical plan options differ by level of coverage, your contribution for coverage and the way you receive medical care. You can enroll in coverage for yourself and your eligible dependents when you are first hired, if you experience a qualified life event and during annual enrollment.

If you choose the no coverage option, you and your eligible family members will not have any medical, prescription drug, or mental health and substance abuse benefits (other than those offered by the Employee Assistance Program (EAP)) through Northrop Grumman.

You cannot change your election until the next annual enrollment period, unless you have a **Qualified Life Event** during the plan year. Consider this option carefully before making your decision.

Even if you waive medical coverage, you may still participate in other benefits under the Northrop Grumman Health Plan, including dental and vision. In addition, all eligible employees are automatically covered by the EAP.

Terms to Know

Coinsurance: The portion of the payment for medical services that you are responsible for. For example, a plan may pay for 80% of the costs of a service, while you will have to pay the remaining 20%. That 20% is known as “coinsurance.”

Deductible: The amount of money you pay each plan year before your plan option begins to pay benefits for eligible expenses.

Maximum Allowed Amount: The amount determined by the claims administrator, that the plan will base its payment on, with respect to covered health services. In general, the claims administrator’s determination of the Maximum Allowed Amount depends on whether you see a network or out-of-network provider.

Network: A group of physicians, dentists, hospitals, labs and other health care providers who agree to treat plan participants at a specified discounted rate so they can be affiliated with the plan.

Out-of-Pocket Maximum: The limit on your total copayments, deductibles and coinsurance under a plan option. Ineligible expenses do not count toward your out-of-pocket maximum.

**Baltimore and Sunnyvale represented employees are not eligible.*

COMPARING THE MEDICAL PLANS*

The Northrop Grumman Health Plan allows you to choose a medical plan based on what's important to you and your estimated medical expenses. You can decide if you want a lower or higher deductible and out-of-pocket maximum during the year. Depending on your choice, you will pay a higher or lower premium. Below is a summary of the medical plans administered by Anthem.

[1]Available to most employees.
[2]Plan 4: Medium Premium/Deductible Utah Extended Network Plan is available in Utah/Idaho. This plan has the same benefit level as Plan 2: Medium Premium/Medium Deductible Plan, but broader network access that includes Intermountain Healthcare Systems.

All three plans:

- Cover preventive care at 100%
- Give you access to the same Anthem network of high-quality providers**
- Give you direct access to specialists with no referral needed
- Include CVS/caremark® prescription drug coverage, which offers savings when you purchase generic drugs and visit in-network pharmacies
- Cover the same services (different limitations for certain services may apply)
- Offer telemedicine services through LiveHealth Online for a low cost

**See the section on Comparing the Medical Plans for Baltimore and Sunnyvale Represented Employees if you are a Baltimore or Sunnyvale represented employee.*

***Plan 4: Medium Premium/Deductible Utah Extended Network Plan has broader network access that includes Intermountain Healthcare Systems.*

The following chart provides a summary of the benefits provided under the Anthem plans for 2026.* Please see the sections for the **Health Maintenance Organization (HMO) Medical Plan Options** or **Cigna Global Medical Plan Option** for details specific to those plans.

	PLAN 1: HIGH PREMIUM/ LOW DEDUCTIBLE PLAN[1]	PLAN 2: MEDIUM PREMIUM/ MEDIUM DEDUCTIBLE PLAN[2]	PLAN 3: LOW PREMIUM/ HIGH DEDUCTIBLE PLAN
Annual In-network Medical Deductible (Out-of-network deductibles are double the in-network deductibles and do not cross accumulate)			
You Only	$1,000	$1,700	$3,500
You + Spouse/ Domestic Partner	$1,500	$3,400	$5,250
You + Child(ren)	$1,500	$3,400	$5,250
You + Family	$2,000	$3,400	$6,750
Annual In-network Medical Coinsurance (For out-of-network coverage, the plans pay 50% of maximum allowed amount after the deductible)			
Preventive	All plans provide 100% coverage for nationally recommended preventive care services		
Non-Preventive	After the deductible, the plan pays 80% and you pay 20%	After the deductible, the plan pays 80% and you pay 20%	After the deductible, the plan pays 70% and you pay 30%
Annual Prescription Drug Deductible			
You Only	$150	Included in medical deductible	Included in medical deductible
You + Spouse/ Domestic Partner	$200		
You + Child(ren)	$200		
You + Family	$250		
Annual Prescription Drug Coinsurance (For out-of-network coverage, the plan pays 50% of the allowed amount)			
Preventive	All plans provide 100% coverage for certain eligible preventive prescription drugs through in-network pharmacies or mail order. Other preventive drugs may require a coinsurance payment that will not be subject to the deductible.		
Non-Preventive	After the applicable deductible is met: • For generic drugs, plans pay 80% and you pay 20% • For preferred brand-name drugs, plans pay 75% and you pay 25% • For non-preferred brand-name drugs, plans pay 65% and you pay 35% • For specialty drugs, the plan pays 75% (maximum amount you pay is $400 per prescription) • Maximum you pay for generic, preferred brand and non-preferred brand drugs if using CVS mail service or CVS/caremark Maintenance Choice® is $200		

**Baltimore and Sunnyvale represented employees are not eligible.*

	PLAN 1: HIGH PREMIUM/ LOW DEDUCTIBLE PLAN	PLAN 2: MEDIUM PREMIUM/ MEDIUM DEDUCTIBLE PLAN	PLAN 3: LOW PREMIUM/ HIGH DEDUCTIBLE PLAN
Annual In-network Out-of-pocket Maximums The out-of-pocket maximum applies to all covered family members combined based on your coverage tier. However, the out-of-pocket maximum for any individual family member is the amount of the "You Only" tier. (Out-of-network out-of-pocket maximums are double the in-network out-of-pocket maximums, and do not count toward each other.)			
You Only	$2,000	$4,000	$6,500
You + Spouse/ Domestic Partner	$3,000	$6,000	$9,750
You + Child(ren)	$3,000	$6,000	$9,750
You + Family	$4,000	$8,000	$13,000
Accounts to Help You Offset Your Deductible or Cover Medical Expenses (see **Tax-Advantaged Accounts**)			
FSA-eligible	Yes	Yes	Yes
HSA-eligible	No	Yes	Yes

[1] *Available to most employees.*

[2] *Plan 4: Medium Premium/Deductible Utah Extended Network Plan is available in Utah/Idaho. This plan has the same benefit level as Plan 2: Medium Premium/Medium Deductible Plan, but broader network access that includes Intermountain Healthcare Systems.*

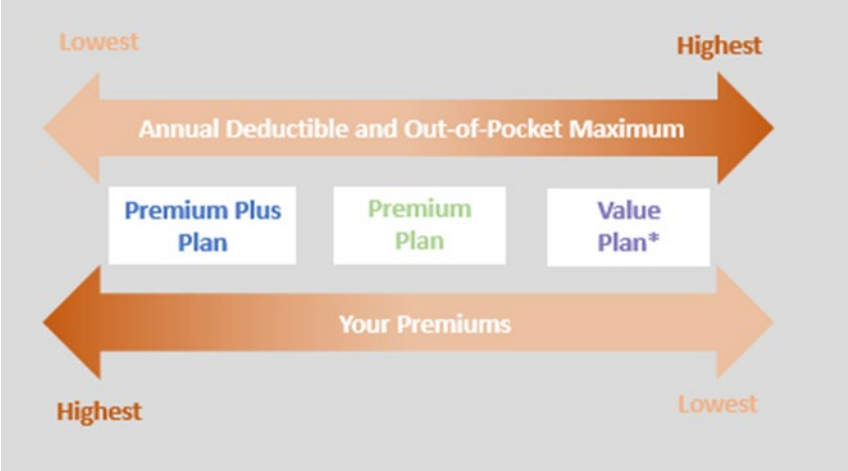
**Baltimore and Sunnyvale represented employees are not eligible.*

Did You Know?

Northrop Grumman offers a Well-being Incentive where you and your covered spouse or domestic partner can each receive $500 for getting an annual physical and completing an online health assessment. See **Well-being Incentive Program*** for more information.

COMPARING THE MEDICAL PLANS FOR BALTIMORE AND SUNNYVALE REPRESENTED EMPLOYEES

The Northrop Grumman Health Plan allows you to choose a medical plan based on what's important to you and your estimated medical expenses. You can decide if you want a lower or higher deductible and out-of-pocket maximum during the year. Depending on your choice, you will pay a higher or lower premium. Below is a summary of the medical plans administered by Anthem.



**High Deductible Health Plan*

All three plans:

- Cover preventive care at 100%
- Give you access to the same Anthem network of high-quality providers
- Give you direct access to specialists with no referral needed
- Include CVS/caremark® prescription drug coverage, which offers savings when you purchase generic drugs and visit in-network pharmacies
- Cover the same services (different limitations for certain services may apply)
- Offer telemedicine services through LiveHealth Online for a low cost. Not subject to deductible

The following chart provides a summary of the Baltimore represented employee benefits provided under the Anthem plans for 2026. Please see the sections for the **Health Maintenance Organization (HMO) Medical Plan Options** for details specific to those plans.

	BALTIMORE PREMIUM PLUS PLAN	BALTIMORE PREMIUM PLAN	BALTIMORE VALUE PLAN
Annual Medical Deductible			
You Only	$1,100 In-Network and Out-of-Network Combined	$1,550 In-Network and Out-of-Network Combined	$1,700 In-Network; $3,200 Out-of-Network
You + Spouse/ Domestic Partner	$1,600 In-Network and Out-of-Network Combined	$2,275 In-Network and Out-of-Network Combined	$3,400 In-Network; $4,800 Out-of-Network
You + Child(ren)	$1,600 In-Network and Out-of-Network Combined	$2,275 In-Network and Out-of-Network Combined	$3,400 In-Network; $4,800 Out-of-Network
You + Family	$2,100 In-Network and Out-of-Network Combined	$3,000 In-Network and Out-of-Network Combined	$3,400 In-Network; $6,400 Out-of-Network
Annual In-network Medical Coinsurance (For out-of-network coverage, the plans pay 50% of maximum allowed amount after the deductible)			
Preventive	All plans provide 100% coverage for nationally recommended preventive care services		
Non-Preventive	After the deductible, the plan pays 80% and you pay 20%		
Annual Prescription Drug Deductible			
You Only	Medical deductible does not apply	Medical deductible does not apply	Included in medical deductible
You + Spouse/ Domestic Partner			
You + Child(ren)			
You + Family			
Annual Prescription Drug Coinsurance (For out-of-network coverage, the plan pays 50% of the allowed amount)			
Preventive	All plans provide 100% coverage for certain eligible preventive prescription drugs through in-network pharmacies or mail order. Other preventive drugs may require a coinsurance payment that will not be subject to the deductible.		
Non-Preventive	After the applicable deductible is met: • For generic drugs, plans pay 80% and you pay 20% • For preferred brand-name drugs, plans pay 80% and you pay 20% • For non-preferred brand-name drugs, plans pay 65% and you pay 35% • For specialty drugs, the plan pays 80% (maximum amount you pay is $200 per prescription) • Maximum you pay for generic, preferred brand and non-preferred brand drugs if using CVS mail service or CVS/caremark Maintenance Choice® is $200		

	PLAN 1: PREMIUM PLUS PLAN	PLAN 2: PREMIUM PLAN	PLAN 3: VALUE PLAN
Annual Out-of-pocket Maximums The out-of-pocket maximum applies to all covered family members combined based on your coverage tier. However, the out-of-pocket maximum for any individual family member is the amount of the "You Only" tier.			
You Only	$4,000 In-Network and Out-of-Network Combined	$5,000 In-Network and Out-of-Network Combined	$6,000 In-Network; $12,000 Out-of-Network
You + Spouse/ Domestic Partner	$6,000 In-Network and Out-of-Network Combined	$7,500 In-Network and Out-of-Network Combined	$9,000 In-Network; $18,000 Out-of-Network
You + Child(ren)	$6,000 In-Network and Out-of-Network Combined	$7,500 In-Network and Out-of-Network Combined	$9,000 In-Network; $18,000 Out-of-Network
You + Family	$8,000 In-Network and Out-of-Network Combined	$10,000 In-Network and Out-of-Network Combined	$12,000 In-Network; $24,000 Out-of-Network
Accounts to Help You Offset Your Deductible or Cover Medical Expenses (see **Tax-Advantaged Accounts**)			
FSA-eligible	Yes	Yes	Yes
HSA-eligible	No	No	Yes

Did You Know?

Northrop Grumman offers an Annual Physical Incentive where you can earn up to $500 for getting an annual physical. See Annual Physical Incentive* for more information.

**Only Baltimore and Sunnyvale represented employees are eligible.*

As a Baltimore represented employee, you may be eligible for a credit as specified in your collective bargaining agreement against your share of the cost of medical coverage under the Plan. To receive the credit, you must complete a tobacco usage attestation certifying you and your covered dependents do not use tobacco. Log on to Fidelity NetBenefits® at **www.netbenefits.com/northropgrumman** to make your attestation.

If you or a covered dependent use tobacco products, you can receive the premium credit if the tobacco user(s) complete the tobacco cessation program through Vida Health (which will be a no cost to you) or any program recommended by your doctor. Visit https://www.vida.com/northropgrumman/ for more information. The credit will be available as long as the tobacco user(s) complete the program, regardless of whether the tobacco user(s) are successful in quitting tobacco.

If you are enrolling during annual enrollment, you must certify that you and your covered family members are non-tobacco users or complete the tobacco cessation program by December 31 following the annual enrollment period in order to obtain the full credit for the following plan year; if you make the attestation or complete the tobacco cessation program after that date, the credit will be applied on a prospective basis only. If you are enrolling during the plan year (e.g., you are a new hire or you experience a qualified life event), you must certify that you and your covered family members are non-tobacco users or complete the tobacco cessation program within 60 days of the date of

enrollment in order to receive the credit for the balance of the plan year; if you make the certification or complete the tobacco cessation program after this 60-day time frame, the credit will be applied on a prospective basis only.

If you have any questions, contact the NGBC or visit the Vida website linked above.

The following provides a summary of the Sunnyvale represented employee benefits under the Anthem plans for 2026. Please see the sections for the **Health Maintenance Organization (HMO) Medical Plan Options** for details specific to those plans.

	SUNNYVALE PREMIUM PLAN	SUNNYVALE VALUE PLAN
Annual Medical Deductible		
You Only	$1,200 In-Network and Out-of-Network Combined	$1,700 In-Network; $3,200 Out-of-Network
You + Spouse/ Domestic Partner	$1,800 In-Network and Out-of-Network Combined	$3,400 In-Network; $4,800 Out-of-Network
You + Child(ren)	$1,800 In-Network and Out-of-Network Combined	$3,400 In-Network; $4,800 Out-of-Network
You + Family	$2,400 In-Network and Out-of-Network Combined	$3,400 In-Network; $6,400 Out-of-Network
Annual In-network Medical Coinsurance (For out-of-network coverage, the plans pay 50% of maximum allowed amount after the deductible)		
Preventive	All plans provide 100% coverage for nationally recommended preventive care services	
Non-Preventive	After the deductible, the plan pays 80% and you pay 20%	
Annual Prescription Drug Deductible		
You Only	Medical deductible does not apply	Included in medical deductible
You + Spouse/ Domestic Partner		
You + Child(ren)		
You + Family		
Annual Prescription Drug Coinsurance (For out-of-network coverage, the plan pays 50% of the allowed amount)		
Preventive	All plans provide 100% coverage for certain eligible preventive prescription drugs through in-network pharmacies or mail order. Other preventive drugs may require a coinsurance payment that will not be subject to the deductible.	
Non-Preventive	After the applicable deductible is met: • For generic drugs, plans pay 80% and you pay 20% • For preferred brand-name drugs, plans pay 80% and you pay 20% • For non-preferred brand-name drugs, plans pay 65% and you pay 35% • For specialty drugs, the plan pays 80% (maximum amount you pay is $200 per prescription) • Maximum you pay for generic, preferred brand and non-preferred brand drugs if using CVS mail service or CVS/caremark Maintenance Choice® is $200	

	PLAN 1: PREMIUM PLAN	PLAN 3: VALUE PLAN
Annual Out-of-pocket Maximums The out-of-pocket maximum applies to all covered family members combined based on your coverage tier. However, the out-of-pocket maximum for any individual family member is the amount of the "You Only" tier.		
You Only	$3,000 In-Network and Out-of-Network Combined	$6,000 In-Network; $12,000 Out-of-Network
You + Spouse/ Domestic Partner	$4,500 In-Network and Out-of-Network Combined	$9,000 In-Network; $18,000 Out-of-Network
You + Child(ren)	$4,500 In-Network and Out-of-Network Combined	$9,000 In-Network; $18,000 Out-of-Network
You + Family	$6,000 In-Network and Out-of-Network Combined	$12,000 In-Network; $24,000 Out-of-Network
Accounts to Help You Offset Your Deductible or Cover Medical Expenses (see **Tax-Advantaged Accounts**)		
FSA-eligible	Yes	Yes
HSA-eligible	No	Yes

Did You Know?

Northrop Grumman offers an Annual Physical Incentive where you can earn up to $500 for getting an annual physical. See Annual Physical Incentive* for more information.

**Only Baltimore and Sunnyvale represented employees are eligible.*

PAYING FOR CARE

Step 1: Deductible	A deductible is the amount you pay each plan year for covered health care expenses before your plan begins to share in the cost of care. Did you know: • The plan pays 100% for certain in-network preventive care, even if you haven't met the annual deductible. • You can use dollars from your savings account (HSA or FSA) to help pay for eligible expenses that will be applied toward your deductible. • If you enroll a dependent in the plan, the entire deductible for your coverage tier (e.g., You + Spouse/Domestic Partner, You + Child(ren) or You + Family) must be paid before the plan begins to pay for your and your family's eligible expenses. The deductible can be met by any combination of family members covered under the plan. • There is a separate deductible for out-of-network benefits that does not combine with the deductible for in-network benefits.
Step 2: Coinsurance	After you have paid the annual deductible, the plan shares a percentage of the cost with you. The plan pays 80% or 70% for expenses incurred from in-network providers (depending on the plan you elect); 50% of the maximum allowed amount for expenses incurred from out-of-network providers.
Step 3: Out-of-Pocket Maximum	This is an annual cap on your out-of-pocket spending toward covered services under the plan you choose; it does not include your premium contributions. Once you reach this maximum, the plan pays the full cost of your eligible medical services (up to the maximum allowed amount) until the end of the plan year. There is an out-of-pocket maximum that applies to all covered family members combined based on your coverage tier. However, the out-of-pocket maximum for any individual family member is the amount of the "You Only" tier. This means if an individual within the family reaches the "You Only" maximum, the plan will pay 100% of the eligible expenses for that individual. You can save money when you use in-network providers and pharmacies. Out-of-network expenses have a separate out-of-pocket maximum that is twice the amount of the in-network out-of-pocket maximum and will cost you more money.

Understanding how you pay for care allows you to make the best decision for you and your family, based on your unique situation. The following generally describes how the Anthem medical plans work.

Deductible

The deductible is the amount of money you pay before the plan begins to pay for your eligible medical and pharmacy expenses. The deductible can be met by any combination of family members covered under the plan. That is, one participant may satisfy the deductible for all covered family members or claims from more than one family member can be combined to meet the deductible.

The deductible will not apply to certain preventive care and certain preventive prescription drugs as defined under the Patient Protection and Affordable Care Act. When the deductible does not apply towards a prescription drug that requires cost-sharing, you will only be responsible for the coinsurance portion of the drug expense. The plan will pay 100% for certain preventive prescription drugs purchased through in-network pharmacies or mail order. See

Prescription Drug Coverage for more information.

Separate deductibles and out-of-pocket maximums for in- and out-of-network services. In-network expenses count toward your in-network deductible and in-network maximum only. Out-of-network expenses count toward your out-of-network deductible and out-of-pocket maximum only. Each plan year, you have a new deductible. Expenses credited to your deductible do not carry over from one plan year to the next. If you transfer from one Anthem plan option to another Anthem plan option as an active employee, amounts you incurred towards your deductible in the plan year will carry over from the previous plan.

ATTN: In Plan 1: High Premium/Low Deductible Plan, there is a separate deductible for prescription drug expenses as described in the

Prescription Drug Coverage section. In addition, the medical deductible amounts may be prorated if you participate in Plan 1: High Premium/Low Deductible Plan for less than a full plan year, depending on when your participation begins.

(Due to IRS guidelines for a high-deductible health plan, the deductible amounts in the Plan 2: Medium Premium/Medium Deductible* and Plan 3: Low Premium/High Deductible* and Baltimore and Sunnyvale Value Plans will not be prorated.)

Keep in Mind

Some medical costs you incur may not count toward your medical deductible, such as:

- Any service that is not a covered service under the plans, such as cosmetic surgery or experimental procedures
- Out-of-network provider expenses that are in excess of the **Maximum Allowed Amount**
- Any preauthorization penalties you incur (See **Preauthorization** for details)
- Charges that exceed the benefit maximums for services, such as acupuncture and acupressure, chiropractic care and private duty nursing
- Copayments made for **LiveHealth Online** services (Plan 1: High Premium/Low Deductible Plan only). However, copayments do apply to the out-of-pocket maximum.
- Any amounts applied to your prescription drug deductible (Plan 1: High Premium/Low Deductible Plan only), or any ineligible prescription drug charges, including costs you incur for not complying with CVS/Caremark's prescription drug policies (See

Prescription Drug Coverage for

**Baltimore and Sunnyvale represented employees are not eligible.*

Coinsurance

Coinsurance is the amount you pay toward eligible expenses for covered health services, generally after you have met the deductible the amount of coinsurance you are required to pay may vary depending on whether you receive services from an in-network provider or an out-of-network provider and which medical plan you are enrolled in.

You must meet the annual deductible before the coinsurance applies for all services unless specifically noted otherwise in this SPD.

Generally, the plans pay 80% or 70% of the cost of most covered services if you use an in-network provider, and you pay 20% or 30%, up to an out-of-pocket maximum for the plan year. If you use an out-of-network provider, the plans pay 50% of the cost of most covered services, up to the **Maximum Allowed Amount**, and you pay 50%, up to the out-of-pocket maximum (plus any amount in excess of the Maximum Allowed Amount or contracted amount). See

Prescription Drug Coverage for information about coinsurance for prescription drug expenses, which is typically expressed as a percentage of the eligible expense.
**Baltimore and Sunnyvale represented employees are not eligible.*

Out-of-Pocket Maximum

The out-of-pocket maximum is the most that you will pay toward covered health expenses in a single plan year. Your out-of-pocket maximum is satisfied by the amounts paid toward the deductible, coinsurance or copayments, including amounts paid with an HSA, Health Reimbursement Account (HRA) or FSA. Expenses credited to your out-of-pocket maximum do not carry over from one plan year to the next. You begin each plan year with $0 credited toward your out-of-pocket maximum.

The plans have separate deductibles and out-of-pocket maximums for in- and out-of-network services. Amounts you pay that are counted toward your in-network deductible count toward your in-network out-of-pocket maximum. Once the deductible has been met, the coinsurance you pay on eligible in-network services for all of your covered family members also counts toward your in-network out-of-pocket maximum.

Amounts you pay that are counted toward your out-of-network deductible count toward your out-of-network out-of-pocket maximum. Once the out-of-network deductible has been met, the coinsurance of 50% of the **Maximum Allowed Amount** that you pay on eligible out-of-network services for all family members also counts toward your out-of-network out-of-pocket maximum. If you meet the maximum, the plan will pay 100% of eligible out-of-network services for all of your covered family members through the remainder of the benefit year. Charges in excess of the **Maximum Allowed Amount** are not included as eligible charges, so those amounts do not count toward the out-of-pocket maximum and are not covered even after the out-of-pocket maximum has been met.

ATTN: The out-of-pocket maximum amounts will be reduced if you participate in Plan 1: High Premium/Low Deductible Plan*, Baltimore Premium Plus Plan, Baltimore Premium Plan or Sunnyvale Premium Plan for less than a full plan year. The amount of the reduction will be equal to the amount by which your medical deductible is reduced pursuant to the pro rata reduction described earlier. (Due to IRS guidelines for a high-deductible health plan, the out-of-pocket maximum amounts in the Plan 2: Medium Premium/Medium Deductible* and Plan 3: Low Premium/High Deductible* and Baltimore and Sunnyvale Value Plans will not be reduced.)

**Baltimore and Sunnyvale represented employees are not eligible.*

Keep in Mind

Any amount you pay toward the cost of certain medical services will not count toward your out-of-pocket maximum, including:

- Any service that is not a covered service under the plans, such as cosmetic surgery or experimental procedures
- Out-of-network expenses that are in excess of **Maximum Allowed Amount** charges
- Charges that exceed the benefit maximums for services, such as acupuncture and acupressure, chiropractic care and private duty nursing
- Ineligible prescription drug charges, including costs you incur for not complying with CVS/caremark's prescription drug policies (See **Prescription Drug** Coverage for details)

The Plan's reimbursement for durable medical equipment, orthotics, prosthetics, hearing aids and wigs (and necessary supplies for those items) will be based on the Maximum Allowed Amount for a standard item that is Medically Necessary to meet your needs. Notwithstanding anything to the contrary in this SPD, if you choose to purchase an item with features that are not Medically Necessary, or if the amount that the provider charges you for the standard item exceeds the Maximum Allowed Amount, benefits will be limited to the Maximum Allowed Amount (less any applicable cost-sharing, such as a deductible or coinsurance) for the standard item, and you will be required to pay any costs that exceed the Maximum Allowed Amount at both network and out-of-network providers regardless of whether you have met the deductible or out-of-pocket maximum (and such costs will not count towards your deductible or out-of-pocket maximum). Please contact Quantum if you have questions about the Maximum Allowed Amount. Please also note that coverage of wigs is subject to the $1500 annual benefit maximum.

In-Network or Out-of-Network Providers

When you need medical care, you may choose a provider in the BlueCard PPO network (also known as the National PPO network in some areas) or a provider outside the network. The choice you make at the time you need medical care will determine what you pay for your care.

When you choose a network provider, you will receive a higher level of coverage, which means you pay less for your care. Plus, there are other advantages — you do not have to worry about charges above the **Maximum Allowed Amount**, and your network provider will file your claims.

Under the Anthem plans, referrals are not required to see a provider. However, certain services, such as specialty or hospital care, require **Preauthorization** from Quantum Health. In-network providers will obtain authorization on your behalf. Services from out-of-network providers require prior approval by Quantum Health. See the **Preauthorization** section for more details.

Here is a comparison of some of the key differences between receiving care from in-network and out-of-network providers in the Anthem plans.

IN-NETWORK	OUT-OF-NETWORK
You must use a provider in the BlueCard PPO or National PPO network*.	You can go to any licensed provider outside the BlueCard PPO or National PPO network.
Your deductible and out-of-pocket maximum are lower when you use in-network providers, which means **less out-of-pocket cost for you**.	Your deductible and out-of-pocket maximum are higher when you use out-of-network providers, which means **more out-of-pocket cost for you**.
The plan pays a higher percentage of eligible expenses after you pay the plan year deductible.	The plan pays a lower percentage of eligible expenses after you pay the plan year deductible.
You do not have to worry about amounts above the **Maximum Allowed Amount**.	You must also pay amounts above the **Maximum Allowed Amount,** which can be significant. These amounts do not help you meet the deductible and do not count toward your out-of-pocket maximum.
You do not have to file claims — your provider will do it for you.	You may have to file your own claims.

*Plan 4: Medium Premium/Medium Deductible uses the Traditional Network.

Keep In Mind

You receive higher benefits (pay less for health care services) if you receive care from an in-network provider.

You can search for in-network providers in your area by using Anthem's *Find Care* tool. The directory will help you locate and find information about doctors and other health care services in your area in the BlueCard PPO or National PPO networks.

To access *Find Care*, log in to the Anthem member website at **anthem.com/ca**. By entering your user name and password, you will be able to access the secure site and search for providers. Under Useful Tools, click on *Find Care* and choose what kind of doctor or health professional you want to find. Contact Quantum Health for support in finding in-network providers.

You do **not** need to choose and coordinate your care through a PCP — for in-network or out-of-network benefits. Some additional points to keep in mind about accessing in-network care:

- You are not limited to in-network providers in your state — you can receive care from any in-network provider in any state in the United States.
- Although you can visit any network physician, specialist or facility without a PCP and receive in-network benefits, you need to ensure that you are treated by network providers. This is not your physician's responsibility. **Do not assume that your physician referred you to a network provider.**

Keep in Mind

Advantages of staying in-network:

- The plan pays a higher percentage of eligible expenses after you pay the plan year deductible
- You do not have to worry about amounts above the **Maximum Allowed Amount**
- You do not have to file claims – your provider will do it for you

- Do not assume that just because a provider holds itself out as a BlueCard PPO network provider that the provider is in the network applicable to the plan. To confirm the network status of the provider, contact Quantum Health or log on to the Anthem website at **anthem.com/ca** and use the *Find Care* tool or call Quantum Health at 800-894-4194.
- If you are unable to locate an in-network provider, please contact Quantum Health for assistance. You may obtain an authorization for services with an out-of-network provider if there is no in-network provider within 30 miles of your home address. While this authorization will cover your services at the in-network level, you are still responsible for any amounts above the Maximum Allowable Amount.

See

Prescription Drug Coverage for information about in-network and out-of-network pharmacies.

Surprise Billing Claims
The Consolidated Appropriations Act of 2021 CAA ("CAA") is a Federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:
- Emergency services (as defined by the CAA and applicable guidance) provided by out-of-network providers;
- Covered services provided by an out-of-network provider at an in-network facility; and
- Out-of-network air ambulance services.

No Surprises Act Requirements
Emergency Services

As required by the CAA, emergency services are covered under the Plan:

- Without the need for pre-certification;
- Whether the provider is in-network or out-of-network;

If the emergency services you receive are provided by an out-of-network provider, covered services will be processed at the in-network benefit level.

Note that if you receive emergency services from an out-of-network provider, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by an in-network provider. However, out-of-network cost-shares i.e., deductibles, copays, and/or coinsurance will apply

to your claim if the treating out-of-network provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the out-of-network provider determines: (i) that you are able to travel to an in-network facility by non-emergency transport; (ii) the out-of-network provider complies with the notice and consent requirement described below; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the out-of-network provider after you are stabilized, you will be responsible for the out-of-network cost-shares, and the out-of-network provider will also be able to charge you any difference between the **Maximum Allowed Amount** and the out-of-network provider's billed charges. This notice and consent exception do not apply if the covered services furnished by an out-of-network provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive covered services from an out-of-network provider at an in-network facility (as defined by the CAA and applicable guidance), your claims will be paid at the out-of-network benefit level if the out-of-network provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for out-of-network cost-shares for those services and the out-of-network provider can also charge you any difference between the **Maximum Allowed Amount** and the out-of-network provider's billed charges. This requirement does not apply to ancillary services. Ancillary services include the following services: (A) emergency services; (B) anesthesiology services; (C) diagnostic services, including laboratory and radiology services; (D) pathology services; (E) neonatology services; (F) services performed by assistant surgeons hospitalists, or intensivists; and (G) any services set out by the U.S. Department of Health & Human Services. In addition, this notice and consent process will not apply if there is not an in-network provider at the facility who can perform the services you require.

Out-of-network providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

How Cost-Shares Are Calculated

Your cost shares for emergency services or for covered services received by an out-of-network provider at an in-network facility (where the notice and consent requirements do not apply or where notice and consent is not given), or out-of-network air ambulance services will be calculated using the median Plan in-network contract rate that the Plan pays in-network providers for the geographic area where the covered service is provided. Any out-of-pocket cost shares you pay with respect to such services will be applied to your in-network deductible and out-of-pocket maximum.

TRANSITION OF CARE

If you are currently receiving treatment for covered health services from a provider whose network status changes from in-network to out-of-network during such treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the in-network level for specified conditions and timeframes (generally, up to 90 days). This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud. To be eligible for transition of care benefits, one of the following must apply: (1) You are undergoing a treatment for a serious and complex condition (as defined by the CAA and applicable guidance) from the provider; (2) You are undergoing a course of institutional or inpatient care from the provider; (3) You are scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider with respect to the surgery; (4) You are pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) You are terminally ill (as defined by the CAA and applicable guidance) and are receiving treatment for such illness from the provider. If you would like help to find out if you are eligible for transition of care benefits, please call the telephone number on your ID card.

The description of the transition of care benefits described in the preceding paragraph is intended to reflect the requirements of the CAA. The transition of care benefits will be administered in compliance with applicable guidance issued under the transition of care provision of the CAA.

ANTHEM BLUE CROSS GLOBAL CORE PROGRAM

When you travel outside of the U.S., you can get help finding doctors and hospitals in nearly 190 countries and territories around the world through the Anthem Blue Cross Global Core Program. Call the Blue Cross Global Core Service Center at 800-810-2583 or call collect at 804-673-1177. Representatives can help you set up a doctor visit or hospital stay.

- If the Blue Cross Global Care Service Center helped get you admitted to a hospital, the hospital will file a claim for you. You will need to pay the hospital for the out-of-pocket fees you normally would pay, such as your deductible or coinsurance.
- For outpatient (no overnight stay at a hospital) and doctor care or inpatient care received without assistance from the Blue Cross Global Core Service Center, you will need to pay the provider directly and submit an international claim form with original bills to Anthem_MTL_Member_Submit_Claim_Mailbox@anthem.com. Claim forms are available online at **bcbsglobalcore.com** or by calling Quantum Health.
- You are responsible, at your expense, for obtaining an English translation of foreign country claim and medical records.
- Exchange rates are based on the following:
  - For inpatient hospital care, the rate is based on date of admission
  - For outpatient and professional services, the rate is based on the service date

FIND URGENT CARE

If it's not an emergency and you can't see your regular doctor, you may save time and money with other quick care options.

- **Telemedicine.** Available through LiveHealth® Online, allows you to visit with a board-certified doctor by using your smartphone, tablet, computer with a webcam or a kiosk at work (where available) for non-urgent services like pinkeye, a cold, the flu, a fever, rashes, infections, allergies or another common health condition.
- **Urgent Care Centers.** Staffed with family, pediatric, emergency room and internal medicine doctors. They treat certain conditions right away that are not as severe as emergencies.
- **Retail Health Clinics.** Often found in a major pharmacy or retail store. They have physician assistants and nurse practitioners onsite to treat basic health conditions.
- **Walk-in Doctors' Offices.** Usually, family practice doctors who can treat many things, even if you're not a regular patient or don't have an appointment.

Always call 911 or go the emergency room if you think you are having a real emergency or if you think you could put your health at serious risk by delaying care.

GENERAL

This section describes how the claims administrator determines the amount of reimbursement for eligible expenses. Reimbursement for services rendered by network and out-of-network providers is based on the Maximum Allowed Amount for the eligible medical or pharmacy service you receive.

The **Maximum Allowed Amount** for the plan is the maximum amount of reimbursement the claims administrator will allow for services and supplies:

- That are covered by the plan and are not excluded;
- That are medically necessary; and

- That are provided in accordance with all applicable preauthorization, utilization management or other requirements.

You may be required to pay a portion of the Maximum Allowed Amount if you have not met the deductible, or if a copayment or coinsurance applies.

When you receive covered services, the claims administrator will, to the extent applicable, apply claim processing rules to the claim submitted. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the claims administrator's determination of the Maximum Allowed Amount. In applying these rules, the claims administrator may determine that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same physician or other health care professional, the Maximum Allowed Amounts for those secondary and subsequent procedures may be reduced because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

NETWORK PROVIDERS

When you receive care from a network provider, the Maximum Allowed Amount is the rate the provider has agreed with the claims administrator to accept as reimbursement in full for the service. If you have satisfied the deductible, your coinsurance will be based on the Maximum Allowed Amount.

If your network provider sends you a bill for expenses above the negotiated fee, this is called "balance billing." You are not responsible for any amount above the negotiated fee, even if your provider bills you. After each visit to a provider, you will receive an explanation of benefits (EOB) statement that clearly states the amount paid to the provider on your behalf and the amount you owe, if any. Your EOB is your official notification of your financial obligation; you are responsible only for the amount stated on the EOB. If you have a question about a bill you receive from your provider, clarify it with Quantum Health before you make the payment.

However, if you incur expenses for certain services that are not authorized by the claims administrator, you may be responsible for these charges. To avoid these additional charges, make sure that your provider authorizes the following types of care with Quantum Health: inpatient and skilled nursing facility admissions, DME purchases or rentals over $1,500, Oncology care and services (chemotherapy, radiation therapy, etc.), Dialysis, Outpatient surgeries, Home health care services, MRI, MRA, PET scans, Organ, Tissue and Bone Marrow Transplants, Hospice Care and Genetic Testing. See **Preauthorization** for details.

OUT-OF-NETWORK PROVIDERS

For covered services you receive from an out-of-network provider, the **Maximum Allowed Amount** will be one of the following as determined by the claims administrator in its discretion:

- An amount based on the claims administrator's out-of-network provider fee schedule/rate, which the claims administrator has established in its discretion, and which the claims administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the claims administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services (CMS) for the same services or supplies, and other industry cost, reimbursement and utilization data; or
- An amount based on reimbursement or cost information from CMS. When basing the **Maximum Allowed Amount** upon the level or method of reimbursement used by CMS, the claims

administrator will update such information, which is unadjusted for geographic locality, no less than annually; or

- An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care; or
- An amount negotiated by the claims administrator or a third-party vendor that has been agreed to by the provider. This may include rates for services coordinated through case management; or
- An amount based on or derived from the total charges billed by the out-of-network provider.

Providers who are not contracted for the network applicable to this Plan, but contracted for other products with the claims administrator, are also considered out-of-network. The Maximum Allowed Amount for services from these providers will be one of the five methods shown above, unless the contract between the claims administrator and that provider specifies a different amount (in which case, that different amount will be the Maximum Allowed Amount).

Unlike network providers, out-of-network providers may send you a bill and collect for the amount of the provider's charge that exceeds the plan's Maximum Allowed Amount. This is called "balance billing" and the amount can be significant. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the provider charges. The difference does not apply to your out-of-pocket maximum. For this reason, you should strongly consider obtaining care in-network whenever possible.

Amounts you pay over the Maximum Allowed Amount charge are not credited to your plan year deductible or out-of-pocket maximum. So, in the example above, only $50 of the $350 you paid would count towards the out-of-pocket maximum.

Quantum Health is available to assist you in estimating the Maximum Allowed Amount for a particular service from an out-of-network provider. In order for the claims administrator to assist you, you will need to obtain from your provider the specific procedure code(s) and diagnosis code(s) for the services the provider will render. You will also need to know the provider's charges to calculate your out-of-pocket responsibility. Although customer service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be determined by the claims administrator based on the actual claim submitted by the provider and may be different than the amount estimated by the claims administrator.

An Example of Balance Billing

Let's assume:

- Your out-of-network physician charges $400 for an office visit
- The Maximum Allowed Amount for an office visit in your area is $100
- You have met the plan year deductible
- This physician charges $300 more than the Maximum Allowed Amount ($400 – $100).
- In-network coinsurance is 20% and out-of-network coinsurance is 50%

Because you have met the plan year deductible, the plan reimburses 50% of the Maximum Allowed Amount charge, or $50 (50% x $100).

Your coinsurance is 50% of the Maximum Allowed Amount charge (50% x $100 = $50). Plus, you pay the difference between the billed amount and the Maximum Allowed Amount charge ($400 – $100 = $300).

In this example, you pay $350 ($50 + $300 = $350). If you had used an in-network provider, you would only have paid $20 (20% of $100), assuming the negotiated rate is $100.

In some instances, you may only be asked to pay the lower network cost-sharing amount when you use an out-of-network provider. For example, if you go to a network hospital or provider facility and receive covered services from an out-of-network provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a network hospital or facility, you will pay the network cost-share amounts for those covered services. However, you also may be liable for the difference between the Maximum Allowed Amount and the out-of-network provider's charge.

AUTHORIZED SERVICES

In some circumstances, such as where there is no network provider available for the covered service, the claims administrator may authorize the network cost-share amounts (deductible, copayment and/or coinsurance) to apply to a claim for a covered service you receive from an out-of-network provider. In such circumstances, you must contact the claims administrator in advance of obtaining the covered service. The claims administrator also may authorize the network cost-share amounts to apply to a claim for covered services if you receive emergency services from an out-of-network provider and are not able to contact the claims administrator until after the covered service is rendered.

If the claims administrator authorizes a network cost-share amount to apply to a covered service received from an out-of-network provider, you also may still be liable for the difference between the Maximum Allowed Amount and the out-of-network provider's charge. Please contact Quantum Health for authorized services information or to request authorization.

BLUE DISTINCTION SPECIALTY CARE

The Blue Distinction Specialty Care Program can help you receive high-quality care, while also managing costs for you and the Plan. The Blue Distinction Specialty Care Program applies to the following services:

- Bariatric surgery
- Cardiac care
- Spine surgery
- Knee and hip replacement

If you choose an in-network facility to receive these services that isn't in the Blue Distinction Specialty Care Program, your plan will continue to provide coverage for services in accordance with the terms of the plan.

To find a Blue Distinction Center, contact Quantum Health or log on to your Anthem account at **anthem.com/ca**, select *Find Care*, then search for *Hospitals and Facilities* in your area. Under *Recognition/Awards*, select *Blue Distinction Total Care* and the required service. If you can't find a provider within 100 miles of where you live, you may be reimbursed for your travel expenses up to $5,000.

ORGAN TRANSPLANT CARE

If you need an organ transplant, Quantum Health's transplant nurses can assist. Transplant nurses will help you and your eligible family members during the transplant process.

- Provides case management to employees or their covered family members identified and approved for solid organ and tissue transplant. The transplant nurse is a single point of contact from time of approval through six months post-transplant.
- Provides education for all phases of transplant, Blue Distinction Centers for Transplant facilities, and transplant-specific benefits such as travel and lodging
- Coordinates care between the member and transplant team in order to establish appropriate plan of care

The plans offer two benefit levels for organ transplant services and follow-up care. Services provided by an in-network facility are covered at 80% of the negotiated rate after the deductible is met. You may receive a higher benefit level if you use a Blue Distinction Center for Transplant as described below. There is no coverage for transplant services if you go to an out-of-network provider.

Blue Distinction Centers for Transplant

A Blue Distinction Center for Transplant (BDCT) is a medical institution and health care provider that has demonstrated they can provide excellent results with regard to your treatment, at a competitive price, with high patient satisfaction ratings.

If you or your family members use a BDCT for organ transplant care and treatment that has been approved by Quantum Health, your transplant-related benefits will be paid at 100% for a period of up to 12 months following the transplant, with no deductible under Plan 1: High Premium/Low Deductible Plan*, Sunnyvale Premium Plan, Baltimore Premium Plus Plan or Baltimore Premium Plan.

If you participate in Plan 2: Medium Premium/Medium Deducible Plan*, or Baltimore and Sunnyvale Value Plans, you must first meet your deductible. Under the Anthem plans, transplant-related care rendered after 12 months will be reimbursed at 80% as appropriate, after the deductible is met except that reimbursement for Plan 3: Low Premium/High Deductible Plan* will be 70% after the deductible is met.

If you receive a bone marrow transplant at a BDCT, the plans will cover the national donor search up to $30,000 when a family member donor is not found.

** Baltimore and Sunnyvale represented employees are not eligible.*

Travel Benefits when you use a Blue Distinction Center for Transplant

If the BDCT facility is more than 100 miles from your home, travel to a BDCT in your personal vehicle for medical treatment will be reimbursed according to IRS regulations.

Airfare, other ground transportation as described below, and overnight accommodations, including hotel, motel, apartment rental and Airbnb, for you and one companion will be reimbursed at 100%, subject to coordination and approval by Anthem. **ATTN:** Under Plan 2: Medium Premium/Medium Deducible Plan,* Plan 3: Low Premium/High Deductible Plan* or Baltimore and Sunnyvale Value Plans, travel benefits are subject to the deductible.

The following methods of transportation are acceptable for reimbursement:

- Bus, taxi, rental care, train or plane fares, or ambulance service
- Transportation expenses of a parent who must go with a child who needs medical care
- Transportation expenses of a nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone

You can also include out-of-pocket car expenses, such as the cost of gas and oil, when you use a car for medical reasons relating to an organ transplant. You cannot include depreciation, insurance, general repair or maintenance expenses.

If you do not want to use your actual car expenses, you can use a standard mileage rate, as defined by the IRS, for use of a car for medical reasons relating to an organ transplant.

You can also include parking fees and tolls. You can add these fees and tolls to your medical expenses whether you use actual expenses or use the standard mileage rate.

If you or your family members use a BDCT facility for organ transplant care and/or treatment that has been pre-approved by Anthem, your travel benefits, subject to the maximums listed below, will be paid at 100% for up to 12 months following the transplant, with no deductible under Plan 1: High Premium/Low Deductible Plan*, Sunnyvale Premium Plan, Baltimore Premium Plus Plan and Baltimore

Premium Plan. **ATTN:** If you participate in Plan 2: Medium Premium/Medium Deducible Plan or Plan 3: Low Premium/High Deductible Plan* or Baltimore and Sunnyvale Value Plans, you must first meet your deductible.

- Per diem maximum of $250 per day for room and board (does not include airfare, which is paid separately)

Lifetime maximum of $10,000 for lodging and all travel expenses, including coach class airfare (excludes air ambulance expenses, which are covered under regular, non-BDCT benefits. Meal expenses are not covered according to IRS regulations). Expenses will begin to accrue at the initial evaluation and end at 365 days post-procedure or when the $10,000 lifetime maximum is reached, whichever occurs earlier. The $10,000 lifetime limit maximum applies across all plan options administered by Anthem, including any legacy medical plans no longer offered. Changing plan options or suspending and re-enrolling in benefits will not restore the benefit.

**Baltimore and Sunnyvale represented employees are not eligible.*

TRAVEL BENEFITS FOR IN-NETWORK CARE

If an in-network provider is not available within 100 miles of your home, reasonable travel costs, including airfare and lodging (up to $50 per day) for treatment at the closest in-network provider will be covered up to $5,000 per occurrence.

Preauthorization

Some procedures require preauthorization. Certain medical procedures may require a post-service review for medical necessity. Post-service reviews often require additional medical records for certification.

Preauthorization is required for the following medical services:

- Medical inpatient admissions and increases in lengths of stay (except for birth parent stays described in the next bullet)
- Birth parent hospital stays for mothers and newborn children are considered medically necessary for at least 48 hours following a normal vaginal delivery or 96 hours following a caesarian birth. Preauthorization is required if there is an increase in the length of stay.
- Inpatient surgery
- Skilled nursing facility care
- Home health care and private duty nursing
- Home infusion therapy
- Hospice care
- Air ambulance services
- Inpatient care for mental health and substance abuse services
- Partial hospitalization, intensive outpatient therapy and residential treatment centers for mental or nervous disorders or substance abuse
- Preauthorization is also required within 72 hours after an emergency-based hospital admission or surgery

Quantum Health (medical/surgical claims) and Anthem (behavioral health/substance use disorder claims) manage the preauthorization process for the plan options. In most cases, your provider will

contact the claims administrator for preauthorization. Ultimately, however, preauthorization is your responsibility — not the doctor's or hospital's responsibility.

1. Pre-certification requests should be made to the Care Coordinators at least three business days before a scheduled service, treatment, procedure, inpatient admission or any other service requiring pre-certification except in the following circumstances:

a. For an "Emergency Medical Condition" hospital admission or outpatient procedure, notification to the Care Coordinators should be made on or before the next business day after the admission or procedure. For the purposes of this subsection only, "Emergency Medical Condition" is defined as a procedure that has not been previously scheduled and cannot be delayed without harming the covered person's health.

b. Notification should be made upon a covered person's identification as a potential organ or tissue transplant recipient.

c. Maternity admission notifications should be submitted thirty (30) days before the expected delivery date.

2. Submission of a Request.

Covered persons are ultimately responsible for ensuring that all pre-certifications are approved and on file prior to the provision of service to maximize benefits under this Plan. Most pre-certification requests are submitted to the Care Coordinators by a designated PCP, other PCP, or other healthcare provider via this Plan's provider portal, facsimile or by calling the Care Coordinators: (833)762-0841 as listed on the back of the covered person's identification card.

3. Evaluation of the Request.

Submitted pre-certification requests are considered pre-service claims and are reviewed to determine if the requested service is: (a) specifically covered or excluded under the terms of this Plan or (b) considered experimental/investigational and (c) is medically necessary under the Plan's Medical Management Standards discussed below. Depending on the request, the Care Coordinators may contact the requesting provider and/or treating provider to obtain additional clinical information to support the request and will suspend the claim for 45 days to allow the provider to send the information. At the end of the 45-day period, the claim will be denied as an administrative denial if the information is not provided.

4. Ongoing Courses of Treatment.

Inpatient hospital stays, other institutional admissions, and ongoing courses of treatment are regularly monitored by Quantum to evaluate continued medical necessity and appropriate level of ongoing care or site of care, if necessary, under the Medical Management Standards discussed below. Quantum Health will communicate regularly with attending providers, discharge planners of facilities, the covered person and/or their family to monitor the covered person's progress and expect and initiate planning for discharge needs.

If an already-approved course of treatment is reduced or terminated or is an ongoing course of treatment in a claim involving urgent care, the claim shall be treated as a concurrent care claim under this Plan's Medical Claim Filing Procedures. Otherwise, it shall be treated as a pre-service or post-service claim as applicable.

5. Understand that Participation in the Program is not a Guarantee of Benefits.

Quantum Health strives to supply accurate and up-to-date information about provider network status, benefit estimates and Plan coverage through the Program. However, engagement with the Care Coordinators for any reason, including Pre-determinations, is not a guarantee of benefits. Covered persons are still responsible for educating themselves on the benefits available to them (under this Plan and as otherwise provided by the plan sponsor, or by other community resources).

Further, pre-certification approvals issued by Quantum Health mean that the medical condition, services, and care settings meet the Medical Management Standards adopted by this Plan. The approvals do not guarantee that the service will be a covered benefit at the time the claim is submitted for processing as a post-service claim, that the covered person is eligible for such benefits, that other benefit conditions such as copays, deductibles, coinsurance, or out-of-pocket limits have been satisfied or that the covered person will not be subject to balance billing where services are provided by an out-of-network provider. Final determinations of coverage and eligibility for benefits are made by this Plan when the claim is submitted for payment.

THE PLAN'S MEDICAL MANAGEMENT STANDARDS

Determinations involving medical judgment (i.e., experimental/investigational and medical necessity) that require interpretation of clinical information are reviewed by a clinician under the terms of this Plan and the clinical review criteria approved by the plan administrator. If the clinician is not able to justify coverage based on the established criteria or no applicable criteria is available, it is referred to a medical director for review using the general clinical review criteria, medical director criteria or is referred to a "Peer Reviewer." A Peer Reviewer is a staff medical director or an independent reviewer but will be a Doctor of Medicine or a Doctor of Osteopathic Medicine or in the same licensure category as the ordering provider.

If an initial adverse benefit determination is pending or issued by Quantum Health based on medical judgment, the ordering provider may request a peer-to-peer conversation with the Peer Reviewer to discuss the determination and supply more information that may support coverage. The peer-to-peer must be requested by the ordering provider prior to the covered person (or authorized representative) filing an appeal under this Plan's Medical/Dental/Vision Claim Filing Procedures.

Prior authorization or approval of a continued stay is not a promise or offer to you or your provider to pay benefits, does not guarantee benefits to you or your provider, and will not result in payment of benefits that would not otherwise be payable. It is a preliminary review based entirely on the limited information provided to the Claims Administrator at the time of the requested service authorization. All claims are subject to review to decide whether services are covered according to Plan limitations and exclusions in force at the time services are rendered. Prior authorization or approval of a continued stay does not create a contract between the Plan and you or your provider, between the Company and you or your provider, or between the Claims Administrator and you or your provider.

Preauthorization is not required for occupational, physical or speech therapy.

For more information about preauthorization call Quantum Health at 800-894-4194.

Medical Necessity

The Plan pays benefits for eligible expenses that are considered medically necessary by the claims administrator. Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) are considered medically necessary if the claims administrator determines that a medical practitioner, exercising prudent clinical judgment, would provide it to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- Ordered and approved by a licensed physician
- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease
- Cost-effective, safe, and provided in accordance with generally accepted standards of medical practice

- Not primarily for the convenience of the patient or the health care provider and, if omitted, would adversely affect the patient's condition
- The most appropriate level of treatment, service or supply that can be safely provided (with respect to hospitalization, this means that acute care as an inpatient is necessary due to the type of services the patient is receiving or the severity of the patient's condition. This also means that safe and adequate care cannot be received as an outpatient or in a less intense medical setting.) Acute care is treatment for an immediate and severe episode of an illness, an injury related to an accident or other trauma or recovery from surgery.
- Not educational, vocational, experimental or investigational in nature as determined by the claims administrator
- Not specifically excluded by the plan or does not exceed specified plan limitations

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Just because your physician or other health care provider prescribes, orders, recommends, or approves a service or supply, it is not automatically considered medically necessary. This rule applies even if the service or supply is not listed in this guide as an ineligible expense.

Services provided to you as a hospital inpatient are medically necessary if they cannot be safely provided to you as an outpatient. And, keep in mind that when you are hospitalized, your provider and the claims administrator determine for how long your hospital stay is medically necessary.

Birth parent hospital stays for mothers and newborn children are considered medically necessary for at least 48 hours following a normal vaginal delivery and 96 hours following a Caesarean birth (see **Statement of Rights Under the Newborns' and Mothers' Health Protection Act**).

Out-of-network services and supplies provided to a newborn child are considered medically necessary if they:

- Meet all of the requirements in **Covered Medical Services**
- Are provided to treat a diagnosed sickness or an injury (including a congenital defect or birth abnormality).

Covered Medical Services

Services for which the plans will pay benefits include the following hospital and medical services and supplies for treatment of an injury or disease, including illness or injury that is incurred as a result of war or any act of war. Unless otherwise noted, a deductible must be met before services, either in-network or out-of-network, are covered. Most services received from in-network providers will be covered at 80% (Plan 1: High Premium/Low Deductible Plan,* Plan 2: Medium Premium/Medium Deductible Plan*, Sunnyvale Premium Plan, Baltimore Premium Plus Plan, Baltimore Premium Plan and Baltimore and Sunnyvale Value Plans) or 70% (Plan 3: Low Premium/High Deductible Plan*) of contracted fees. Most services received from out-of-network providers will be covered at 50% of **Maximum Allowed Amount**. **Only those services, supplies and treatments that are for the treatment of an injury or disease, are medically necessary and appropriate, and are rendered by a licensed provider are covered.**

This section provides a description of services covered by Plan 1: High Premium/Low Deductible Plan*, Plan 2: Medium Premium/Medium Deductible Plan*, Plan 3: Low Premium/High Deductible

Plan* Plan 4: Medium Premium/Deductible Utah Extended Network Plan*, Sunnyvale Premium Plan, Baltimore Premium Plus Plan, Baltimore Premium Plan and Baltimore and Sunnyvale Value Plans.

**Baltimore and Sunnyvale represented employees are not eligible.*

Acupuncture and Acupressure

Acupuncture and acupressure services will be covered, up to 12 visits (for both acupuncture and acupressure combined) per plan year per covered individual, if rendered by a licensed provider.

Allergy Care — Injections and Tests

Allergy care is covered when administered by a physician, allergist or specialist. Serum is covered only when received and administered within the provider's office. If received from a pharmacy, the serum *may* be covered under the pharmaceutical benefit. The following services are covered:

- Allergy Injections — Immunotherapy. Also called allergy desensitization or allergy shots; immunotherapy is given to increase a person's tolerance to the substances that provoke allergy symptoms (allergens). Allergy shots reduce the sensitivity to certain substances but do not cure allergies.
- Allergy Tests
  - An allergy **skin test**, also called a scratch test, is used to identify the substances that cause allergy symptoms. It is the application of the allergen extract to the skin, and then scratching or pricking the skin to allow exposure, and evaluating the skin's reaction.
  - A **scratch test** is a test in which one or more small scratches or superficial cuts are made in the skin, and a minute amount of the substance to be tested is inserted in the scratches and allowed to remain there for a short time. If no reaction has occurred after 30 minutes, the substance is removed and the test is considered negative. If there is redness or swelling at the scratch sites, the test is considered positive.
  - **RAST** (radioallergosorbent test) is a blood test used to identify the substances that are causing allergy symptoms and to estimate a relative sensitivity.

Ambulance

Professional **ground transportation ambulance** services are covered in the following circumstances:

- When used to transport the patient from the place of accidental injury or serious medical incident to the nearest facility where treatment can be given
- To transport a patient from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the patient
- To transport a patient from hospital to home, skilled nursing facility or nursing home when the patient cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available
- To transport a patient from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the patient
- To transport a patient upon medical stabilization from a non-discounted facility to a discounted facility when they were admitted due to a medical emergency to a non-discounted facility
- Coverage is provided for **air ambulance transport** for medical emergencies in the following circumstances:
  - Patient requires transport to a hospital or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the patient, and ground transportation is not medically appropriate because of the distance involved

- The patient has an unstable condition requiring medical supervision and rapid transport

  Preauthorization is required for air ambulance except in a life-threatening circumstance. You must notify Quantum Health within 72 hours of using air ambulance services by calling the number listed on the back of your Anthem ID card.

Ambulance benefits will be reimbursed at 80% for in-network providers or 80% of the **Maximum Allowed Amount** for out-of-network providers after the deductible is met (70% for in-network and out-of-network providers if you are enrolled in Plan 3: Low Premium/High Deductible Plan*).

Anesthesia

Coverage is provided for the administration of anesthesia in connection with a covered surgical procedure.

Anesthesia benefits will be reimbursed at 80% for in-network providers or 80% of the **Maximum Allowed Amount** for out-of-network providers after the deductible is met (70% for in-network and out-of-network providers if you are enrolled in Plan 3: Low Premium/High Deductible Plan*).

**Baltimore and Sunnyvale represented employees are not eligible.*

Birth Parent Care

Benefits are payable for pregnancy-related expenses of employees and covered dependents on the same basis as a covered illness. The expenses must be incurred while the person is covered under the plans.

Also covered are services rendered in a birthing facility, provided that the physician in charge is acting within the scope of their license and the birthing facility meets all legal requirements, and midwife delivery services, provided that the state in which such services are performed has legally recognized midwife delivery, and provided the midwife is licensed at the time delivery is performed.

Nursery charges, other hospital services, and supplies and physician's charges for hospital visits for healthy newborn children will be covered under the birth parent's benefit.

Expenses related to the newborn child are not covered unless the child is added as a dependent under the plan within 31 days of the birth.

Blood Transfusions

Coverage is provided for blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen, and in exchange for blood that has been removed in the treatment of Rh incompatibility in the newborn, liver failure in which toxins accumulate in the blood or in some other types of toxemia.

Coverage is included for the following:

- Autologous
- Direct donation
- Regular administration
- Whole blood

Breast Reconstruction Coverage

Coverage includes breast reconstruction in connection with a mastectomy, specifically:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas

Cardiac Rehabilitation Therapy

Coverage for cardiac rehabilitation therapy is provided in two phases. Phase I begins during/after the acute event (i.e., by-pass surgery, myocardial infarction, angioplasty). It includes nursing services, physical therapy and teaching the patient how to deal with his/her condition. Phase II is a hospital-based outpatient program after inpatient hospital discharge. It is physician directed with active treatment and EKG monitoring.

Chiropractic

Chiropractic services are defined as those services for the detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Coverage includes initial consultation and treatment. Benefits for chiropractic treatment are limited to a maximum of 24 treatments per plan year per covered individual. All treatments apply to the annual maximum limit regardless if the expense is applied to the deductible or subject to coinsurance.

Dental Services and Oral Surgery

Covered dental services and oral surgery include charges for care rendered by a physician or dentist that is required as a result of an accidental injury to the jaws, sound natural teeth, mouth or face. Injury as a result of chewing or biting will not be considered an accidental injury.

Charges for surgical benefits for cutting procedures for the treatment of disease, injuries, fractures and dislocations of the jaw when the service is performed by a physician or dentist are also considered covered services.

Charges for general anesthesia would be considered under the plans when administered in an approved inpatient or outpatient setting. Coverage of anesthesia for dental procedures is subject to medical necessity.

Note: Normal extraction and care of teeth and structures directly supporting the teeth are not covered.

Diagnostic Lab Services and X-rays

Coverage is provided when services are performed to diagnose specific symptoms or rule out medical conditions. Services include:

- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging
- Diagnostic laboratory and pathology tests
- Diagnostic medical procedures consisting of EKG, EEG and other electronic diagnostic medical procedures
- Pre-admission presurgical tests that are made prior to a covered person’s inpatient or outpatient surgery

In most cases, the tests can be performed in the outpatient department of a hospital, at an independent medical testing laboratory or in your doctor’s office.

Pre-admission tests will be covered even if hospitalization is delayed, postponed or canceled.

Dietary Formulas

Coverage is provided for dietary formulas for participants whose esophagus does not function and who require processed food with a feeding device, such as a feeding tube. Expenses for dietary formulas are also eligible for those with a diagnosis of phenylketonuria or another, similar disease and must be considered medically necessary. The dietary formula must be the primary source of nutrition intake for the participant. The dietary formula must be used under the supervision of a physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments.

Durable Medical Equipment

Coverage is provided for rental or, at the discretion of the plan, purchase of durable medical equipment, which is prescribed by a professional provider and required for therapeutic use. If purchased, charges for repair or medically necessary replacement of durable medical equipment will be considered a covered expense.

Coverage includes but is not limited to crutches, commodes, hospital beds, nebulizers, monitoring equipment and wheelchairs.

Emergency Room Care

Facility and professional provider services and supplies for the initial treatment of traumatic bodily injuries resulting from an accident are covered.

Emergency medical care meeting the following definition is also covered: facility and professional provider services and supplies for the initial treatment of a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Permanently placing the covered person's health in jeopardy
- Causing other serious medical consequences
- Causing serious impairment to bodily functions, or causing serious and permanent dysfunction of any bodily organ or part

For an emergency medical condition hospital admission or outpatient procedure, notification to the Care Coordinators should be made on or before the next business day after the admission or procedure. For the purposes of this subsection only, Emergency Medical Condition is defined as a procedure that has not been previously scheduled and cannot be delayed without harming the covered person's health.

Emergency room care as described above will be reimbursed at 80% for in-network and out-of-network providers after the deductible is met (70% if you are enrolled in Plan 3: Low Premium/High Deductible Plan*.)

** Baltimore and Sunnyvale unions not eligible.*

Family Planning

Coverage for family planning is provided for:

- D&C/Abortion — therapeutic or voluntary
- Diaphragm — device and/or fitting*
- IUD — device and/or insertion and removal*
- Tubal ligation*

- Vasectomy
- Sterilization*
- Contraceptives administered in a doctor's office are covered, such as Depo-Provera®*

Note: Reversal of sterilization is not a covered service.

**Services may be covered at 100% under preventive care.*

Foreign Claims

Claims for services rendered while you are out of the country are reimbursed at the in-network level of 80% after the deductible is met (70% if you are enrolled in Plan 3: Low Premium/High Deductible Plan*) for emergency care and for non-emergency care. Preventive care is reimbursed at 100% of charges.

All monetary conversions and rates of exchange are calculated based on the date of service.

**Baltimore and Sunnyvale represented employees are not eligible.*

Hearing

Coverage includes annual hearing exams, hearing aid repair and up to two new hearing aids per participant per plan year. Contact Quantum Health for assistance with locating an in-network Durable Medical Equipment provider. Hearing aid batteries are not covered.

Home Health Care

Home Health Care is care provided in your home by an agency licensed by the state in which you live. Benefits may be approved for individuals who are homebound for medical reasons, physically unable to obtain necessary medical care as an outpatient, or under the care of a physician. Home health care expenses are covered if the services are provided by a licensed home health care agency, and all of the following conditions are met:

- The charge is made by a home health care agency
- The care is given according to a home health care treatment plan
- The care is given to a person in his or her home

Home health expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available
- Part-time or intermittent home health aide services for patient care
- Physical, occupational and speech therapy
- The following to the extent they would have been covered under this plan option if the person had been confined in a hospital or convalescent facility:
  - Medical supplies
  - Drugs and medicines provided by a physician
  - Lab services provided by a home health care agency

The following expenses are not considered payable under home health care:

- Services or supplies that are not part of the home health care treatment plan

- Services of a person who usually lives with the patient or who is a member of the patient's family
- Services of a social worker
- Transportation

Home health care benefits are limited to 100 visits per person per plan year. A visit is considered to be four hours. Preauthorization is required.

Hospice Care

Hospice is a health care program providing a coordinated set of services rendered at home, in an outpatient setting or in an institutional setting for those suffering from a condition that has a terminal prognosis.

To be covered, the hospice program must be licensed and the attending physician must certify that the covered person is terminally ill with a life expectancy of six months or less.

Hospice care for you and your eligible dependents is covered for up to six months. Preauthorization is required for hospice care services. Quantum Health Care Coordinators are available to coordinate coverage beyond six months.

Services and supplies typically provided and billed by a hospice are:

- Inpatient care
- Nutrition counseling and special meals
- Part-time nursing
- Homemaker services
- Respite care — limited to five days per episode
- Physical and chemical therapy

Hospital and Facility Services

Most services received from in-network hospitals and facilities will be covered at 80% or 70% of contracted fees after the deductible is met or 50% of **Maximum Allowed Amount** charges for out-of-network providers after the deductible is met. For more information on eligible services, please see the appropriate topic within this section:

- Emergency room care
- Emergency room care for non-emergencies
- Inpatient medical facility
- Inpatient rehabilitation facility
- Skilled nursing facility
- Urgent care center

Immunizations for Travel

Immunizations for travel are covered, such as immunizations for yellow fever and typhoid.

Infertility Treatment

Infertility treatment or assisted reproductive technologies (ART) are covered under the plans*

- Artificial insemination
- In vitro technologies (IVF)
- Gamete intrafallopian transfer (GIFT)
- Zygote intrafallopian transfer (ZIFT)

Once the ART procedures listed above have been attempted by the plan participant, all future office visits, drugs, lab tests or any other treatments to aid conception will fall under the infertility treatment portion of the plan. Infertility medications prescribed for your treatment are covered under the medical portion of your plan. You will have to purchase the medication and submit a claim to Anthem for coverage under the plan.

Infertility treatment benefits are limited to a lifetime maximum of $25,000 per person. After you reach the $25,000 lifetime maximum, your infertility coverage ends under the Northrop Grumman Health Plan. The lifetime maximum includes reproductive technology, such as in vitro fertilization and prescriptions to treat an infertility condition. You begin incurring expenses toward the lifetime maximum when you start participating in the Northrop Grumman Health Plan. The $25,000 maximum applies across all medical plan options including any legacy medical plans no longer offered. Changing plan options or suspending and re-enrolling in coverage will not restore the benefit.

*Baltimore and Sunnyvale Value Plans are not eligible.

Inpatient Medical Facility

The plans pay benefits toward the cost of the following types of inpatient hospital care services:

- Inpatient room and board
- Inpatient ancillary services

Preauthorization is required.

Inpatient Room and Board

Coverage provided for room and board is limited to the semi-private room rate. Private room, intensive care, coronary care and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition.

When room and board for other than semi-private care is at the convenience of the patient, payment will be made only for semi-private accommodations.

Inpatient Ancillary Charges

Coverage is provided for necessary inpatient ancillary charges, such as services and supplies, including but not limited to admission fees, use of operating, delivery and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not services of a physician, or drugs or supplies not consumed or used in the facility.

Inpatient Rehabilitation Facility

Coverage is provided for inpatient rehabilitation facilities. Most people who are admitted to an inpatient rehabilitation facility are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case management (this is a process in which a registered nurse and case management team are assigned to an individual patient to assess, coordinate, monitor, and evaluate the options and services required to meet the patient's health care needs. Case managers access all available resources to promote quality and cost-effective outcomes).
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy
- Onsite orthotic and prosthetic services
- Physical therapy
- Psychology
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services.

Preauthorization is required

Mental health/chemical dependency rehabilitation is not covered under this benefit but is covered under the mental health and chemical dependency benefit.

Medical Supplies

Medical supplies that are prescribed by a licensed provider for a medical condition or diagnosis are covered, ***except*** for those that are available over the counter. Over-the-counter supplies, such as Band-Aids and aspirin, are ***excluded*** from the plans.

Examples of medical supplies include:

- supplies for people with diabetes (lancets, glucometers, syringes, if not covered under the pharmacy benefit)
- Surgical dressings not purchased over the counter
- Blood and blood plasma
- Casts and splints
- Ostomy supplies
- Oxygen and rental of equipment for its administration, up to the purchase price
- Trusses, braces and crutches

Mental Health and Substance Abuse

The Anthem plan options include mental health and substance abuse benefits as described in this section. The plan options will cover services from in-network providers at 80% or 70% after the deductible is met; services from out-of-network providers will be covered at 50% of **Maximum Allowed Amount** charges after the deductible are met.

Eligible Mental Health and Substance Abuse Expenses

The plans pay for a wide range of inpatient and outpatient services when they are medically necessary. For benefits to be considered medically necessary, the service or treatment must be:

- Appropriate, adequate and essential for your condition
- Expected to improve your condition or level of functioning

The fact that your physician prescribes, orders, recommends, or approves a service or supply does not make it medically or psychologically necessary. That determination is made by Anthem. Call Anthem if you have questions about a particular service.

Covered mental health and substance abuse expenses and services include:

- Inpatient Services in a Hospital or any Facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.
- Residential Treatment in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
    - Observation and assessment by a physician weekly or more often,
    - Rehabilitation and therapy.
- Outpatient Services including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs and (when available in your area) Intensive In-Home Behavioral Health Services.
- Virtual Visits as described under the "**Telemedicine**" section.

Ineligible Mental Health and Substance Abuse Expenses

The following mental health and substance abuse services and treatments are not eligible for coverage. Although a service or supply may not specifically be listed as an ineligible expense, it is not necessarily eligible. If you are uncertain whether a service or treatment is eligible, call Anthem.

- Aversion therapy (that is, therapy intended to induce dislike for certain habits or antisocial behavior by using association with a noxious and/or graphic stimulus)
- Services or treatment rendered by you, your spouse or your child, or by your parent, parent-in-law, brother, sister, brother-in-law or sister-in-law
- Conditions resulting from:
    - Insurrection
    - Atomic explosion
    - Other release of nuclear energy under any conditions (except when used solely as a medical treatment)
- Couples therapy, except when certified as a medically necessary part of the treatment plan of a spouse with a Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) mental disorder that is covered under the mental health and substance abuse program
- Court-ordered psychiatric or substance abuse treatment, except when certified by Anthem as

medically necessary

- Custodial care
- Educational rehabilitation or treatment of learning disabilities, regardless of the setting in which services are provided
- Evaluations, consultations or therapy for educational or professional training, or for investigational purposes relating to employment
- Experimental or investigational services or supplies, as determined by Anthem, such as wilderness therapy or outdoor therapy programs. Any of the following criteria may be cause for classification as experimental or investigational:
  - Lack of federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
  - Insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the plan's evaluation of the therapeutic value of the service or supply
  - Inconclusive evidence that the service or supply has a beneficial effect on health outcomes
  - Evidence that the service or supply is not as beneficial as any established alternatives
  - Insufficient information or inconclusive scientific evidence that, when used in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives
- Injuries or illnesses caused by the conduct or omission of a third party for which you have a claim for damages or relief, unless you provide Anthem with a lien against such claim for damages or relief
- Non-abstinence-based or nutritionally based treatment for substance abuse
- Prescription drugs. However, your prescription may be eligible under the pharmacy benefit administered by CVS/caremark. See
- **Prescription Drug** Coverage**.** (Prescription drugs prescribed during a medically necessary inpatient treatment are covered as part of the inpatient benefit.)
- Private duty nursing, except when medically necessary
- Remedial education beyond evaluation and diagnosis of learning disabilities, education rehabilitation, academic education and educational therapy for learning disabilities
- Services to treat conditions not attributable to a mental disorder but as additional conditions that may be a focus of clinical attention, such as V Codes as identified in the DSM IV-TR
- Services, treatment or supplies provided as a result of any workers' compensation law or similar legislation
- Services, treatment or supplies obtained through, or required by, any governmental agency or program, whether federal, state or any subdivision thereof (exclusive of Medicaid/MediCal)
- Sex therapy programs
- Therapies that do not meet national standards for mental health professional practice, including — but not limited to — Erhard/The Landmark Forum, primal therapy, Rolfing, sensitivity training, bioenergetics therapy and crystal healing therapy

- Treatment for caffeine or nicotine addiction, withdrawal or dependence
- Treatment for co-dependency
- Treatment for personal or professional growth, development, training or professional certification
- Treatment of congenital and/or organic disorders (for example, intellectual disability) except for Pervasive Development Disorder (PDD) or Autism
- Treatment at a Residential Treatment Center/Facility that is not fully accredited by TJC, CARF, NIAHO or COA
- Alternative/ Complementary Medicine Services or supplies for alternative or complementary medicine for the treatment of a mental health or substance abuse diagnosis. This includes, but is not limited to:
    - Acupuncture
    - Acupressure, or massage to help alleviate pain, treat illness or promote health by putting pressure to one or more areas of the body
    - Holistic medicine
    - Homeopathic medicine
    - Hypnosis
    - Aroma therapy
    - Massage and massage therapy
    - Reiki therapy
    - Herbal, vitamin or dietary products or therapies
    - Naturopathy
    - Thermography
    - Orthomolecular therapy
    - Contact reflex analysis
    - Bioenergetic synchronization technique (BEST)
    - Iridology-study of the iris
    - Auditory integration therapy (AIT)
    - Colonic irrigation
    - Magnetic innervation therapy
    - Electromagnetic therapy
    - Biofeedback

Nutritional Counseling

Coverage is provided for health services rendered by a registered dietician, or other licensed provider, for individuals with medical conditions that require a special diet or mental health/substance use disorder conditions. Some examples of such medical conditions include diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure,

phenylketonuria and hyperlipidemias. Coverage for nutritional counseling is limited to six visits per person per plan year. The six-visit limit does not include diabetic nutritional counseling or mental health/substance use disorder counseling.

Orthognathic Surgery

Orthognathic surgery is covered when medically necessary. Call Quantum Health at the number provided on your ID card for details on medical necessity requirements.

Orthotic Devices

Coverage is provided for orthotic devices (a rigid or semi-rigid supportive device that restricts or eliminates motion for a weak or diseased body part), including custom shoes or custom molded inserts prescribed by a physician (up to one pair per person per plan year).

Podiatry

Coverage is provided for certain surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Podiatry services not covered are those procedures considered to be a part of a routine foot care, or of a cosmetic nature.

Prescription Drug Benefits

Prescription drug coverage in the Anthem plan options is provided through CVS/caremark. See

Prescription Drug Coverage for details.

Preventive Care

The plans cover preventive services for covered participants based on guidelines from the U. S. Preventive Services Task Force, American Cancer Society, the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics and in accordance with the Patient Protection and Affordable Care Act. The preventive benefits include routine office visits, lab services, screening tests, immunizations, certain contraceptive methods, and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death. Please contact Quantum Health for a complete list of covered preventive services.

Please note that all preventive services, including colonoscopies, must be coded by the provider as routine in order to be covered at 100%. To the extent required by law, services and medications that are considered preventive under the Patient Protection and Affordable Care Act are covered at 100%. Preventive services are not subject to the deductible.

What Counts as Preventive Care?

Preventive care includes routine health care services to maintain your health and prevent disease, including services such as annual physical exams, well-woman exams, well-child exams and certain immunizations. Counseling on topics such as quitting smoking, losing weight, eating healthy and treating depression may also be included as preventive care.

Diagnostic care, on the other hand, is health care services you receive when you have symptoms or risk factors that your doctor wants to diagnose.

Keep in mind that preventive services must be coded as preventive by the provider to be covered 100%.

Private Duty Nursing

Coverage is provided for the services of a private duty nurse on an outpatient basis only. Nursing services must be rendered by a nurse who neither resides in the patient's home, nor is a member of the immediate family. To be covered, the physician in charge of the case must certify that the patient's

condition requires the requested care, which can only be provided by an R.N. or L.P.N. Private Duty nursing applies only for care given in the patient's home and not part of the home health care agency's plan of treatment.

Private duty nursing benefits are limited to 100 visits per person per plan year. Preauthorization is required. Note, visits are combined in and out of network and with home health care.

Professional Services

Professional services are those services billed by a provider's office rather than by a facility — such as office visits and inpatient hospital visits. Covered professional services are:

- **Office Visits** — visits made by patients to health service providers' offices for diagnosis, treatment and follow-up
- **Inpatient Hospital Visit** — a visit by a provider for persons admitted to health facilities that provide room and board, for the purpose of observation, care, diagnosis or treatment

Prosthetics

Coverage is provided for the purchase and fitting of external prosthetic appliances that are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, injury or congenital defect.

Replacement or repair, as appropriate, of external prosthetic appliances is covered if necessitated by such circumstances as normal anatomical growth, physical changes that render the device ineffective or excessive wear.

Coverage is also provided for internal prosthetic appliances; this includes the purchase, maintenance, or repair of permanent or temporary internal aids and supports for defective body parts, specifically, intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints and other surgical materials such as screw nails, sutures and wire mesh.

Second Surgical Opinion

Coverage is provided for an opinion provided by a second physician, when one physician recommends surgery to an individual. Second opinions will be covered at 80% for an in-network provider after the deductible is met and 80% of the **Maximum Allowed Amount** for an out-of-network provider after the deductible is met (70% for in-network and out-of-network if you are enrolled in Plan 3: Low Premium/High Deductible Plan*.)

Second opinion services are also available through ConsumerMedical. You may contact ConsumerMedical at 888-361-3944 or visit **myconsumermedical.com** (use company code NGC to register).

**Baltimore and Sunnyvale represented employees are not eligible.*

Skilled Nursing Facility

Coverage is provided for skilled nursing facilities, a residential care setting offering a protective, therapeutic environment for individuals who require rehabilitative care or can no longer live independently because of a chronic physical or mental condition requiring round-the-clock skilled nursing care. Skilled nursing facilities must be licensed by the state and are subject to certain state and federal regulations.

Skilled nursing facility care is limited to 100 days per person per plan year. **Preauthorization** is required.

Covered services and supplies include semi-private room and board, charges for other medical services and supplies, and physician's services.

Surgery

Coverage is provided for surgery rendered in both inpatient and outpatient settings for the treatment of disease or injury. Separate payment will not be made for pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.

Surgical Services (Other)

Coverage is provided for the following surgical personnel and services, as described below:

- Assistant surgeon
- Bilateral surgical procedures
- Co-surgeon
- Multiple surgical procedures
- Gender affirmation surgery
- Transplant services
- Weight reduction surgery

Assistant Surgeon

Benefits may be provided for services of a physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

When considered necessary by the surgeon, the service of an assistant surgeon is a covered service.

Bilateral Surgical Procedures

Bilateral surgical procedures are defined as more than one procedure associated with a single surgical event.

Co-Surgeon

A co-surgeon is usually a surgeon who is in the operating room performing a different surgery than the other surgeon who is present at the same time. Also, a co-surgeon is allowed in complicated surgeries (such as heart surgery) due to the length of time of the operation. The co-surgeons have the same responsibility.

Multiple Surgical Procedures

For multiple surgeries (related operations or procedures performed through the same incision or in the same operative field, performed at the same operative session), Anthem considers as an eligible expense to be 100% of the **Maximum Allowed Amount** for the highest-paying procedure. For the remaining eligible surgical procedures, the plan will base its payment on 50% of the maximum allowed amount for the procedure.

Gender Affirmation Surgery

Gender affirming care for adults may be medically necessary when all criteria under the World Professional Association of Transgender Health (WPATH) SOC 8 is met.

Hormone therapy for Gender Affirming Care may be individuals who complete the following:

- A referral from a qualified medical professional

Surgical treatment for Gender Affirming Care may be indicated for individuals 19 and over who provide the following documentation:

- Requirements for Breast Removal:
  - Signed letter from a qualified mental health professional assessing the transgender/gender diverse individual's readiness for physical treatment; *and*
  - Documentation of marked and sustained gender dysphoria; *and*
  - Other possible causes of apparent gender incongruence have been excluded; *and*
  - Mental and physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed; *and*
  - Capacity to consent for the specific physical treatment; *and*
  - Risk factors associated with breast cancer have been assessed.
- Requirements for Breast Augmentation (Implants/Lipofilling):
  - Signed letter from a qualified mental health professional assessing the transgender/gender diverse individual's readiness for physical treatments; *and*
  - Documentation of marked and sustained gender dysphoria; *and*
  - Other possible causes of apparent gender incongruence have been excluded; *and*
  - Mental and physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed; *and*
  - Capacity to consent for the specific physical treatment; *and*
  - Completion of six months of feminizing hormone therapy prior to breast augmentation surgery, unless hormone therapy is not desired or medically contraindicated); *and*
  - Risk factors associated with breast cancer have been assessed.
- Requirements for Gonadectomy (Hysterectomy and Oophorectomy or Orchiectomy):
  - Signed letter from a qualified mental health professional assessing the transgender/gender diverse individual's readiness for physical treatments; *and*
  - Documentation of marked and sustained gender dysphoria; *and*
  - Other possible causes of apparent gender incongruence have been excluded; *and*
  - Mental and physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed; *and*
  - Capacity to consent for the specific physical treatment; *and*
  - Six months of continuous hormone therapy as appropriate to the member's gender goals unless hormone therapy is not desired or medically contraindicated.
- Requirements for Genital Reconstructive Surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis, penectomy, vaginoplasty, labiaplasty, clitoroplasty and electrolysis or laser hair removal sessions for skin graft preparation for genital surgery):

- Signed letter from a qualified mental health professional assessing the transgender/gender diverse individual's readiness for physical treatments; *and*
- Documentation of marked and sustained gender dysphoria; *and*
- Other possible causes of apparent gender incongruence have been excluded; *and*
- Mental and physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed; *and*
- Capacity to consent for the specific physical treatment; *and*
- Six months of continuous hormone therapy as appropriate to the member's gender goals , unless hormone therapy is not desired or medically contraindicated.

- For facial surgeries and other masculinizing and feminizing reconstructive procedures, including thyroid cartilage reduction and/or voice modification surgery (e.g., laryngoplasty, glottoplasty or shortening of the vocal cords):
  - Documentation of marked and sustained gender dysphoria; *and*
  - Other possible causes of apparent gender incongruence have been excluded; *and*
  - Mental and physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed; *and*
  - Capacity to consent for the specific physical treatment; *and*
  - In addition to the above, for the below surgical procedures a requirement of six months of continuous hormone therapy as appropriate to the member's gender goals, unless hormone therapy is not desired or medically contraindicated.
    - Facial surgeries:
      - Blepharoplasty.
      - Brow lift.
      - Cheek/malar implants.
      - Chin implants.
      - Face-lifting.
      - Facial bone reduction.
      - Forehead lift.
      - Hair removal (electrolysis).
      - Hair transplantation (hairplasty).
      - Jaw shortening.
      - Lip enhancement.
      - Lip reduction.
      - Rhinoplasty.
      - Collagen injections.
      - Liposuction of the face.

        - Lipofilling of the face.
    - Other masculinizing and feminizing surgical procedures:
        - Body contouring (e.g., fat transfer, lipoplasty, panniculectomy)
        - Liposuction (e.g., calf, gluteal, hip, pectoral)
        - Lipofilling (e.g., calf, gluteal, hip, pectoral)
        - Tracheal shave
        - Voice modification surgery (chondrolaryngoplasty)

In addition to the criteria referenced above, a treatment plan that includes ongoing follow-up and care by a qualified behavioral health provider experienced in treating gender dysphoria is also required.

Gender affirmation surgery, excluding cosmetic surgery, may be covered. Benefits are subject to Quantum Health's Clinical Utilization Guidelines and preauthorization requirements. Call Quantum Health for details.

Transplant Services

Coverage is provided for expenses related to non-investigative organ or tissue transplants, including:

- Kidney
- Heart/lung
- Cornea
- Liver
- Bone marrow/stem cell
- Pancreas
- Heart
- Lung
- Kidney/pancreas
- Liver/small bowel
- Small bowel

The Anthem plans cover the following expenses:

- Transplant procedures performed at a Blue Distinction Center for Transplants are covered at 100% after the deductible is met.
- Transplant procedures performed at an in-network provider are covered at 80% after the deductible is met (Plan 1: High Premium/Low Deductible Plan*, Plan 2: Medium Premium/Medium Deductible Plan*, Sunnyvale Premium Plan, Baltimore Premium Plus Plan, Baltimore Premium Plan and Baltimore and Sunnyvale Value Plans) or 70% (Plan 3: Low Premium/High Deductible Plan*).
- Transplant procedures performed at an out-of-network facility are not covered.

**Baltimore and Sunnyvale represented employees are not eligible.*

Weight Reduction Surgery

Gastric plication and gastric bypass surgeries are covered under the surgical benefit. Gastric bypass surgery requires preauthorization for medical necessity determination prior to scheduling the member's procedure. For details, call Quantum Health at 800-894-4194.

Telemedicine

Services provided by LiveHealth Online (where you can have online video service with a doctor) are covered urgent care. **ATTN**: If you participate in Plan 1: High Premium/Low Deductible Plan*, Plan 2: Medium Premium/Medium Deductible Plan*, Plan 3: Low Premium/High Deductible Plan*, Sunnyvale Premium Plan, Baltimore Premium Plus Plan or Baltimore Premium Plan or Baltimore and Sunnyvale Value Plans, you pay $10 for each visit. Your $10 copayment does not apply to your deductible, but it does apply to your out-of-pocket maximum.

LiveHealth Online also offers dermatology services for skin, hair or nail concerns and behavioral health services (where you can have an online video service with a therapist for psychology or psychiatry). The service is covered at 80% (Plan 1: High Premium/Low Deductible Plan* or Plan 2: Medium Premium/Medium Deductible Plan*) or 70% (Plan 3: Low Premium/High Deductible Plan*) after your deductible has been met, you pay a coinsurance of 20% or 30%.

**Baltimore and Sunnyvale represented employees are not eligible.*

Temporomandibular Joint Dysfunction

Coverage is provided for surgical treatment only of temporomandibular joint dysfunction (TMJ) if due to accident, congenital defect or developmental defect. No coverage is provided for appliances or therapy services related to TMJ.

Therapy Services

Coverage is provided for therapy services when used for the treatment of a sickness or injury to promote the recovery of the covered person. To be covered, the therapy services must be rendered in accordance with a physician's written treatment plan.

Services covered under the plans include:

- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents (the cost of the antineoplastic agent is included)
- **Dialysis Treatment** — the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis
- **Occupational Therapy** — the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living (**ATTN**: Maximum combined limit for occupational and physical therapy visits* is 90 per person per year in Plan 1: High Premium/Low Deductible Plan** and Baltimore Premium Plus Plan, 60 per person per year in Plan 2: Medium Premium/Medium Deductible Plan** and Baltimore and Sunnyvale Premium Plans and 30 visits per person per year in Plan 3: Low Premium/High Deductible Plan** and Baltimore and Sunnyvale Value Plans)
- **Physical Therapy** — the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (**ATTN**: Maximum combined limit for occupational and physical therapy visits* is 90 per person per year in Plan 1: High Premium/Low Deductible Plan** and Baltimore Premium Plus Plan, 60 per person per year in Plan 2: Medium Premium/Medium Deductible Plan** and Baltimore and Sunnyvale Premium Plans and 30 visits per person per year in

the Plan 3: Low Premium/High Deductible Plan** and Baltimore and Sunnyvale Value Plans)

- **Radiation Therapy** — the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes
- **Respiratory Therapy** — the introduction of dry or moist gases into the lungs for treatment purposes
- **Speech Therapy** — speech therapy is covered when medically necessary to correct a speech problem
- **Vision Therapy** — vision therapy is covered when medically necessary; call Quantum Health at the number provided on your ID card for details about medical necessity requirements

**Maximum applies to treatment and does not include consultation. All visits for treatment apply to the annual maximum limit regardless if the expense is paid through an HRA, HSA, FSA, applied to the deductible or paid by the plan.*
***Baltimore and Sunnyvale represented employees are not eligible.*

Urgent Care Center

Coverage is provided at an emergency medical service center, which is separate from any other hospital or medical facility.

Wigs

Benefits are provided when baldness is a result of chemotherapy, alopecia, radiation therapy, gender affirming care or surgery. Benefit is limited to $1,500 per person per plan year.

SERVICES, SUPPLIES AND MEDICAL EXPENSES NOT COVERED

Certain services and supplies — and certain medical expenses — are not eligible for benefits under the Anthem plans.

The following is a list of services that are not covered. Ineligible treatments, services and supplies include:

- The cost of ambulance service for non-emergencies or patient convenience
- The cost of anesthesia for non-covered services, unless otherwise specified
- The cost of caffeine or nicotine addiction, withdrawal or dependence-related care, including prescription and non-prescription drugs (these costs may be covered under prescription drug benefits through CVS/caremark)
- Charges above the **Maximum Allowed Amount** limits
- Charges for claims filed after the filing deadline
- Charges for an injury incurred while committing a crime
- Charges for services or supplies that are not medically necessary, including charges for equipment containing features of an aesthetic nature or features of a medical nature not required by the patient's condition
- Charges for services that are not ordered by a physician for the diagnosis, care or treatment of an illness, injury or pregnancy, except preventive or well-child care
- Charges that you are not legally required or obligated to pay, or charges that would not have been billed, such as for free immunizations provided at a local clinic or drugstore
- The cost of comfort or convenience equipment or supplies, such as exercise and bathroom

equipment, seat-lift chairs, air conditioners, humidifiers, dehumidifiers and purifiers, shoes or related corrective devices, spas or computer “story boards” or “light talkers”

- Costs of nutritional supplements whether obtained over the counter or by prescriptions
- Expenses related to cosmetic surgery, except as described under **Covered Medical Services**
- Expenses related to court-ordered treatment, unless certified as medically or psychologically necessary
- Expenses related to custodial care or maintenance therapy, including care for conditions not typically responsive to treatment as well as conditions that are no longer responsive to treatment due the attainment of maximum ability levels
- The cost of transplant donor fees
- The cost of dental services, including the extraction of wisdom teeth, except those described under **Covered Medical Services**. (This exclusion encompasses shortening or lengthening the maxilla or mandible for cosmetic purposes or correction of malocclusion. If you select dental coverage, these expenses may be eligible under your dental plan option. Refer to **Dental** for more information)
- Expenses for vocational, work hardening or training programs regardless of diagnosis or symptoms or for non-medically necessary education, except as specifically provided under each plan option
- Expenses related to educational programs for mental impairment or for developmental disorders such as cluttering and stuttering
- Expenses related to experimental or investigational services or supplies, as determined by the claims administrator, in its discretion. Any of the following criteria may be cause for classification as experimental or investigational:
  - Requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the FDA or final approval from any other governmental body for use in treatment of a specified condition. Any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval.
  - Insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the claims administrator’s evaluation of the therapeutic value of the service or supply
  - Inconclusive evidence that the service or supply has a beneficial effect on health outcomes
  - Evidence that the service or supply is not as beneficial as any established alternatives
  - Insufficient information or inconclusive scientific evidence that, when utilized in a non-investigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives
- Charges for eye refractions, eyeglasses and contact lenses, except after cataract surgery
- Expenses for any deductibles or copayments under a separate health care plan, managed care plan, health maintenance organization, or pharmacy plan, either through Northrop Grumman or any other company’s plan
- Expenses reimbursed or paid through Medicare or any other public program, or, if the participant did not sign up for Medicare A and/or B, expenses that would have been eligible for reimbursement through Medicare, where permitted by law
- The cost of foot treatment for:
  - Weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open-cutting operations)

  - Corns, calluses or toenails, except the removal of nail roots and necessary services prescribed by a physician (M.D. or D.O.) to treat metabolic or peripheral-vascular disease
- The cost of homeopathic or related treatment
- The cost of treating any illness or injury related to employment that is covered under workers' compensation or similar laws
- Expenses related to infertility administration fees that are not medically necessary, such as egg and sperm costs, donor search fees and surrogate mother charges, unless the surrogate mother is eligible and enrolled in an available plan option at the time services are rendered
- Charges for massage therapy not rendered by a licensed provider or physician
- The cost of care for the newborn child of an enrolled child, unless the newborn becomes enrolled as an eligible dependent under the Northrop Grumman Health Plan
- The cost of over-the-counter medications or dietary supplements that do not require a prescription by law (unless required to be covered by applicable law)
- Expenses related to periodontal or periapical disease, or any condition other than a malignant tumor involving teeth, surrounding tissue or structure, except as described under **Covered Medical Services** (If you select dental coverage, these expenses may be eligible under your dental plan option. Refer to **Dental** for details.)
- Personal non-medical expenses, such as telephone and television charges while in a hospital
- Expenses related to any exercise program, except as part of Phase I and Phase II cardiac rehabilitation
- Fees for physician assistant services, if not accepted medical practice in your state
- Expenses related to home births, including Doula services
- Expenses for counseling services for the purpose of career or financial reasons
- Fees for private duty nursing while a patient is in a hospital or other treatment facility
- Physician charges for duplication of records, telephone consultations, failure to keep a scheduled appointment or for completion of claim forms
- The cost of radial keratotomy, photo refractive keratectomy, astigmatic keratectomy, LASIK or other similar surgical procedures to improve or correct vision problems
- Expenses related to the reversal of voluntary sterilization, treatment of sexual dysfunction not related to organic disease, and for any drugs or devices used for contraception, unless otherwise specified in this SPD
- The cost of services furnished by a hospital or facility operated by the U.S. government or any authorized agency of the U.S. government, or furnished at the expense of such government or agency, unless payment is legally required
- Charges for shipping and handling for covered items
- The cost of services or supplies that any school system provides as required by law
- The cost of services or supplies provided by any Northrop Grumman Medical Department
- Charges related to services or treatment rendered by you or your spouse, child, parent, parent-in-law, brother, sister, brother-in-law or sister-in-law

- The cost of services received before coverage begins or after coverage ends
- Expenses related to physical, occupational, or speech therapy for maintenance purposes
- Expenses related to the non-surgical treatment of temporomandibular joint disorders and related conditions by any method, including therapy services related to temporomandibular joint disorders
- Expenses related to weight reduction treatment, unless medically necessary for obesity
- Marriage counseling (though coverage may be available through the EAP)

These examples are not intended to be all-inclusive. Charges for other procedures, services or supplies may be excluded if it is determined by the claims administrator that they are not medically necessary, reasonable or covered by the plans. In addition, to be covered, services must be provided legally.

No inference should be drawn from the inclusion or exclusion of any specific condition, disease, ailment or illness, or its related treatment, diagnosis or care, in this section or otherwise.

PRESCRIPTION DRUG COVERAGE

This section describes your coverage through CVS/caremark, including how you can access a wide range of eligible prescription drugs at retail pharmacies and through the CVS/caremark Maintenance Choice Program. Please keep in mind that in certain states, CVS/caremark may limit access to some aspects of the prescription drug coverage described in this section. Please contact CVS/caremark for more information.

Your Prescription Drug Costs

Your prescription drug coverage — and how much you pay for your prescription medications — depends on two things:

- How you purchase your prescription (at a retail pharmacy in the CVS/caremark network, at an out-of-network pharmacy, or through the CVS Mail Service Pharmacy or Maintenance Choice Program). See **How to Purchase Your Prescription Drugs through CVS/caremark** for details.
- The type of medication (generic, preferred brand, brand, preventive or specialty). When available and appropriate, your prescription will automatically be filled with a generic drug. See **Mandatory Generics Program** for details.

You do not need to satisfy the deductible in order to be reimbursed for certain preventive prescription medications. When the deductible does not apply towards a prescription drug that requires cost-sharing, you will only be responsible for the coinsurance portion of the expense. The plan will pay 100% for certain preventive drugs through in-network pharmacies or the CVS Retail Pharmacy Program. A comprehensive list of preventive drugs can be found on the CVS/caremark website (**caremark.com**).

ATTN: Under Plan 1: High Premium/Low Deductible Plan*, the prescription drug deductible is separate from the medical deductible. You must meet the prescription drug deductible before the plan begins to pay. Your prescription expenses will be applied to the plan's out-of-pocket maximum.

ATTN: Under Plan 2: Medium Premium/Medium Deductible Plan,* Plan 3: Low Premium/High Deductible Plan* and **Baltimore and Sunnyvale Value Plans, the medical and prescription drug deductible is combined.** You must meet this combined deductible before the plan begins to pay.

Want to Know How Much Your Prescription Drug Will Cost?

Use the prescription drug cost comparison tool at the CVS/caremark website, **caremark.com**, to estimate your costs of specific prescription drugs — at a retail pharmacy and through the CVS/caremark Maintenance Choice Program.

The first time you access the CVS/caremark site, you will need to register and set up a user name and confidential password. To access the cost comparison tool, you will need to provide the name of the medication, the dosage and the number of days' supply. These costs are estimates only and subject to change.

**Baltimore and Sunnyvale represented employees are not eligible.*

PRESCRIPTION DRUG COVERAGE FEATURES				
	Plan 1: High Premium/Low Deductible Plan*		**Plan 2: Medium Premium/Medium Deductible Plan[1*] and Plan 3: Low Premium/High Deductible Plan***	
	Retail Program (up to 30-day supply)	**Maintenance Choice Program (up to 90-day supply)[2]**	**Retail Program (up to 30-day supply)**	**Maintenance Choice Program (up to 90-day supply)[2]**
Refill limit	None	Two refills per prescription	None	Two refills per prescription
Prescription Drug Deductible[3]				
You only	$150		**Medical Deductible applies**	**Medical Deductible applies**
You + Spouse/ Domestic Partner	$200			
You + Child(ren)	$200			
You + Family	$250			
Coinsurance for CVS/caremark Pharmacies (Coinsurance applies after the deductible is satisfied, except for preventive drugs)				
Generic drugs	20% coinsurance	20% coinsurance, up to a maximum of $200	20% coinsurance	20% coinsurance, up to a maximum of $200
Preferred Brand drugs	25% coinsurance	25% coinsurance, up to a maximum of $200	25% coinsurance	25% coinsurance, up to a maximum of $200
Non-Preferred Brand drugs	35% coinsurance	35% coinsurance, up to a maximum of $200	35% coinsurance	35% coinsurance, up to a maximum of $200
Preventive drugs	0% coinsurance for certain preventive drugs[4]; 20% coinsurance for all other preventive drugs	0% coinsurance for certain preventive drugs[4]; 20% coinsurance for all other preventive drugs, up to $200 maximum	0% coinsurance for certain preventive drugs[4]; 20% coinsurance applies for all other preventive drugs	0% coinsurance for certain preventive drugs[4]; coinsurance applies for all other preventive drugs, up to $200 maximum
Specialty drugs	25% coinsurance up to a maximum of $400 per prescription for a 30-day supply. After one retail fill, specialty drugs must be obtained through CVS/caremark Specialty Pharmacy		25% coinsurance up to a maximum of $400 per prescription for a 30-day supply. After one retail fill, specialty drugs must be obtained through CVS/caremark Specialty Pharmacy	
Coinsurance for Non-CVS/caremark Pharmacies				
All prescription drugs	50% coinsurance, after deductible	N/A	50% coinsurance, after deductible	N/A

[1]Plan 2: Medium Premium/Medium Deductible Plan or Plan 4: Medium Premium/Deductible Utah Extended Network Plan

[2]Maintenance and/or long-term prescription drugs must be purchased through the CVS Mail Service Pharmacy or Maintenance Choice Program

[3]One participant may satisfy the deductible for all of the covered family members or claims for more than one family member can be combined to meet the deductible.

[4]To the extent required by law, medications that are considered preventive care under the Patient Protection and Affordable Care Act are covered at 100%. Coinsurance does not apply.

**Baltimore and Sunnyvale represented employees are not eligible.*

PRESCRIPTION DRUG COVERAGE FEATURES				
	Baltimore Premium Plus Plan, Baltimore Premium Plan, Sunnyvale Premium Plan		**Baltimore Value Plan and Sunnyvale Value Plan**	
	Retail Program (up to 30-day supply)	**Maintenance Choice Program (up to 90-day supply)[1]**	**Retail Program (up to 30-day supply)**	**Maintenance Choice Program (up to 90-day supply)[1]**
Refill limit	None	Two refills per prescription	None	Two refills per prescription
Prescription Drug Deductible[2]				
You only	**Medical Deductible applies**		**Medical Deductible applies**	**Medical Deductible applies**
You + Spouse/ Domestic Partner				
You + Child(ren)				
You + Family				
Coinsurance for CVS/caremark Pharmacies (Coinsurance applies after the deductible is satisfied, except for preventive drugs)				
Generic drugs	20% coinsurance	20% coinsurance, up to a maximum of $200	20% coinsurance	20% coinsurance, up to a maximum of $200
Preferred Brand drugs	25% coinsurance	25% coinsurance, up to a maximum of $200	25% coinsurance	25% coinsurance, up to a maximum of $200
Non-Preferred Brand drugs	35% coinsurance	35% coinsurance, up to a maximum of $200	35% coinsurance	35% coinsurance, up to a maximum of $200
Preventive drugs	0% coinsurance for certain preventive drugs[3]; 20% coinsurance for all other preventive drugs	0% coinsurance for certain preventive drugs[3]; 20% coinsurance for all other preventive drugs, up to $200 maximum	0% coinsurance for certain preventive drugs[3]; 20% coinsurance applies for all other preventive drugs	0% coinsurance for certain preventive drugs[3]; coinsurance applies for all other preventive drugs, up to $200 maximum
Specialty drugs	25% coinsurance up to a maximum of $400 per prescription for a 30-day supply. After one retail fill, specialty drugs must be obtained through CVS/caremark Specialty Pharmacy		25% coinsurance up to a maximum of $400 per prescription for a 30-day supply. After one retail fill, specialty drugs must be obtained through CVS/caremark Specialty Pharmacy	
Coinsurance for Non-CVS/caremark Pharmacies				
All prescription drugs	50% coinsurance, after deductible	N/A	50% coinsurance, after deductible	N/A

[1]Maintenance and/or long-term prescription drugs must be purchased through the CVS Mail Service Pharmacy or Maintenance Choice Program

[2]One participant may satisfy the deductible for all of the covered family members or claims for more than one family member can be combined to meet the deductible.

[3]To the extent required by law, medications that are considered preventive care under the Patient Protection and Affordable Care Act are covered at 100%. Coinsurance does not apply.

Eligible Prescription Drugs

To be eligible for coverage, a prescription drug must be:

- Necessary for the treatment of a disease or illness, and widely accepted as effective, appropriate and essential — based on the recognized standards of the medical community and as approved by CVS/caremark for reimbursement
- Prescribed by a licensed physician
- Prescribed in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies

In addition, the drug must be provided legally in order for it to be covered. As new drugs become available, they will be considered for coverage under the Northrop Grumman Health Plan.

Note: Compounds can contain substances that have not been rigorously tested for safety or effectiveness. Due to the lack of FDA approval for many ingredients included in compounds, they may not be covered or may require a prior authorization. **Preauthorization** is required for any compound prescription drug with costs exceeding $300. Please contact CVS/caremark for additional information or with questions.

Keep in Mind

The fact that your physician prescribes, orders, recommends or approves a prescription or supply does not automatically mean it is an eligible expense. Always call CVS/caremark to confirm coverage. If you have questions about a particular prescription drug, or if you go to your pharmacy and are told that a particular drug is not covered, call CVS/caremark at 855-361-8565.

Visit the CVS/caremark website (**caremark.com**) for the lists of prescription drugs that are eligible and ineligible for reimbursement under the CVS/caremark prescription drug program, including a formulary drug list.

How to Purchase Your Prescription Drugs through CVS/caremark

You have two options for purchasing your prescription drugs:

- For short-term medications or medications you need right away, take your prescription to a retail pharmacy. You can go to any retail pharmacy, but you will pay less when you go to one that participates in the CVS/caremark pharmacy network. You will receive up to a 30-day supply of the medication. See **CVS/caremark Maintenance Choice Program**.
- For long-term and maintenance medications that you take on a regular basis (for example, medications to treat high blood pressure, diabetes medication and birth control pills), you must use the **CVS/caremark Maintenance Choice Program**.

When you need a short-term medication, such as an antibiotic, take your prescription to a retail pharmacy in the CVS/caremark pharmacy network. To receive in-network benefits for your short-term medications, you are not required to use a CVS/pharmacy, rather you may select a pharmacy in the CVS/caremark pharmacy network, which includes most major pharmacies. You will receive up to a 30-day supply of the medication, depending on your prescription.

For a full list of pharmacies, to confirm that a particular pharmacy participates in the CVS/caremark network, and to find the pharmacy closest to you, call CVS/caremark directly at 855-361-8565 or go to the CVS/caremark website, **caremark.com**.

When you use a CVS/caremark-participating pharmacy:

1. Ask your doctor to write a prescription for up to a 30-day supply of your medication, plus refills, if appropriate
2. Take your prescription to a CVS/caremark-participating pharmacy
3. Show your prescription drug ID card to the pharmacist. If you do not have your card, your coverage may be limited to 50% of your eligible expenses. (If you do not have your ID card with you at the time your prescription is filled, you may return to the pharmacy within seven days with your ID card.)
4. Pay the appropriate deductible or coinsurance at the pharmacy
5. If you participate in a **Health Savings Account, General Purpose Health Reimbursement Account** or a **General Purpose Health Care Flexible Spending Account** and have funds available, you may pay your expense with the applicable benefit card or submit your receipts for reimbursement

Note: To receive the in-network level of coverage, your prescription drug claim must be filed electronically by the network pharmacy. Present your ID card to the pharmacy at the time your prescription is filled (or at least within seven days). Otherwise, your prescription will be filled at the out-of-network level.

OUT-OF-NETWORK PHARMACIES

With CVS/caremark's extensive pharmacy network, it is easy to find a participating pharmacy near you. However, you may choose to take your prescription to a retail pharmacy that does not participate in the CVS/caremark network. When you use an out-of-network pharmacy, you pay the full prescription price at the pharmacy and then submit your prescription drug claim form and receipt to CVS/caremark. CVS/caremark will reimburse you for 50% of your eligible expenses, after you pay the plan-year deductible.

If you want to switch your prescription from an out-of-network pharmacy to a CVS/caremark-participating pharmacy, go to the CVS/caremark pharmacy you wish to use and tell the pharmacist where your prescription is currently being filled. The pharmacist will call the other pharmacy and switch your prescription for you.

CVS/CAREMARK MAINTENANCE CHOICE® PROGRAM

If you take any prescriptions on a regular basis — such as birth control pills or medications for high blood pressure or diabetes — you can save time by using the CVS/caremark Maintenance Choice Program. With the CVS/caremark Maintenance Choice Program, you can have a 90-day supply of your medication filled directly at a CVS/pharmacy location. You must use this program or the CVS Mail Service Pharmacy for any medication that requires more than two fills.*

When you purchase prescriptions through the CVS/caremark Maintenance Choice Program, you pay your deductible, if applicable, and the appropriate coinsurance and receive up to a 90-day supply of your medication. The maximum you will pay if you have met the deductible is $200.

You may also use the CVS Mail Service Pharmacy to have your 90-day supply of medications sent directly to your home.

Choose one of four ways to start filling your 90-day prescriptions through CVS/caremark:

1. **In Person:** Take your prescription to a CVS/pharmacy location
2. **Phone:** Call CVS/caremark Customer Care at 855-361-8565

3. **Mail:** Fill out and return a mail service order form. You can download one from the CVS/caremark website, **caremark.com**, or request one from CVS/caremark Customer Care

4. **Online:** Visit **caremark.com/faststart** and log in. You may then request a new mail service prescription from your doctor using *Request a Prescription with Fast Start*

* The Maintenance Choice Program may not be available in all states. Contact CVS/caremark for more information.

The earliest you can refill your prescription is the date indicated on your prescription label. So, it is important to plan ahead when ordering through the mail. Mark your calendar in advance, so you do not run out. If you are currently receiving prescription medications through a program other than CVS/caremark Maintenance Choice or the CVS Mail Service Pharmacy, ask your doctor to write a new prescription (for up to a 90-day supply plus refills).

Maintenance Medications

You must use the CVS/caremark Maintenance Choice Program or mail order through CVS Mail Service Pharmacy for any medication that requires more than two fills.

The prescription drug benefit covers up to two fills of a maintenance medication at a participating retail pharmacy. After that, you must fill 90-day supplies either through the CVS/caremark Mail Service Pharmacy or at a CVS/pharmacy location.

If you decide not to use the CVS/caremark Maintenance Choice Program or mail order, you will pay the full retail cost of the medication at your participating retail pharmacy. In addition, the expense will not apply to your annual deductible or out-of-pocket maximum. If you have a **Health Savings Account, General Purpose Health Reimbursement Account** or a **General Purpose Health Care Flexible Spending Account**, you may use those funds to cover the expense at the retail pharmacy.

Mandatory Generics Program

Through the Mandatory Generics Program, whenever you fill (or refill) a brand-name prescription drug, your pharmacist will automatically check whether a chemically equivalent generic drug is available. You won't sacrifice quality by using a generic drug — it has the same chemical makeup as the brand-name drug, works the same in your body and delivers the same medical benefits. Generics are approved by the FDA, and currently account for more than 50% of all medications prescribed in the U.S.

If you continue with the brand-name prescription drug when a medically appropriate generic is available, you will pay your share of the cost (i.e., your remaining deductible and/or coinsurance), plus the difference in cost between the generic and the brand-name prescription drug. The excess charge will not apply toward your deductible or out-of-pocket maximum. If you have a **Health Savings Account, General Purpose Health Reimbursement Account** or a **General Purpose Health Care Flexible Spending Account,** you may use those funds to pay for these charges.

Generic Step Therapy

With the Generic Step Therapy Program, you are required to try a lower-cost, and equally effective, generic medication before "stepping up" to a high-cost brand-name medication.

Generic Step Therapy will apply to any new first-time prescriptions or those that have not been filled in 130 days or more, even if your doctor writes "Dispense as Written" on your prescription. If you attempt to fill a prescription for a second-line (higher-cost or brand) medication without having tried the front-line medication or more than 130 days have passed since your last refill of one of these drugs, **your prescription will not be covered and you will be responsible for 100% of the cost**. The amount paid by you will not be applied toward your deductible or out-of-pocket maximum. If this happens, your pharmacist can immediately call your doctor to ask if you can switch to a lower-cost, equivalent front-line alternative, or you can speak to your doctor on your own. If you have a **Health Savings Account,**

General Purpose Health Reimbursement Account or a **General Purpose Health Care Flexible Spending Account**, you may use those funds to pay for these charges.

CVS/caremark may add or remove conditions and/or prescription drugs included in the Generic Step Therapy program at any time. For more information about the program, call CVS/caremark.

CVS/caremark Specialty Pharmacy

CVS/caremark Specialty Pharmacy is designed to help patients with specialized prescription drug needs obtain their prescriptions quickly, conveniently and cost effectively. Specialty drugs are defined as having one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring
- Need for intensive patient training and compliance assistance
- Limited or exclusive product availability and distribution
- Specialized product handling/administration

Some conditions treated with medications considered specialty drugs include, but are not limited to: asthma, Crohn's disease, growth hormone deficiency, multiple sclerosis, hepatitis B or C, rheumatoid arthritis, respiratory syncytial virus, immune deficiency and hemophilia.

Patients needing specialty drugs, as identified on the exclusive specialty list, must use an exclusive specialty pharmacy for specialty drug prescriptions. The specialty pharmacy is designed to provide the personalized care, education and support needed for patients to get the full benefit of their treatment with specialty medications. Services include:

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with the patient and doctor
- Direct delivery to the patient or doctor's office
- Medicine-specific and disease-specific education and counseling
- Online support through **CVSCaremarkSpecialtyRx.com**, including disease-specific information and interactive capabilities that allow patients to submit questions to pharmacists and nurses

You pay the 25% coinsurance up to a maximum of $400 per prescription for a 30-day supply. You must first meet your applicable deductible before the 25% coinsurance and $400 maximum apply.

Call CVS/caremark at 855-361-8565 or access the CVS/caremark website (**caremark.com**), for more information about the CVS/caremark Specialty Pharmacy and to verify your coverage for certain therapies and medications related to your condition. (For immune deficiency and bleeding disorders, call 855-361-8565.)

Special Information for Patients with Diabetes

The prescription drug benefit includes a special provision for diabetic kits. When you purchase a diabetic kit, your coinsurance will be based on the highest-cost diabetes medication, and any additional medications and supplies be provided at no cost to you.

The savings only applies if:

- The order includes a diabetes medication, and
- You order all the supplies at the same time through the CVS/caremark Maintenance Choice Program. If you fill the order at a CVS/pharmacy, make sure the pharmacist processes the insulin or oral diabetes medication first. If the insulin or oral diabetes medication is not processed first, the copayment will apply to the other supplies.

The kit includes these supplies:

- Diabetes medication (insulin or oral)
- Alcohol wipes
- Diagnostic strips
- Lancets and syringes

Blood glucose monitors are not included in the diabetes kits. There is a $125 maximum annual benefit per covered individual, per year for blood glucose monitors.

If you need a glucose monitor, you can order one at no charge by calling CVS/caremark at 855-361-8565.

In addition, you have access to the Vida Health Program for diabetes prevention and management.

HEALTH MAINTENANCE ORGANIZATION (HMO) MEDICAL PLAN OPTIONS

Depending on your home ZIP code area, you may have access to an HMO option.

HMOs provide care through a network of PCPs and specialists. In most HMO plan options, you must choose a network PCP to provide or coordinate all of your care (including specialist referrals). A PCP may be a family practitioner, general practitioner, internist or pediatrician. All network PCPs meet the HMO's qualification standards and are subject to periodic review. Care that is not coordinated by your PCP is not covered by the HMO.

Your PCP will refer you to other HMO providers, when necessary. **The HMO options pay no benefits if you use a physician, hospital or other provider that is not a member of the HMO's network — except in an emergency situation.**

If you enroll in one of the HMO plan options, you will receive prescription drug coverage and mental health and substance abuse coverage directly through the HMO.

The HMO, not Northrop Grumman, is responsible for the payment of all benefits covered under the HMO contract and has the sole authority, discretion and responsibility to interpret the terms of the HMO contract, and by enrolling in an HMO, you agree to be bound by all terms of the HMO contract.

More information about your specific HMO options is available by logging on to NetBenefits at **netbenefits.com/northropgrumman**. If you are currently enrolled in an HMO, you may contact the HMO's member services directly. You can find member services contact information in your HMO member materials and on your medical plan ID card.

CIGNA GLOBAL MEDICAL PLAN OPTION

The Cigna Global Medical plan provides medical and prescription drug coverage designed to meet the needs of our overseas employees and to comply with specific country insurance laws and mandated coverage levels. The **Cigna Global Dental** plan provides dental coverage.

To ensure employees working overseas have adequate health insurance, Cigna Global Medical coverage is mandatory for employees who are on:

- An overseas assignment of 180 days or longer (may be less for certain countries such as Australia, the Netherlands, Poland, Saudi Arabia, South Korea and the United Arab Emirates (UAE), and Guam), or
- A rotational assignment where 50% or more of their time is spent outside of the U.S.

You may opt out of the Cigna Global Medical plan by providing proof of other international medical or TRICARE coverage. Domestic coverage will not satisfy this requirement. Waiving the Cigna Global Medical plan is not an option in some countries, including Australia, the Netherlands, Poland, Saudi Arabia, South Korea and the UAE. If you are a retired military service member and enrolled in TRICARE coverage, you may be eligible to opt out of the Cigna Global Medical plan. Please call the NGBC at 800-894- 4194 for information on opting out of coverage.

If your assignment is for 90 to 179 days, you may voluntarily enroll in the Cigna Global Medical Plan. Please contact the Northrop Grumman Global Mobility Office (GMO) for more information.

For employees with dependents that remain in the United States, the Cigna Global Medical and Dental plans provide domestic coverage through a Cigna network of providers.

For details about the coverage provided by Cigna Global Health Benefits, refer to your plan material or call Cigna Global toll-free at 800-441-2668 or direct at 001-302-797-3100 (collect calls accepted).

Cigna Global, not Northrop Grumman, is responsible for the payment of all benefits covered under the insurance contract and has the sole authority, discretion and responsibility to interpret and apply the terms of the contract.

If you live outside the United States and are not offered this plan option, contact the NGBC at 800-894-4194.

TRICARE SUPPLEMENT PLAN

A TRICARE Supplement is also available through Selman & Company, an insurance broker. The TRICARE Supplement Plan is not part of the Northrop Grumman Health Plan.

Northrop Grumman offers limited administrative and recordkeeping services support to our employees who are eligible for TRICARE and want to enroll in the TRICARE Supplement. Northrop Grumman will collect the premiums for this coverage and will forward payments to Selman & Company on behalf of employees who choose to purchase the TRICARE Supplement. If you choose to purchase the TRICARE Supplement, you pay the full cost of coverage. Northrop Grumman is not permitted to pay any part of the cost of coverage under TRICARE Supplement. Northrop Grumman will not receive any compensation, direct or indirect, for offering these administrative services and does not endorse, recommend, or sponsor the TRICARE Supplement.

TRICARE is the health care program for uniformed service members, retirees, and their families. The TRICARE Supplement Plan is available to you and your eligible dependents if you are:

- Eligible for and enrolled in TRICARE Prime, Select or Reserve Select, and
- Under age 65 and not Medicare-eligible.

The TRICARE Supplement Plan provides additional benefits to your TRICARE Prime, Select or Reserve Select coverage, including the reimbursement of the following:

- Certain copayments and cost shares
- A portion or all of your annual deductible, depending on your TRICARE plan

For more information about the TRICARE Supplement, including dependent eligibility, please call Selman & Company at 800-638-2610 or call the NGBC at 800-894-4194.

Selman & Company, not Northrop Grumman, is responsible for the payment of all benefits covered under the insurance contract and has the sole authority, discretion, and responsibility to interpret and apply the terms of the contract.

BENEFIT MAXIMUMS

The Plan does not impose lifetime or annual dollar limits on essential health benefits. A lifetime dollar limit is the total amount the Northrop Grumman self-insured medical plan options pay for benefits for each enrolled individual over the course of the individual's lifetime; an annual dollar limit is the total amount the Northrop Grumman self-insured medical plan options pay for benefits for each enrolled individual during the Plan year.

The plan options may have lifetime and Plan year dollar limits on specific services that are not essential health benefits. All medical plan options administered by Anthem utilize the Utah state benchmark plan for purposes of identifying essential health benefits.

For information about maximums in the plans administered by Anthem, refer to those sections of the SPD. For information about maximums in the other plan options, please refer to your subscriber contract or coverage certificate, or contact the HMO or insurance carrier directly.

THIRD-PARTY REIMBURSEMENT (RIGHT OF SUBROGATION)

In some situations, another person or insurance company may be financially responsible for your medical expenses. For example, in the case of an automobile accident, a no-fault automobile insurance policy may be responsible for paying all or part of your medical expenses. If the plan reimburses expenses for which you or a dependent later recovers damages, you are required to reimburse the plan for those expenses. When you accept benefit payments made on your behalf from a Northrop Grumman medical plan option, you agree to:

- Immediately notify the plan of any instance in which a third party may be responsible for your medical expenses
- Reimburse the plan for the full amount of benefit payments made on your behalf
- Hold any amounts you receive from a third party associated with your medical expenses for which the plan has a reimbursement right in a constructive trust for the benefit of the plan
- Provide any documents that allow the plan to recover the payments it made to you or to a medical professional
- Provide any other assistance to the plan in enforcing these rights and not do anything to hinder the plan

The legal terms for the plan's rights of recovery are reimbursement and subrogation. The Plan has the right to recover 100% of the benefits paid or to be paid by the Plan in connection with the injury or illness for which another person or insurance company may be responsible.

The plan's reimbursement and subrogation rights apply to any and all payments made, or to be made to the injured person or the person's heir, guardian or other representative relating to the injury or illness. This includes, but is not limited to, payments as a result of judgment or settlement and payments from any automobile, homeowners, business or other insurance policy, including the covered person's own insurance policy. The Plan's rights apply regardless of whether the payments are designated as payment for pain and suffering, medical benefits, punitive, or other specified damages. The plan has the right of first recovery, regardless of whether the covered person has been made whole. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights. This means, for example, that the plan is entitled to recovery before attorneys' fees and other legal expenses are paid, and even if the amount paid or payable relating to the injury or illness is less than the individual's total loss, including medical expenses, lost wages, pain and suffering, and other damages.

In the event that a covered person dies as a result of his/her injuries and a wrongful death or survivor claim or similar claim is asserted or could be asserted against a third party, the Plan's subrogation and reimbursement rights shall also apply with respect to such claims.

You must notify the claims administrator when you take legal action against a third party as a result of an illness or injury, or if a third party is responsible for payment. You may be required to sign a reimbursement agreement before plan benefits are paid in connection with the injury or illness, but the plan's subrogation and reimbursement rights are not dependent on having a signed agreement. If a determination is made that you received benefits that should not have been paid, or that you have failed or refused to reimburse the plan as required, the plan may (in addition to taking other action) withhold future benefit payments.

ADDITIONAL INFORMATION ABOUT YOUR MEDICAL BENEFITS

Important Notice About the Women's Health and Cancer Rights Act

If you receive plan benefits in connection with a mastectomy, you are entitled to coverage for the following under the plan:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes)

The plan will determine the manner of coverage in consultation with you and your attending doctor. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

If you would like more information about the Women's Health and Cancer Rights Act, call the NGBC at 800-894-4194.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, the plan may not restrict benefits for the mother or newborn child to less than:

- 48 hours for any childbirth-related hospital stay following a vaginal delivery
- 96 hours following a delivery by Caesarean section

However, the mother's or newborn's attending physician may discharge the mother or newborn earlier than 48 hours (or 96 hours as applicable) after consulting with the mother.

Also, under federal law, the plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated less favorably for the mother or newborn than any earlier portion of the stay.

In addition, the plan may not, under federal law, require that a physician or other health care provider obtain authorization to prescribe a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification.

If You Have Other Health Care Coverage: Non-Duplication of Benefits

Remember, the benefits you receive from a Northrop Grumman medical plan option may affect the benefits you receive from another group health plan, and vice versa. It is very important to let your health care providers and claims administrator know if you or a family member is enrolled in more than one health plan (for example, if your spouse is enrolled in a Northrop Grumman medical plan option and his or her employer's plan). When this happens, the Northrop Grumman medical plan option will apply a non- duplication of benefits provision to coordinate payments with the other plan.

Under the non-duplication of benefits provision, the Northrop Grumman medical plan options consider the benefit payments you receive from another group plan. When the Northrop Grumman medical plan is the secondary payer, the Northrop Grumman medical plan makes up the difference between the amount the other plan pays and the benefit that otherwise would be payable under the Northrop Grumman medical plan option.

This provision ensures that payments from the other plan, plus any payments from the Northrop Grumman medical plan, do not exceed the amount the Northrop Grumman medical plan would have paid if there were no other coverage.

To calculate non-duplication of benefits, it is necessary to determine which plan is the primary plan and which is the secondary plan. The primary plan pays benefits first. The secondary plan pays benefits after the primary plan has paid.

The Northrop Grumman medical plan is always secondary to any automobile insurance coverage, including, but not limited to, no-fault coverage and uninsured motorist coverage, and to any medical payment provision under homeowner's or renter's insurance.

For all other plans subject to coordination of benefits, the following rules apply to determine which plan is primary:

- If a plan does not have a coordination of benefits provision, that plan will always be primary
- The plan that covers the person as an employee (or retiree) is primary over a plan covering the person as a dependent, unless the person is enrolled in Medicare. If the person is enrolled in Medicare (and if under the Medicare rules, Medicare is secondary to the plan that covers the person as a dependent and primary to the plan that covers the person as an employee or retiree), the plan that covers the individual as a dependent is primary, Medicare is secondary, and the plan that covers the claimant as an employee or as a retiree pays third.
- The plan covering the person as an active employee, or as that employee's dependent, is primary over the plan covering the person as a retiree (or laid-off employee) or as that person's dependent. However, if the other plan does not determine the order of benefits in this same way and, as a result, does not agree on the order of benefits, this rule will be ignored.
- If two or more plans cover the person receiving care as a dependent, then the plan of the parent whose birthday (month and day) falls earlier in the calendar year is primary unless the other plan uses a rule based on the person's gender and — as a result — the plans do not agree on the order of benefits. In that case, the rule in the other plan will be used to determine which plan is primary. If the birthday rule applies and both parents have the same birthday, the plan covering a parent longer will be primary.
- If you are divorced or not married to your child's parent and your child is enrolled in both a Northrop Grumman medical plan option and the other parent's employer's plan, the plans pay in this order:
  - First, the plan of the parent awarded financial responsibility for the child's medical expenses by a court decree
  - Then, the plan of the parent with custody of the child
  - Then, the plan of the stepparent whose spouse/domestic partner has custody of the child
  - Then, the plan of the parent who does not have custody of the child

If none of these rules determine the order of payment, the plan that covered the child in question the longest is the primary plan.

To ensure proper payment of claims under the non-duplication of benefits provision, the plan administrator may ask you to confirm your other coverage, if any. Your claims administrator will send

you a coordination of benefits (COB) questionnaire, usually after your claims administrator receives the first claim for your enrolled spouse or children, and annually thereafter.

The COB questionnaire requests information about any other insurance under which your dependents are covered. Claims administrators vary on their process for processing the claim associated with the questionnaire. In some cases, until your claims administrator receives your completed questionnaire (which can be completed in writing or over the telephone with the claims administrator), the claim that triggered the questionnaire is "pended" or put on hold. If your claims administrator does not receive a completed questionnaire, the claim is denied and you are sent an explanation of benefits (EOB) statement. The statement provides the reason for the denial and instructs you to complete the COB questionnaire and submit it to your claims administrator along with the denied claim. In other cases, the claims administrator will pay the claim while the questionnaire is being processed. If a determination is made that you received benefits that should not have been paid, or that you have failed or refused to reimburse the plan as required, the plan may (in addition to taking other action) withhold future benefit payments.

Coordination with Medicare for Active Employees

While you are an active employee, if you or one of your dependents has coverage under the Northrop Grumman Health Plan and under Medicare due to age or disability, the Northrop Grumman medical plan pays primary to Medicare. That means the Northrop Grumman plan pays benefits first, and then Medicare pays benefits second. A separate rule applies to individuals who are eligible for coverage under Medicare due to end-stage renal disease.

Medicare coverage will be available to you (or your spouse or dependents) when you (or they) become age 65, whether you are retired or still working. You (or your spouse or dependents) may become eligible for Medicare before age 65 as a result of a qualified disability or end-stage renal disease.

If you plan to work past age 65, you can:

- Apply for Medicare when you become age 65, or
- Decide to wait until you retire to apply for Medicare, if you are enrolled in one of the Northrop Grumman medical plan options. Because the plan pays primary, you do not have to enroll in Medicare while you are still an active employee and covered under a Northrop Grumman medical plan option as an active employee (or spouse/domestic partner of an active employee). However, you and your dependents who are or may become eligible for Medicare should consult with your/their Medicare advisor or personal financial advisor to determine when to enroll in Medicare to avoid any Medicare late enrollment penalty.

When your active employment ends, you and/or any Medicare eligible dependent should enroll in Medicare Part B for coverage to be effective as soon as your employment ends, even if you are continuing coverage under COBRA or a severance plan. If you and/or your dependent does not enroll in Medicare Part B as soon as you (and/or they) become eligible after your active employment ends, you (and/or they) may pay higher Medicare premiums. A similar rule applies with regard to Medicare Part D (Prescription Drug) coverage. If you and/or your dependent do not enroll in Medicare Part D coverage as soon as you (and/or they) become eligible after your active employment ends, you (and/or they) may pay higher premiums for Medicare Part D prescription drug coverage if you (and/or they) later enroll. In addition, the Northrop Grumman Health Plan will pay benefits as if the Medicare-eligible individual has enrolled in Medicare, and as if Medicare made a payment, whether or not the individual has enrolled in Medicare and whether or not the provider accepts Medicare.

Consequently, if you do not enroll in Medicare when first eligible after your active employment ends, you could be responsible for paying significant medical expenses that would have been covered by Medicare.

End-Stage Renal Disease

If you (or a covered dependent) receive Medicare coverage because of end-stage renal disease, your Northrop Grumman medical plan option pays primary for the first 30 months you (or they) are enrolled in (or eligible to enroll in) Medicare. Thereafter, the plan pays secondary to Medicare.

If Your Dependent Resides Out of Area

You might have eligible dependents living away from home, such as a child who is away at college. If you have eligible dependents living away from home, an Anthem medical option — rather than an HMO — may be the best choice for you.

If you enroll in the Plan 1: High Premium/Low Deductible Plan,* Plan 2: Medium Premium/Medium Deductible Plan,* Plan 3: Low Premium/High Deductible Plan,* Plan 4: Medium Premium/Medium Deductible Utah Extended Plan,* Baltimore Premium Plus Plan, Baltimore and Sunnyvale Premium or Value Plans, your dependents can visit a physician in the Bluecard PPO network, also known as the National PPO network in some areas, anywhere in the nation and receive reimbursement at the higher in-network benefit level. If your dependents go to an out-of-network provider, reimbursement will be made at the out-of-network level; you will be responsible for the difference between the billed charges and the amount paid by the medical plan.

In general, if you participate in an HMO, your dependent must use in-network providers for all care. In an HMO, out-of-network care is not covered, except in an emergency.

Contact your medical plan carrier for more information on how to access care.

If you enroll in the Cigna Global Medical Plan option, any covered dependents who are living in the United States will receive coverage through that plan option.

**Baltimore and Sunnyvale represented employees are not eligible.*

Dental

Regular dental care is an important part of your overall health.

That's why Northrop Grumman offers dental coverage for you and your eligible family members. All of the dental plan options cover preventive and routine care, which can contribute to better health for you and your family and may help you avoid more costly and extensive treatments later.

This section of your SPD includes information about the Northrop Grumman dental coverage options available to you. Read this section carefully for the information that applies to your specific dental coverage options.

For More Information

To find out more about the Dental Plan and covered services, contact the NGBC at 800-894-4194.

See the **Eligibility and Participation** section of this SPD for information on when you become eligible for coverage, whom you may cover and how to enroll.

DENTAL PLAN OPTIONS

The Northrop Grumman Health Plan is designed to give you the flexibility to choose what you want to pay for your dental care. The Plan offers you a choice of four Delta Preferred Provider Organization (PPO) plan options, as well as a Dental Maintenance Organization option and a plan for employees working outside of the U.S.

- **Delta Dental Preferred Provider Organization (PPO) Dental Plan Options:**
  - Dental Care Plus
  - Dental Care
  - Preventive Care
- **CIGNA Dental Care Access Plan, a Dental Health Maintenance Organization (DHMO) Option** (formerly the Cigna DHMO) option, if offered in your ZIP code area
- **Cigna Global Dental Plan Option** (for employees working outside of the U.S.)

You can enroll in coverage for yourself and your eligible dependents when you are first hired and during annual enrollment. **If you choose the no coverage option**, you and your eligible family members will not have dental coverage through Northrop Grumman.

You cannot change your election until the next annual enrollment period, unless you have a **Qualified Life Event** during the plan year. Consider this carefully before making your decision.

Even if you waive dental coverage, you can still participate in other benefits under the Northrop Grumman Health Plan, including medical and vision coverage.

Support for Your Oral Health (for Delta Dental Plan Participants)

As a Delta Dental plan participant, you have access to the **SmileWay® Wellness Program and website**. Take advantage of the tools and resources provided:

- Online oral health risk assessment with the opportunity to sign up for customized communications based on results
- Interactive quizzes to see your potential risk of developing cavities and gum disease
- Extensive library of 100+ articles and videos on dental health-related topics
- Ongoing oral health communication through Facebook and Twitter to stay up-to-date with oral health news and information
- SmileWay Challenge that encourages you to review your dental habits and learn dental health tips
  - Interactive tools for kids through the award-winning children's website, **mysmilekids.com**, which is also available in Spanish (**es.mysmilekids.com**)

Preferred Provider Organization (PPO) Dental Plan Options

OVERVIEW OF PPO DENTAL PLAN COVERAGE

PPO dental plan options include: the Dental Care Plus, the Dental Care and the Preventive Care dental plans.

The PPO dental plan options all work in much the same way. You can go to any licensed dental provider for your dental care, but you save money when you access care through an in-network provider. Delta Dental administers the PPO dental plans and provides the PPO network of dental providers.

- If you want to receive the highest in-network benefits in any of the dental PPO plan options, be sure you receive care from a dentist who is in the Delta Dental PPO network. This same network applies to all three of the PPO dental plan options.
- Delta dentists who do not participate in the PPO network are called Delta Dental Premier Dentists. If you go to one of these Delta dentists, you will receive reduced in-network coverage.
- If you go to a non-Delta dentist, you will receive out-of-network coverage. Your costs may be higher because non-Delta dentists are not subject to contracted fees and the amount charged to you may be above that accepted by Delta Dental dentists.
- Likewise, if you live in an area where you do not have access to at least one Delta Dental orthodontist (or other specialist) within a 30-mile radius, you may be eligible to receive in-network coverage for specialist services, even if you use a non-Delta specialist provider. This will not qualify you to use non-network generalist dentists unless you also meet the requirements listed above.

How the PPO dental plan options differ is by some of the services they cover, your cost for coverage, and by your out-of-pocket costs when you receive care. The chart below compares the key similarities and differences between the PPO plan options. **Note:** The Preventive Care PPO option covers preventive and diagnostic care only (up to an annual maximum of $500 per person).

Keep In Mind

When you use a Delta Dental PPO network provider, you will receive in-network benefits in the PPO dental plan options, which means you pay less for your care. It is important to note that not every Delta dentist participates in the PPO network, so you must be careful when choosing your dentist. If you access care from a dentist who is not in the PPO network, you will receive a lower level of coverage — even if the dentist is in another Delta Dental network.

To find a dentist in the PPO network, visit Delta's website, **deltadentalins.com** (select Delta Dental PPO to search the provider list for all four PPO dental plan options) or call Delta Dental at 800-765-6003.

Keep in mind that the Delta Dental network of dentists is constantly changing. If you are eligible or become eligible for out-of-area coverage, you will remain eligible through the end of the plan year. You will be notified by Delta Dental if you are eligible for this out-of-area feature.

PPO PLAN:	DENTAL CARE	DENTAL CARE PLUS	PREVENTIVE CARE
About the plan	Designed to be the "preferred" plan option for the majority of employees because it provides coverage for routine preventive and diagnostic care, and basic and major restorative care at a moderate cost. This option does not cover orthodontia.	Provides the same coverage as the Dental Care Plan option, but also covers eligible orthodontia expenses.	Designed to provide basic coverage for preventive and diagnostic care only, this plan has the lowest contribution for coverage. This option has an annual maximum and does not cover restorative or orthodontia care.
What the plan covers	Preventive and diagnostic Basic and major restorative	Preventive and diagnostic Basic and major restorative Orthodontia	Preventive and diagnostic
Plan Features			
Deductible	PPO network: $100 individual/ $200 family Premier network: $150 individual/ $300 family Non-Delta Dental network: $200 individual/ $400 family	PPO network: $100 individual/ $200 family Premier network: $150 individual/ $300 family Non-Delta Dental network: $200 individual/ $400 family	$0
Annual maximum per person (in- and out-of-network combined) *Please see note below for additional restrictions*	PPO network: $1,500 Premier network: $1,250 Non-Delta Dental network: $1,000	PPO network: $2,500 Premier network: $2,000 Non-Delta Dental network: $1,500	$500
Orthodontia lifetime maximum per person (in- and out-of-network combined)	Not covered	PPO network: $3,000 Premier network: $2,000 Non-Delta Dental network: $1,500	Not covered
Non-surgical treatment of TMJ (in- and out-of-network combined)	PPO network: $500 lifetime maximum Premier network: $300 lifetime maximum Non-Delta Dental network: $250 lifetime maximum	PPO network: $500 lifetime maximum Premier network: $300 lifetime maximum Non-Delta Dental network: $250 lifetime maximum	Not covered
Implants (in- and out-of-network combined)	PPO network: $1,000 lifetime maximum Premier network: $750 lifetime maximum Non-Delta Dental network: $500 lifetime maximum	Subject to annual maximum	Not covered

PPO PLAN:	DENTAL CARE	DENTAL CARE PLUS	PREVENTIVE CARE
Your Coinsurance			
Preventive and diagnostic care (up to two cleanings, exams, and bite-wing X-rays each calendar year)*	0%; deductible does not apply	0%; deductible does not apply	0%; deductible does not apply
Basic restorative care (such as fillings, crowns, extractions)	PPO network: 20% Premier network: 30% Non-Delta Dental network: 50%	PPO network: 20% Premier network: 30% Non-Delta Dental network: 50%	Not covered
Major restorative care (such as bridges, TMJ treatment, implants, dentures)	50%	50%	Not covered
Orthodontia	Not covered	50%	Not covered

Note: There is one lifetime maximum, even if you change to another PPO dental plan option. In other words, your lifetime maximum does not reset if you change dental plans.

* A bite-wing X-ray is a simultaneous X-ray of teeth in both the upper and the lower jaw.

A Closer Look: How the PPO Dental Plan Options Work

To get the most out of your dental plan option, it is important to understand how it works and how much you will pay when you access care. If you enroll in one of the dental PPO plan options, you have a choice to make each time you need care — you may choose to see a provider in the Delta Dental PPO network, Delta Dental Premier Network, or a provider outside the Delta Dental network. However, when you use a PPO network provider, you will receive a higher level of coverage, which means you pay less for your care. Plus, there are other advantages — you do not have to worry about charges above Delta Dental's allowed fees, and your dentist will file your claims for you.

If you want to receive PPO network benefits in any of the PPO dental plan options, be sure you receive care from a dentist who is in the PPO network. This same network applies to all four of the PPO dental plan options. To find a PPO dentist, call Delta Dental at 800-765-6003 or visit Delta Dental at **deltadentalins.com/ngc**, (select "Delta Preferred" to search the provider list for all three Dental PPO plans).

Here is a comparison of some of the key differences between receiving care from Delta Dental providers and non-Delta Dental providers in the dental PPO plans:

Terms to Know

Out-of-Network — when you receive care from a dentist outside the Delta Dental network, you will receive out-of-network benefits in the PPO dental plan options, which means you pay more for your care. If you access care from a dentist who is not in the PPO or Premier network, you will receive a lower level of coverage. You also pay any expenses that exceed the plan allowance for dentists in your area, as determined by Delta.

Deductible — the amount you must pay each calendar year before the plan begins to pay benefits for most services. You do not have to meet the deductible before the plan begins paying for your diagnostic and preventive dental care.

Coinsurance — the percentage of the covered charges you pay after you meet the deductible.

Annual Maximum — the maximum benefit amount your plan option will pay each plan year. If you visit a PPO or Premier Network provider, your in-network claims are applied to both the in- and out-of-network annual maximums. As a result, if you reach the annual out-of-network maximum while using in-network providers and services, you will not be eligible for out-of-network benefits until the next plan year (when the annual maximum starts over). Likewise, if you visit an out-of-network provider, your out-of-network claims are applied to the in- and out-of-network annual maximums.

	IN-NETWORK (DELTA DENTAL PPO PROVIDERS)	**IN-NETWORK** (DELTA PREMIER PROVIDERS)	**NON-NETWORK** (NON-DELTA DENTAL PROVIDERS)
Your Network Costs	PPO dentists agree to discount their fees; your out-of-pocket costs will be the lowest under this network	Payment is based on the Delta Dental Premier dentists' contracted fees	There are no contracted fees, therefore, your out-of-pocket expenses will typically be higher when visiting an out-of-network dentist
Providers	Delta Dental PPO network	Delta Dental Premier network	You can go to any licensed provider outside the networks
Deductible and Annual Maximum	Your deductible is lower and annual maximum is higher when you use PPO providers, which means less out-of-pocket cost for you*	Your deductible is higher and annual maximum lower when you use Delta Premier providers, but you still pay less than if you were to use a non-network provider*	Your deductible is highest and annual maximum lowest when you use out-of-network providers, which means more out-of-pocket cost for you*
What the Plan Pays	The plan pays a higher percentage of eligible expenses after you pay the plan year deductible*	The plan pays a lower percentage of eligible expenses after you pay the plan year deductible*	The plan pays the lowest percentage of eligible expenses after you pay the plan year deductible*
Non-Network Responsibility	You do not have to worry about amounts above Delta Dental's contracted fees	You do not have to worry about amounts above Delta Dental's contracted fees	You are responsible for amounts above Delta Dental's allowed fee
Claims	You do not have to file claims — your PPO provider will do it for you	You do not have to file claims — your Delta Premier provider will do it for you	You may have to file your own claims

**Deductibles do not apply to diagnostic and preventive services, which are paid at 100%. Also, deductible amounts accumulate separately for each network. For example, amounts applied to the PPO network deductible do not apply to the Premier deductible (and vice versa).*

Non-Network Responsibilities in the PPO Dental Plan Options: If you go to a non-network provider, you may be responsible for any charges that exceed Delta Dental's allowed fees because non-Delta dentists do not contract with Delta Dental. The additional charges are not applied toward the annual out-of-pocket maximum.

When you use a dental provider who participates in the Delta Dental network, you do not have to worry about amounts above the contracted fees. Delta dentists charge Delta patients only the negotiated fees.

Help Cover Dental Costs with an FSA

To help you pay for expenses the Dental Plan does not cover or covers only in part, consider enrolling in a Health Care Flexible Spending Account (FSA). With a Health Care FSA, you set aside money on a pre-tax basis to pay for eligible medical, dental and vision care expenses (see **Flexible Spending Accounts** for more information).

PREDETERMINATION OF BENEFITS

If you do not have a predetermination of benefits for any treatment costing more than $300, your claim is reviewed after treatment, and reimbursement may be less than you expect. To avoid this risk, for dental treatments likely to cost more than $300, your dentist should request a predetermination of benefits before beginning treatment. To make this request, you do not need a special claim form. Your dentist should complete a regular Delta Dental or universal claim form, with a diagnosis of the condition, the proposed course of treatment with itemized services, and charges for each procedure. Dates of service do not need to be included with this initial approval request.

Delta Dental reviews the proposed treatment to determine how coverage would apply and sends back to the dentist a Notice of Predetermination, which estimates how much you will have to pay. A predetermination does not guarantee payment. It is an estimate of the amount Delta Dental will pay if you are eligible and meet all the requirements of your plan at the time the treatment is completed.

If alternative, less costly treatments are available, Delta Dental informs you and your dentist, in writing, of benefits that the dental plan option pays. You and your dentist are free to pursue any treatment plan. However, Delta Dental pays only for the least expensive but equally effective procedure.

EXTENSION OF BENEFITS

If your dental coverage ends, you may extend your Delta Dental coverage for 30 days for the following dental services, provided your dental plan option would have otherwise paid benefits:

- For an appliance — or modification of an appliance — for which an impression was taken before your coverage ended
- For a crown or bridge for which the tooth was prepared before your coverage ended
- For root canal therapy, provided the pulp chamber was opened before your coverage ended

You may also be eligible for dental coverage under COBRA. Refer to **COBRA Continuation Of Coverage** for details.

ELIGIBLE DENTAL EXPENSES

The dental plan options pay benefits for treatment that is necessary for good dental health care and is within plan limits.

The options do not pay benefits for cosmetic dentistry or any treatment more costly or elaborate than needed. If two or more dental services are, in Delta Dental's opinion, appropriate for a treatment, the dental plan options pay benefits on the basis of the least expensive service expected to produce a professionally satisfactory result (for example, amalgam [metal] fillings instead of composite [gold] fillings).

Following is a summary of eligible dental expenses under the PPO dental plan options, which are administered by Delta Dental.

ELIGIBLE EXPENSE	DENTAL CARE	DENTAL CARE PLUS	PREVENTIVE CARE
Preventive and Diagnostic Care	Yes	Yes	Yes
Basic Care	Yes	Yes	No
Major Care	Yes	Yes	No
Orthodontic Services	No	Yes	No

Following is a detailed description of eligible expenses under the PPO dental plan options. If you have questions about eligible expenses under your dental plan option, call Delta Dental at 800-765-6003. If

you do not find an expense listed under “Eligible Dental Expenses” or “Ineligible and Limited Dental Expenses,” call Delta Dental at 800-765-6003 for coverage eligibility.

Preventive and Diagnostic Care

The PPO dental plan options all provide coverage for the following preventive and diagnostic care expenses (you do not have to meet the plan deductible):

- Biopsy tissue examination
- Bitewing X-rays — Includes two per plan year for children to age 19, and one set every plan year for adults age 19 and older
- Emergency treatment — Includes relief of dental pain when the dental plan option pays no other benefit, other than required X-rays
- Fluoride treatment — Includes up to two treatments in a plan year
- Panoramic and full-mouth X-rays — Includes one set every 60 months
- Office visits and specialist consultations — Only the first two oral examinations, including office visits for observation and specialist consultations, or combination thereof, are covered benefits during a plan year
- Pulp vitality testing
- Sealants — allowed for permanent first molars (through age 8) and second molars (through age 14) only. One replacement per tooth per lifetime after three years from the first placement. Includes topically applied acrylic, plastics, or composite material applied to permanent posterior molars to seal teeth and prevent decay.
- Space maintainers for children to age 14, once every five years
- Teeth cleaning (prophylaxis) — Includes up to two in a plan year (up to three in a plan year for participants who are pregnant)
- Full mouth debridement is allowed once in a lifetime and counts toward the cleaning frequency in the year provided
- Caries risk assessments are allowed once in 36 months for participants age three (3) to 19

Basic Care

The Dental Care and Dental Care Plus Plan options provide coverage for the following basic dental care after you meet the deductible:

- Anesthesia — General anesthesia (including IV sedation) coverage in conjunction with oral surgery and select endodontic and periodontal procedures
- Nitrous oxide, when medically necessary. This benefit is limited to children age 16 and below and handicap members.
- Crowns and cast restorations — Limited to once every five years per tooth. The dental plan option covers this treatment for cavities that cannot be restored with amalgam, synthetic, plastic, or resin fillings. A broken tooth is also covered. A tooth worn down by day-to-day wear is not covered.

- Drugs — Includes antibiotic injections and other drugs administered by a dentist. Drugs prescribed by your dentist and filled at your pharmacy are not covered under the dental plan, but may be covered through your medical or prescription drug coverage.
- Endodontics — Includes treatment of tooth pulp, such as root canals and other endodontic treatments
- Oral surgery — Includes extractions of one or more teeth, cutting procedures in the mouth, and treatment of fractures and dislocations of the jaw
- Periodontics — periodontal scaling and root planning (including deep cleaning and scaling, treatment of disease of the gums, mouth tissue and bones supporting teeth) is a benefit once for each quadrant each 24-month period. See note on additional benefits during pregnancy.
- Gingivectomy, gingival curettage, muco gingival surgery are a benefit once every 24 months
- Osseous surgery and osseous grafts limited to once every 36 months
- Restorative (fillings) — includes amalgam, synthetic, plastic, or resin fillings for treatment of cavities (decay). Direct composite (resin) restorations are only benefits on anterior teeth and the facial surface of bicuspids. Any other posterior direct composite (resin) restorations are optional services, and Delta's payment is limited to the cost of the equivalent amalgam restorations.

Major Care

The Dental Care and Dental Care Plus Plan options provide coverage for the following major dental care after you meet the deductible:

- Implants — Implant surgery, including the removal of implants, and implant devices (subject to an annual or lifetime maximum)
- Prosthodontics — Limited to once every five years, unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Construction or repair of fixed bridges, partial dentures, and complete dentures if provided to replace missing natural teeth.
- Non-surgical treatment of TMJ disorder — Includes night guards, splints, occlusal orthotic devices, and equilibration (subject to lifetime maximum)

Orthodontic Services

The Dental Care Plus Plan options provide coverage for the following orthodontic care:

- Bands
- Braces
- Correction of malocclusion
- Orthodontic appliances
- Services for strengthening teeth

The lifetime maximum for in-network orthodontia is $3,000 in the Dental Care Plus Plan and $6,000 in the Dental Care Platinum Plan.* Please note that if you switch from one option to the other option, orthodontia expenses paid under one option will also count towards the lifetime maximum of the other option.

SmileWay Wellness Benefits

SmileWay Wellness Benefits are available to help improve the oral health of participants with certain chronic conditions. If you have been diagnosed with heart disease, cancer, diabetes, stroke, HIV/AIDS, Amyotrophic Lateral Sclerosis, joint replacement, Lupus, chronic kidney disease, Opioid misuse and addition, Parkinson's Disease, Sjogren's Syndrome, Huntington's Disease or rheumatoid arthritis, you may be eligible for additional teeth cleanings, and periodontal scaling and root planning. You must opt in to receive the SmileWay Wellness Benefits. For more information and to opt in, log on to your Delta Dental Online Services account and go to Optional Benefits.

INELIGIBLE AND LIMITED DENTAL EXPENSES

The dental plan options limit or exclude some medical treatments, services, and supplies. The following list provides some examples of items that are not eligible for reimbursement; however, this list is not all-inclusive. If you do not find an expense listed under "Eligible Dental Expenses" or "Ineligible and Limited Dental Expenses," call Delta Dental at 800-765-6003 for coverage eligibility.

Ineligible Dental Expenses

Ineligible treatments, services, and supplies are:

- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility
- Charges incurred for oral hygiene instruction, a plaque control program, preventive control programs including home care times, dietary instruction, x-ray duplications, cancer screening, tobacco counseling or broken appointments
- Crowns and cast restorations used to treat cavities that could be restored with amalgam, synthetic, plastic, or resin fillings
- Crowns and cast restorations to replace a tooth more than once every five years
- Diagnostic photos except under the Dental Care Plus plan
- Applications of other anti-cavity substance to adult teeth (other than fluoride)
- Experimental procedures, techniques, or materials that are used by some dentists but have not received the full approval of government, scientific, or dental committees; procedures remain experimental until studies are completed under scientific conditions and published in scientific literature, and when it is determined by Delta Dental that a procedure is "generally accepted dental practice"
- Grafting of tissue from outside the mouth to tissue inside the mouth (extraoral grafts)
- Orthodontic services, unless you are enrolled in the Dental Care Plus Plan
- Postoperative examinations, the removal of stitches, or any other procedure included in the cost of surgery
- Repair or replacement of a sealant on any tooth within three years of its application
- Services for cosmetic purposes or for conditions that are a result of heredity or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth, and teeth that are discolored or lacking enamel
- Services for injuries covered by workers' compensation or employer's liability laws, or services paid for by a federal, state, or local government agency — except Medi-Cal or Medicaid benefits
- Services performed by someone other than a dentist, except where performed by a qualified

technician under the direction of a dentist

- Services that, in the absence of dental coverage, are furnished without cost
- Services started before the participant became covered by the Northrop Grumman dental plan except for ongoing active orthodontic treatment provided after a participant's effective date under this plan
- Specialized techniques involving precision attachments, personalization or characterization, and additional charges for adjustments within six months of the installation of prosthetic appliances
- Temporary dentures, except when an interim partial denture is placed on an extracted anterior tooth during the healing process
- Treatment that restores worn tooth structure, rebuilds or maintains chewing surfaces that are damaged because teeth are out of alignment or occlusion, or stabilizes the teeth, such as equilibration and periodontal splinting

The following list provides some examples of coverage limitations; however, this list is not all-inclusive. Call Delta Dental at 800-765-6003 for coverage eligibility.

Limited Dental Expenses

Limited treatments, services, and supplies include:

- Only the first two oral examinations, including any office visits for observation and specialist consultations, or combination thereof, provided to a patient in a plan year while he or she is an enrollee under any Delta program are covered
- Panoramic and full-mouth X-rays are each covered after five years have elapsed following any prior provision of panoramic and full-mouth X-rays under a Delta program
- Bitewing X-rays are covered on request by the dentist, but not more than twice per calendar year for children up to age 18, and once per calendar year for adults age 18 and older
- Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series when the fees for any combination of intraoral x-rays in a single treatment series meet or exceed the Accepted Fee for a complete intraoral series
- When a panoramic film is submitted with supplemental film(s), Delta Dental will limit the total reimbursable amount to the Provider's Accepted Fee for a complete intraoral series
- If a panoramic film is taken in conjunction with an intraoral complete series, Delta Dental considers the panoramic film to be included in the complete series
- Cephalometric x-rays, oral/facial photographic images (once per case) and diagnostic casts (once per case) are benefits only when orthodontic services are a covered benefit (Dental Care Plus plan only)
- Only the first two cleanings (three for participant who is pregnant), or single procedures that include cleaning, or combination thereof, provided to a patient in a plan year while he or she is an enrollee of any Delta program are covered
- Recementation of space maintainers is limited to once per lifetime. The removal of a fixed space maintainer is considered to be included in the fee for the space maintainer; however, an exception is made if the removal is performed by a different Provider/Provider office.
- The plan will not cover to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is

provided by the same Provider/Provider office

- Sealant benefits include the application of sealants only to permanent first molars through age eight and second molars through age 14 if they are without caries (decay) or restorations on the occlusal surface. Repair or replacement is limited to once every three years.
- Direct composite (resin) restorations are benefits on anterior teeth and the facial surface of bicuspids. Any other posterior composite (resin) restoration is an optional service, and Delta's payment is limited to the cost of the equivalent amalgam restorations. Delta Dental will not cover to replace an amalgam, synthetic porcelain or plastic restorations (fillings) or prefabricated resin and stainless steel crowns within 24 months of treatment if the service is provided by the same Provider/Provider office.
- Crowns, inlays, onlays, and cast restorations on the same tooth will be replaced only after five years have elapsed following any prior provision under any Delta program, unless Delta determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or change to tooth structure or supporting tissues since the replacement of the restoration
- Crown repairs are covered not more than once in any five-year period
- Delta Dental limits payment for prefabricated resin crowns under this section to services on baby (deciduous) teeth. Stainless steel crowns are allowed on baby (deciduous) teeth and permanent teeth up to age 16
- Retreatment of root canal therapy within 24 months of the initial procedure is not a benefit when performed by the same Provider/Provider office
- Recementation of crowns, inlays/onlays or bridges is not a benefit when performed by the same Provider/Provider office within six months of the initial placement. After six months, payment will be limited to one recementation.
- Therapeutic pulpotomy is a benefit once every five years for baby (deciduous) teeth only
- Prosthodontic appliances that were provided under any Delta program, including but not limited to fixed bridges and partial or complete dentures, will be replaced only after five years have passed unless Delta determines that there is such extensive loss of remaining teeth or change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement will be made of a prosthodontic appliance not provided under a Delta program if it is unsatisfactory and cannot be made satisfactory.
- Delta will pay the applicable percentage of the dentist's fee for a standard cast chrome or acrylic partial denture or a standard complete denture (a standard complete or partial denture is defined as a removable prosthetic appliance provided to replace missing natural, permanent teeth and that is constructed using accepted and conventional procedures and materials)
- Tissue conditioning is limited to two per arch in a 12-month period. However, tissue conditioning is not allowed as a separate benefit when performed on the same day as a denture, reline or rebase service.
- When a posterior fixed bridge and a removable partial denture are placed in the same arch in the same treatment episode, only the partial denture will be a benefit
- Delta Dental limits payment for dentures to a standard partial or denture (Coinsurances apply.) A standard denture means a removable appliance to replace missing natural, permanent teeth that is made from acceptable materials by conventional means and includes routine post-delivery care including any adjustments and relines for the first six months after placement.

  - Denture rebase is limited to one per arch in a 24-month period and includes any relining and adjustments for six months following placement
  - Denture relines and tissue conditioning are limited to two per arch in a 12-month period. Tissue conditioning provided on the same day a denture is delivered or a reline or rebase has been performed is not a benefit.
- If an enrollee selects a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta will pay the applicable percentage of the lesser fee, and the patient is responsible for the remainder of the dentist's fee (such as a crown where a silver filling would restore the tooth, or a precision denture where a standard denture would suffice).
- Periodontal maintenance is a benefit following active periodontal therapy (surgery and/or root planning), provided treatment commences after the first three-month post-operative period. Limited to two per plan year alone or in combination with prophylaxis and/or fluoride procedures.
- Nitrous oxide analgesia is limited to cases of medical necessity, such as young children or handicapped patients
- Delta Dental's payment for implant removal is limited to one for each implant during the enrollee's lifetime whether provided under the Delta Dental or any other dental care plan. Delta Dental will not pay for bone grafts provided with implants on the same day of service.
- Benefits are not paid to repair or replace any orthodontic appliance received under the program
- Prescribed or applied therapeutic drugs, premedication or analgesia except for therapeutic drug injections when performed on the same day as an extraction

CIGNA Dental Care Access Plan, a Dental Health Maintenance Organization (DHMO) Option

Depending on your ZIP code area, you may have access to the CIGNA Dental Care Access Plan option (formerly the CIGNA Dental Care DHMO Plan option).

The CIGNA Dental Care Access Plan option is a dental health maintenance organization (formerly CIGNA DHMO) that gives you access to dental care through the CIGNA Dental Health network of dental care providers. The plan provides coverage for preventive and diagnostic care, basic and major restorative care, and orthodontia.

To receive benefits under this option, you must select a primary dental office for you and each of your enrolled dependents from a list of CIGNA network providers. Your primary dental office will provide or coordinate all of your dental care, including specialist referrals.

In this option, you must receive all care from general dentists and specialists in the CIGNA network — except in an emergency. If you go to an out-of-network dentist for non-emergency care, you will not receive coverage. To find a CIGNA network dental provider, call CIGNA Dental Health at 800-244-6224 or search the CIGNA Dental Health website, **my.cigna.com**.

When you access care in the plan, you pay a copayment for most services according to CIGNA's copayment schedule, and then the plan pays the remaining cost. Also:

- You do not have to meet a deductible
- There is no plan year maximum
- You do not have to worry about filing claim forms

For information about the copayment schedule that applies for you, call CIGNA Dental Health at 800-244-6224 or go to their website, **my.cigna.com**.

When you enroll in the CIGNA Dental Care Access Plan option, you agree to resolve all differences between you or your dependents and the dental health maintenance organization through binding arbitration. Binding arbitration is a legal method used to efficiently resolve disputes outside the court system.

Keep In Mind

Changing Your Cigna Dental Provider

If you decide to change your dental office, simply call CIGNA at 800-244-6224. There is no charge to transfer to another dental office. However, your current dentist must be paid in full for any amounts due before your transfer can be processed.

Transfers are effective the first day of the month after your request is processed. Unless you have a dental emergency, you may be unable to schedule an appointment at the new dental office until your transfer is effective.

A CLOSER LOOK: HOW THE CIGNA DENTAL CARE ACCESS OPTION WORKS

Selecting a CIGNA Dental Provider

If you select the CIGNA Dental Care Access Plan option, you must choose a network dentist or specialist. If you like, you and each of your enrolled dependents may choose a different dental office in the network.

Any office you choose must be a private dental practice operated by a licensed, independent dentist and a qualified dental health team of hygienists, dental assistants, and technicians. Each dentist selected for the program contracts with CIGNA to provide care for members who enroll in this option.

If your first or second choice of dentist is no longer accepting new patients, you are assigned to the network dental office nearest your home. Call CIGNA at 800-244-6224 to request network dentist information, or go to the CIGNA website, **my.cigna.com**.

If You Need Specialized Dental Care

If your network dentist determines you need specialized dental care, your dentist will refer you to a specialist. Simply follow your dentist's instructions. Care from a network specialist is covered when CIGNA Dental Health authorizes payment.

If you receive specialty care that is not authorized by CIGNA, you are responsible for 100% of the charges.

If You Need Emergency Dental Care

If you have a dental emergency, contact your network dentist immediately. You pay an additional $25 charge for emergency care provided after office hours.

If you have an emergency while you are out of your CIGNA dental health maintenance organization service area or are unable to contact your network general dentist, you may receive emergency covered services from any general dentist. Routine restorative procedures as well as definitive treatment are not considered emergency care. You should return to your network dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your patient charge schedule. CIGNA Dental will reimburse you for the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $50 per incident. To receive reimbursement, submit your dental reports and X-rays to CIGNA Dental Health. Contact CIGNA Dental Health at 800-244-6224 for details.

ELIGIBLE DENTAL EXPENSES IN THE CIGNA PLAN

After you pay the required copayment shown on your CIGNA Dental Health copayment schedule, the dental plan option pays the balance. The following is a partial list of eligible expenses. Contact CIGNA Dental Health at 800-244-6224 for:

- A list of copayments
- Questions about any expenses listed below
- Coverage eligibility for services that are not listed below or under **Ineligible Dental Expenses in the CIGNA Plan**

PROCEDURE	DESCRIPTION
Diagnostic	• X-rays, as needed
Preventive	• Prophylaxis (routine cleaning)

PROCEDURE	DESCRIPTION
	• Sealants (per tooth up to age 19) • Fluoride treatments (once every six months up to age 19)
Restorative (fillings)	• Amalgam (primary or permanent) • Resin/composite (anterior primary or permanent) • Resin or composite one surface (posterior primary or permanent) • Sedative filling
Oral Surgery	• Simple extraction, first tooth • Additional extractions (per tooth) • Soft tissue impaction • Full bony impaction
Endodontics	• Root canal treatment: anterior, bicuspid, molar
Prosthetics (dentures)	• Full upper and lower dentures • Upper or lower partials, resin based • Interim partial denture, upper or lower
Crowns and Bridges (once every five years for each tooth)	• Replacement bridge • Ceramic or porcelain crowns or bridges • Stainless steel crowns, each • Crown, abutment • Pontic, full cast metal
Orthodontic Services (braces)	• Orthodontic treatment plan and records • Fixed appliance insertion (banding) for comprehensive treatment • Interceptive orthodontic treatment 24-month orthodontic treatment • Children (for banding that begins before age 19) • Adults (for banding that begins at age 19 or older)
Broken Appointments	• Canceling appointments with less than a 24-hour notice

INELIGIBLE DENTAL EXPENSES IN THE CIGNA PLAN

The CIGNA Dental Care Access Plan option limits or excludes some medical treatments, services, and supplies. The following list provides some examples of items that are not eligible for reimbursement; however, this list is not all-inclusive. If you do not find an expense listed below or under **Eligible Dental Expenses in the CIGNA Plan**, call CIGNA Dental Health at 800-244-6224 for coverage eligibility.

Ineligible treatments, services, and supplies are:

- Completion of crowns and bridges, dentures, or root canal treatment already in progress on the effective date of your CIGNA Dental Health coverage
- Cosmetic dentistry or cosmetic dental surgery (performed solely to improve appearance)
- General anesthesia, sedation, or nitrous oxide
- Hospitalization, including any associated incremental charges for dental services performed in a

hospital

- Implants (material implanted into bones or soft tissue) or the removal of implants
- Prescription drugs prescribed by your CIGNA dentist
- Procedures, appliances, or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact)
- Procedures, appliances, or restorations if the main purpose is to diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on your CIGNA Dental Health patient charge schedule
- Procedures or appliances for minor tooth guidance or to control harmful habits, such as thumb sucking
- Replacement of fixed and/or removable prosthodontic appliances that were lost or stolen or appliances damaged due to patient abuse, misuse, or neglect
- Services considered by CIGNA Dental Health to be unnecessary or experimental in nature
- Services for any disturbance of the jaw joints (temporomandibular joint or “TMJ” disorders) or associated muscles, nerves, or tissues (may be covered under your medical plan option)
- Services not listed on your CIGNA Dental Health patient charge schedule
- Services provided by a non-network general dentist or a non-network specialist without CIGNA Dental Health’s prior payment approval (except for emergencies)
- Services provided or paid for by or through a federal or state government agency or authority or political subdivision or a public program, other than Medicaid and Medi-Cal
- Services related to an injury or illness covered under workers’ compensation, occupational disease or similar laws
- Services related to injuries intentionally self-inflicted
- Services required while serving in the armed forces of any country or international authority
- Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy

CIGNA GLOBAL DENTAL PLAN OPTION

The CIGNA Global Dental Plan option provides dental coverage designed to meet the needs of our employees working overseas and their eligible dependents. For details about the coverage provided by the CIGNA Global Benefits Dental Plan, refer to Plan materials available on ***Total Rewards Gateway***. CIGNA, not Northrop Grumman, is responsible for the payment of benefits covered under the insurance contract and has the sole authority, discretion and responsibility to interpret and apply terms of the contract.

ADDITIONAL INFORMATION ABOUT YOUR DENTAL BENEFITS

If You Have Other Dental Coverage: Coordination of Benefits

You and your dependents may be covered by more than one group dental plan, such as a Northrop Grumman dental plan option and your spouse's employer's plan. When this happens, the benefits you receive under your Northrop Grumman dental plan may be coordinated with benefits you receive from other plans. When the Northrop Grumman dental plan is the secondary payer, the benefits from other plans are taken into account, and you can receive payment for up to 100% of your eligible expenses from both plans combined. This provision prevents double payments of benefits.

For example, assume you receive dental services to fill a cavity, and your eligible expenses total $100. Also assume the primary plan pays 80% (or $80) of eligible expenses for this service and your Northrop Grumman dental plan — the secondary plan — typically pays 80% of eligible expenses. In this case, since payment cannot exceed 100% of the fees charged, your Northrop Grumman dental plan pays only the remaining $20, and you pay nothing.

Coordination of benefits under the dental plan options differs from the "non-duplication of benefits" provision under the medical plan options. However, the approach to determining your primary and secondary plans is the same. See **If You Have Other Health Care Coverage: Non-Duplication of Benefits** for details.

Remember to inform your dentist of all programs under which you have dental coverage and have him or her complete the dual coverage portion of the Attending Dentist's Statement. This helps ensure that you receive all of the benefits to which you are entitled. For more information, contact Delta Dental at 800-765-6003 or CIGNA Dental Health at 800-244-6224.

Vision

If you wear eyeglasses or contacts, you know how expensive vision care can be. Northrop Grumman recognizes this and offers vision care through Vision Service Plan (VSP) to help you with those expenses.

The Vision Plan gives you the opportunity to receive coverage and/or discounts on eye exams, eyeglasses, contact lenses and laser vision correction when you receive services from a VSP-participating provider. You can also receive reimbursement, up to certain limits, for services you receive from a non-participating provider.

Note: Expenses related to eye disease, such as cataracts or glaucoma, would be covered under your medical plan coverage option.

VISION PLAN OPTIONS

The Plan offers two vision plan options:

- Vision Care
- Vision Care Plus*

The options differ by how much the plan pays toward your vision care and the cost of coverage.

You can choose vision coverage for yourself and your eligible dependents when you are first hired and during annual enrollment. Your choice remains in effect for the entire plan year, and you cannot make changes until the next annual enrollment, unless you experience a **Qualified Life Event**.

For More Information

To find out more about the Vision Plan and covered services, contact the Northrop Grumman Benefits Center (NGBC) at 800-894-4194.

See the **Eligibility and Participation** section of this SPD for information on:

• When you become eligible for coverage

• Whom you may cover and

• How to enroll

The Northrop Grumman vision plan options help you pay for vision exams and corrective eyewear. Each time you need vision care, you can choose to see a provider who participates in the provider network or any licensed provider outside the network — but you will save money when you access care from a network provider.

Vision Service Plan (VSP) insures the plans and administers the network of vision care providers. VSP has one of the nation's largest networks of vision care providers, so finding a participating provider is easy in most locations. To locate a VSP Choice provider, call VSP at 888-463-9954 or go to the VSP website, **vsp.com**. VSP, not Northrop Grumman, is responsible for the payment of all benefits covered under the insurance contract and has the sole authority, discretion and responsibility to interpret the terms of the insurance contract.

The following is a summary of the coverages provided under the insurance contract. In the event of an inconsistency between the following summary and the terms of the insurance contract, the insurance contract will govern.

**Baltimore and Sunnyvale represented employees are not eligible.*

Here is how the Vision plan options provide coverage:

PLAN PROVISION	VISION PLAN	VISION CARE PLUS PLAN*
Well Vision Exam	Once per calendar year with a $10 copay	Once per calendar year with a $10 copay
Frames	Once every other calendar year *VSP Provider:* • $10 copay (for lenses and/or frames) • $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 allowance at Costco® *Non-VSP Provider:* • Covered up to $70	Once per calendar year *VSP Provider:* • $10 copay (for lenses and/or frames) • $200 allowance for a wide selection of frames • $220 allowance for featured frame brands • $110 allowance at Costco® • 20% savings on the amount over your allowance *Non-VSP Provider:* • Covered up to $70
Lenses	Once per calendar year *VSP Provider:* • $10 copay (for lenses and/or frames) • Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children *Non-VSP Provider:* • $50 for single vision lenses • $75 for lined bifocal lenses • $100 for lined trifocal lenses	Once per calendar year *VSP Provider:* • $10 copay (for lenses and/or frames) • Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children *Non-VSP Provider:* • $50 for single vision lenses • $75 for lined bifocal lenses • $100 for lined trifocal lenses
Lens Enhancements	Once per calendar year *VSP Provider:* • $0 copay for standard progressive lenses • $30 copay for premium progressive lenses • $30 copay for custom progressive lenses • Average 30% savings on other lens enhancements *Non-VSP Provider:* • $100 for progressive lenses	Once per calendar year *VSP Provider:* • $0 for scratch-resistant coatings • $0 copay for standard progressive lenses • $95-$105 copay for premium progressive lenses • $150-$175 copay for custom progressive lenses • Average 20% - 25% savings on other lens enhancements *Non-VSP Provider:* • 100 for progressive lenses

PLAN PROVISION	VISION PLAN	VISION CARE PLUS PLAN*
Contact Lenses (instead of glasses)		
Contacts	Once per calendar year *VSP Provider:* • Up to $60 copay for contact lens exam (fitting and evaluation) • $150 allowance for contacts; copay does not apply *Non-VSP Provider:* • Up to $105	Once per calendar year *VSP Provider:* • Up to $60 copay for contact lens exam (fitting and evaluation) • $200 allowance for contacts; copay does not apply *Non-VSP Provider:* • Up to $105
Primary Eyecare	*VSP Provider:* • Retinal screening for members with diabetes • Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration • Treatment and diagnosis of eye conditions, including pink eye, vision loss and cataracts available for all members • Limitations and coordination with medical coverage may apply. Ask your VSP network doctor for details	
Extra Savings	*VSP Provider:* Glasses and Sunglasses • Extra $20 to spend on featured frame brands. Go to **vsp.com/specialoffers** for details • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam Laser Vision Correction • Average 15% savings on the regular price or 5% savings on the promotional price; discounts only available from contracted facilities Routine Retinal Screening • No more than a $20 copay on routine retinal screening as an enhancement to a WellVision Exam	
VSP EasyOptions	*N/A*	Once per calendar year Choose ONE of these enhancements when purchasing your eyewear: • Additional $50 frame allowance • Fully covered premium or custom progressive lenses • Fully covered light-reactive lenses • Fully covered anti-glare coating • Additional $50 contact lens allowance

PLAN PROVISION	VISION PLAN	VISION CARE PLUS PLAN*
VSP Lightcare	Instead of prescription glasses or contacts, $150 allowance for ONE of these options: • Ready-made non-prescription sunglasses • Ready-made non-prescription blue light filtering glasses	Instead of prescription glasses or contacts, $250 allowance for ONE of these options: • Ready-made non-prescription sunglasses • Ready-made non-prescription blue light filtering glasses

Coverage with a retail chain may be different or not apply. VSP guarantees coverage from VSP providers only. Coverage information is subject to change.

**Baltimore and Sunnyvale represented employees are not eligible.*

A CLOSER LOOK: HOW THE VISION PLAN OPTIONS WORK

If you enroll in a vision plan, you have a choice to make each time you need vision care: you may choose to see a provider in the Vision Service Plan (VSP) Choice network, a VSP Participating Retail Chain (such as Costco or Visionworks), or a provider outside the VSP network. However, when you use a network provider or VSP Participating Retail Chain, you will receive a higher level of coverage, which means you pay less for your care.

Here is a comparison of some of the key differences between receiving care from in-network and out-of-network vision care providers:

IN-NETWORK	OUT-OF-NETWORK
You must use a VSP provider*	You can go to any licensed provider outside the VSP network
The plan pays more of your eligible expenses, which means less out-of-pocket cost for you	The plan pays less of your eligible expenses, which means more out-of-pocket cost for you
You do not have to file claims — your VSP provider will do it for you	You may have to file your own claims
VSP providers discount their services, so your share of the cost will be less	Out-of-network providers may charge more for their services

Coverage with a VSP Participating Retail Chain may differ from coverage with a VSP Choice provider including lens options and discounts on non-covered items. Once your coverage is effective, go to **vsp.com for details.*

How to Use the Vision Plan Options

Maximize Your Coverage with VSP Providers

You have the option of receiving services from any eye care provider you choose. However, you receive a higher level of coverage and pay less out of your own pocket when you go to a provider who participates in VSP's network.

Visit **vsp.com** for details, if you plan to see a provider other than a VSP network provider.

If you want to access services from a VSP Choice provider, follow these steps:

1. Select and contact a VSP provider by calling VSP at 888-463-9954 or by visiting **vsp.com**.
2. When you go to the provider's office, identify yourself as a VSP member. Your provider will verify your eligibility directly with VSP (you will not receive a VSP ID card).
3. Pay the applicable copayment and any additional costs not covered by the plan directly to the provider.

Help Cover Vision Costs with an FSA

To help you pay for expenses the Vision Plan does not cover or covers only in part, consider enrolling in a Health Care Flexible Spending Account (FSA). With a Health Care FSA, you set aside money on a pre-tax basis to pay for eligible medical, dental and vision care expenses (see **Flexible Spending Accounts** for more information).

If you want to access services from a vision care provider who does not participate in the VSP network, follow these steps:

1. Pay the full cost of your services to the provider at the time of service and keep a copy of the itemized receipt.
2. For reimbursement of your eligible expenses, complete and file a VSP claim form with VSP within six months of receiving the services. You can do this electronically at the VSP website, **vsp.com** (at the VSP site, go to *My Forms* and select *Out-of-Network Reimbursement Form*).

   If you do not have Internet access, send the following to VSP:

   - An itemized receipt listing the services received
   - The name, address and phone number of the out-of-network provider
   - The last four digits of the member's Social Security number, name, address, phone number, and employer (Northrop Grumman)
   - The patient's name, date of birth, address, and phone number
   - The patient's relationship to the covered member, such as "self," "spouse," "child"

Keep a copy of the claim information and send the originals to: VSP, P.O. Box 385018, Birmingham, AL 35238-5018.

Eligible Vision Expenses

Following is a description of eligible vision care expenses under the vision plan options. If you have a question about eligible vision expenses — including services not listed below or under "Ineligible Vision Expenses" — call VSP at 888-463-9954.

- Comprehensive eye exam once every plan year, which may include the following related services:
  - Case history review
  - Visual system evaluation using ophthalmoscopy (retina, optic nerve head, and blood vessels)

  - External and internal exams, including direct and/or indirect ophthalmoscopy
  - Extraocular muscle assessment
  - Analysis of pupillary reflexes
  - Cornea, lens, iris, conjunctive, lids, and lashes observation
  - Visual fields screening test
  - Tonometry test
  - Refractive evaluation
  - Binocular function
  - Diagnosis and treatment plan
- Eyeglass lenses* (single vision, bifocal, or trifocal lenses), once every plan year, and related necessary professional services, such as:
  - Prescribing and ordering proper lenses
  - Assisting in the selection of frames
  - Verifying the accuracy of finished lenses
  - Proper fitting and adjustment of frames
  - Subsequent adjustments to frame to maintain comfort and efficiency
  - Progress or follow-up work, as necessary
- Eyeglass frame,* once every or every other plan year depending on the plan option
- Contact lenses* of any kind, excluding cosmetic lenses, once every plan year

**You may choose coverage for either eyeglasses or contact lenses, but not both, during any plan year. For example, if you choose contacts, you will not be eligible for eyeglass lenses and frames during the plan year.*

Ineligible Vision Expenses

Plan benefits are provided only when services are determined to be visually necessary or appropriate for the proper treatment of a vision problem. Following is a list of expenses not eligible for coverage under the vision plan options. Please note that this is not an all-inclusive list. Always call VSP at 888-463-9954, if you have a question about a particular vision service or expense.

- Coating of the lens or lenses (scratch resistant coating obtained in-network is covered in full in the Vision Care Plus** plan option)
- Oversize lenses
- Corrective vision treatment of an experimental nature
- Cosmetic lenses
- Cosmetic processes that are optional
- Eye exams as a condition of employment
- The cost of frames that exceeds the plan allowance
- Medical or surgical treatment
- Non-prescription (Plano) lenses (less than +.50 dioptic power)
- Non-prescription contact lenses

- Orthoptics or vision training and any associated supplemental training
- Photochromatic lenses
- Tinted lenses except Pink #1 and Pink #2
- Replacement/repair of lost or broken lenses or frames
- Services or materials covered under workers' compensation
- Two pairs of glasses instead of bifocals
- The additional cost of adding UV (ultraviolet) protection to lenses
- Certain limitations on low vision care

** *Baltimore and Sunnyvale represented employees are not eligible.*

If You Have Other Vision Coverage

You and your dependents may receive vision coverage from more than one plan. For example, you may receive vision care coverage from the Northrop Grumman vision plan and your spouse's employer's medical and/or vision plan.

When this happens, the Northrop Grumman vision plan considers the benefit payments you receive from the other plan. When the Northrop Grumman vision plan is the secondary payer, the Northrop Grumman vision plan will pay for amounts that are considered out-of-pocket charges (including copays, frame overage, lens options) up to the coordination of benefit allowances. For more information, contact VSP or your vision care provider.

This provision ensures that payments from the other plan, plus payments from the Northrop Grumman vision plan option, do not exceed the amount the Northrop Grumman vision plan would have paid if there were no other coverage.

If the other plan is also administered by VSP, VSP will coordinate coverage between the two plans.

The approach to determining your primary and secondary plans is covered under **If You Have Other Health Care Coverage: Non-Duplication of Benefits**.

Remember to inform your vision care provider of all programs under which you have vision coverage. This helps ensure that you receive all of the benefits to which you are entitled. For more information, contact VSP at 888-463-9954 or visit **vsp.com**.

Note About HMO Vision Exam Benefits: Most HMO plans cover 100% of your vision care exam cost. Therefore, if you are in an HMO plan option and receive a vision care exam, you should use your HMO benefit for full coverage. If you need corrective eyewear, those expenses may be covered through the Northrop Grumman vision plan option.

If You Live Outside the United States

If you reside outside the United States, you are eligible for the Northrop Grumman vision plan option, and your expenses will be covered at the out-of-network level unless you incur expenses through a network provider in the United States.

Tax-Advantaged Accounts

FSAs. HSAs. The acronyms may sound confusing but with these saving accounts, you can reduce your taxable income and save money to pay for certain eligible health care and dependent day care expenses on a pre-tax basis.

The **Health Savings Account (HSA)** must be paired with a high-deductible health plan to help you set aside money for eligible health care expenses now or later.

The **Health Care Flexible Spending Account (FSA)** helps you pay for certain eligible health care expenses your health care plans do not cover—or cover only in part. A **General Purpose Health Care FSA** may be used for eligible medical, prescription drugs, dental and vision expenses. If you are contributing to an HSA and like the advantages of an FSA, you could contribute to a **Limited Purpose Health Care FSA,** which reimburses only for eligible dental and vision expenses.

The Dependent Day Care FSA reimburses you for eligible dependent child care or dependent elder care expenses while you (and your spouse, if married) work, look for work or attend school.

Some employees may have a **Health Reimbursement Account (HRA)** resulting from their participation in certain medical plan options that are no longer available.

FSA AND HSA: WHAT ARE THE DIFFERENCES?

	General Purpose Health Care FSA	Limited Purpose Health Care FSA	Dependent Day Care FSA	HSA
Who's eligible	All benefits-eligible employees except those who establish/are contributing to an HSA	All benefits-eligible employees, however, generally only those contributing to an HSA would elect the Limited Purpose Health Care FSA	All benefits-eligible employees	Participants in the: • Plan 2: Medium Premium/Medium Deductible Plan** • Plan 3: Low Premium/High Deductible Plan** • Plan 4: Medium Premium/Medium Deductible Utah Extended Network Plan** • Kaiser Mid-Atlantic HDHP • Baltimore and Sunnyvale Value Plan
Northrop Grumman contributes	No	No	No	Yes (Well-being Incentive**)
You can change your contributions at any time	No	No	No	Yes
You can use money for eligible health care expenses (pre-tax) Medical and Prescriptions Dental Vision	 Yes Yes Yes	 No Yes Yes	 No No No	 Yes Yes Yes
2026 Contribution Limit	$3,300	$3,300	$7,500, or $4,300 if you earn more than $160,000/year	$4,400 employee only coverage $8,700 family coverage PLUS additional $1,000 if you are age 55 or older by the end of the year
Availability of money	Your full annual contribution amount is immediately	Your full annual contribution amount is immediately	Reimbursement amount of eligible expenses cannot	Reimbursement amount of eligible expenses cannot exceed the balance in your account

	General Purpose Health Care FSA	Limited Purpose Health Care FSA	Dependent Day Care FSA	HSA
	available for use as of January 1	available for use as of January 1	exceed the balance in your account	
You can use money for other expenses	No	No	Yes, for your dependent day care expenses	Yes (a tax penalty will apply)
You can roll over unused funds year to year	Yes (up to $660***) if you enroll for the new plan year	Yes (up to $660***) if you enroll for the new plan year	No	Yes
You can take your account with you if you leave Northrop Grumman or retire (portability)	No*	No*	No	Yes

**COBRA continuation coverage may be available.*
***Baltimore and Sunnyvale represented employees are not eligible.*
**** The maximum carryover amount may change from year to year. The carryover maximum will be communicated in the annual enrollment materials.*

HSA and FSA: Can I Have Both?

IRS rules don't allow you to contribute to both an HSA and a General Purpose Health Care FSA. Northrop Grumman offers HSA participants a Limited Purpose Heath Care FSA which has the same features as the General Purpose Health Care FSA but may be used for dental and vision expenses only.

HEALTH SAVINGS ACCOUNT

An HSA is an employee-owned, tax-advantaged account that can be used to reimburse eligible health care expenses on a tax-free basis. The HSA may be funded by your own pre-tax (or post-tax) contributions and contributions from Northrop Grumman for completing the Well-being Incentive,* up to a certain annual limit. You own the HSA, and it's designed to help you save and budget for eligible expenses. Because you own the HSA, whatever you don't use, you keep even after you leave or retire from Northrop Grumman. Your HSA is not part of the Northrop Grumman Health Plan.

**Baltimore and Sunnyvale represented employees are not eligible.*

Eligibility

To contribute to an HSA, you need to meet certain criteria (See IRS Publication 969 for further details):

- You must be enrolled in an IRS-qualified high-deductible health plan
- You cannot be enrolled in coverage under another non-qualified plan (although eligibility for other coverage is permitted). For example, employees covered by their spouse's HMO or a General Purpose Health Care Flexible Spending Account (FSA) would not be eligible for an HSA
- You must not be enrolled in Medicare or TRICARE
- You cannot be claimed as a dependent on someone else's tax return

Our HSA-compatible high deductible health plans include:

- Plan 2: Medium Premium/Medium Deductible Plan
- Plan 3: Low Premium/High Deductible Plan
- Plan 4: Medium Premium/Deductible Utah Extended Network Plan
- Kaiser Mid-Atlantic HDHP

IRS Limits

There are IRS limits that determine how much you can contribute annually to an HSA and the contribution maximum may be increased for inflation annually. You may contribute to your HSA as long as the combined contributions (yours and the Company's, if any) do no exceed the IRS calendar year limits. Please see IRS Publication 969 for the current IRS limits.

Participants age 55 and older (as of the end of the calendar year) may contribute up to an additional $1,000 per calendar year. Employees are responsible for making sure they don't exceed the annual IRS limit.

- Generally, the amount you are eligible to contribute for a calendar year is based on the level of coverage (you only or you + one or more family members) you have in effect at the beginning of each month during the year in which you were covered by a high-deductible health plan and otherwise HSA eligible. However, if you enroll in a high-deductible health plan midyear, you can generally contribute up to the annual contribution maximum based on your level of coverage on December 1. You must stay in the HSA-compatible high-deductible health plan and remain eligible to contribute to an HSA for the entire 12 months of the following calendar year. This "last month" rule is described in IRS Publication 969.

- If you contribute too much to your account, IRS rules will require you to pay a 6% excise tax if you do not take a timely corrective distribution of the excess (and earnings on the excess). You will also have to include the excess amounts in your income. See IRS Publication 969 or consult with your

tax advisor for details.

SETTING UP YOUR HSA

The HSA is not part of the Northrop Grumman Health Plan. Northrop Grumman helps employees facilitate pre-tax payroll deductions to an HSA by providing access to an HSA through Fidelity Investments®. Northrop Grumman may also make contributions on your behalf if you complete the Well-being Incentive.* However, you own the HSA and must establish your account on your own.

After enrolling in one of the Northrop Grumman Health Plan's high-deductible health plans, you will be asked to set up your HSA with Fidelity on *NetBenefits* at **netbenefits.com/northropgrumman**. If you do not want to make your own contributions, but are eligible to receive Northrop Grumman's HSA contribution on your behalf, you should elect to contribute $0.00 to the Fidelity HSA.

Keep in Mind

You can stop or change your HSA contributions at any time through *NetBenefits* at **netbenefits.com/northropgrumman** or by calling the NGBC at 800-894-4194. Election changes will be implemented as soon as administratively possible.

Please be aware that neither Northrop Grumman nor Fidelity will monitor your contributions and whether you exceed the limits. Please review your contribution amounts closely to ensure you have not exceeded the IRS limits.

**Baltimore and Sunnyvale represented employees are not eligible.*

LIMITED PURPOSE FSA WITH AN HSA

If you enroll in a high-deductible health plan and elect to establish an HSA through Fidelity, and you enroll in (or are automatically re-enrolled in) the Health Care FSA, your FSA will be a Limited Purpose Health Care FSA. A Limited Purpose FSA can be used for eligible dental and vision expenses only. IRS rules prohibit individuals with a General Purpose Health Care FSA from establishing and contributing to an HSA. Once you start contributing to a Limited Purpose FSA, you cannot change to a General Purpose FSA during the plan year.

If you do not elect to establish an HSA when you first enroll in a high-deductible health plan, you may still choose to have a Limited Purpose FSA instead of a General Purpose FSA. You may want to have a Limited Purpose FSA, for example, if you want to delay establishing an HSA until later in the plan year (because you will be covered under your spouse's non-calendar plan year Health Care FSA at the beginning of the plan year) or if you choose to establish an HSA other than through Fidelity (for example, at the bank where you do your personal banking). When you make your enrollment elections either through NetBenefits or by calling the NGBC, be sure to select the Limited Purpose FSA option.

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSAs) let you pay certain health and dependent day care expenses with pre-tax dollars. By setting aside amounts from your pay on a pre-tax basis, you reduce the amount of your income that is subject to most federal and state taxes, and may increase the amount of your take-home pay.

Through payroll deductions, you can set aside pre-tax dollars in the FSAs that can be used to reimburse you for eligible health care and dependent day care expenses. The pre-tax dollars come out of each paycheck. You submit eligible expenses to each account for reimbursement.

Your Options

Health Care FSA: Set aside $52 to $3,300 of pre-tax dollars annually in the Health Care FSA for reimbursement of your and your dependent(s)'s eligible health care expenses. This limit may change from plan year to plan year. You will be notified of the limit in the annual enrollment materials.

Dependent Day Care FSA: Set aside $52 to $7,500 of pre-tax dollars annually in the Dependent Day Care FSA for reimbursement of your eligible dependent day care expenses. If you and your spouse are both Northrop Grumman employees, the maximum you may both elect on a combined basis is $7,500, subject to the limit for highly compensated employees. The contribution limit for highly compensated employees is $4,300. In 2026, you will generally be a highly compensated employee if you earn $160,000 or more in 2025. This compensation threshold may change from year-to-year pursuant to cost of living adjustments.

Note: This contribution limit may be adjusted periodically as required to pass IRS nondiscrimination requirements.

You can enroll in one or both of the FSAs — or you can choose not to participate — when you are first hired and during annual enrollment. Your choice remains in effect for the entire plan year, and you cannot make changes until the next annual enrollment, unless you experience a **Qualified Life Event**.

At the time of a qualified life event, you may have a negative balance in your Health Care FSA. A negative balance occurs when you contribute less money to your account than you receive in reimbursements. In this case, any changes you make to your contributions must allow you to repay the negative balance by the end of the plan year.

Are you enrolled in a high deductible health plan option? If you enroll in one of the high deductible health plan options available under the Plan, and elect to establish an HSA through Fidelity during annual enrollment or as part of your elections as a new hire, the FSA will be a Limited Purpose Health Care FSA, which can be used for eligible dental and vision expenses only. See **Limited Purpose FSA with an HSA** for details.

Your Contributions

If you choose to enroll in one or both of the FSA options, your contributions are deducted from your paychecks on a pre-tax basis during each pay period throughout the plan year (January 1 through December 31). The money is available for you to use on eligible expenses. Because of payroll system limitations, the total deducted over the year might be slightly more or less than the total amount of your election, but the total amount deducted constitutes the cost of your FSA coverage. The Plan does not refund or seek payment of those slight differences. If you believe there is a significant discrepancy between the amount of your FSA election and the amount being deducted from your paychecks, you must notify the Plan administrator immediately.

When you enroll in the FSA in the middle of the plan year, your maximum contribution is the applicable annual maximum for the plan year — $7,500 for Dependent Day Care FSA, $3,300 for Health Care FSA. For example, suppose you have a qualified life event effective July 1, and you enroll in the Health Care FSA. You can elect to contribute from $52 to $3,300 for the remainder of the plan year (six months). The annual contribution amount you elect will be divided by the number of paychecks remaining and deducted accordingly.

Note: FSA elections for the plan year must be made on or before November 30 of that plan year. This means that participants who are newly eligible for coverage or who experience a qualified life event in December may not newly participate in the FSAs nor increase or decrease their existing FSA elections for that plan year.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

You can use the Health Care FSA for most health care expenses that are considered eligible medical expense deductions on your federal income tax return, but are not reimbursed by another health plan. For example, you can use the account for your out-of-pocket costs, including deductibles, coinsurance and copayments.

You can use the account to reimburse you for eligible medical expenses even if you are not enrolled for medical, dental or vision coverage. For example, even if you do not have vision coverage in a vision plan, you can submit your expenses for vision exams, eyeglasses, contact lenses and vision correction laser surgery.

Note: Your premium contributions for coverage under the Northrop Grumman Health Plan are not eligible for reimbursement through the Health Care FSA because your premium payments are already made on a pre-tax basis.

Eligible health care expenses can only be for:

- You
- Your spouse
- Any person you claim as a dependent on your tax return
- Any person you could have claimed as a dependent on your tax return but for the fact that:
  - The person filed a joint return
  - The person had gross income greater than the applicable exemption amount for the year, or
  - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's return.
- Your biological child, adopted child, stepchild or foster child who is under age 27 at the end of your tax year

Please Note: IRS rules prohibit the use of a Health Care FSA for expenses incurred by domestic partners and children of domestic partners, unless you claim the person as your dependent on your tax return or you would be able to claim the person as a dependent on your tax return but for the circumstances described in the fourth bullet point above.

Eligible Health Care FSA Expenses

See **IRS Publication 502** for details about Eligible Expenses. IRS publication 502 generally provides a list of expenses eligible for reimbursement through an FSA. (Note: Not all items listed in Publication 502 are eligible for reimbursement — for example, premiums for coverage in the medical, dental, and vision plan options). The publication is available:

- At your local IRS office
- From the IRS by calling 800-829-3676
- At **irs.gov**

The Health Care FSA reimburses you for the eligible expenses described below. However, in order to be reimbursed, you must incur the expense during your period of coverage. The period of coverage is January 1 through December 31, although your period of coverage may be shorter if you make your Health Care FSA election after annual enrollment or if you lose your Health Care FSA coverage during the plan year and do not elect COBRA. An expense is considered incurred on the date you obtain the

medical service or medical item, and not on the date you make a payment. For example, if you had a medical procedure in a previous plan year, you will not be reimbursed for any payments you make towards that procedure in the current plan year. This is true even if, as part of a payment plan, you make payments towards that procedure during your period of coverage. Likewise, you will not be reimbursed from your Health Care FSA for any prepayments you might make towards a medical procedure, unless and until you have the procedure during your period of coverage. The only exception is orthodontia. Since orthodontia is considered ongoing treatment, those claims are paid based upon the date the payment is made.

The Health Care FSA reimburses you for these eligible expenses:

- Medical and dental plan copayments, deductibles and coinsurance
- Charges above the medical plans' **Maximum Allowed Amount** and dental plans' plan allowance
- Expenses that are partially covered by your medical, dental or vision plan, such as the cost of:
  - Alcoholism/substance abuse (chemical dependency) treatment (including meals and lodging provided by a treatment center)
  - Birth control devices
  - Chiropractic or physical therapy
  - Dental bridges and dentures
  - Eyeglasses or contact lenses (including contact lens solutions)
  - Hearing aids and their batteries
  - Infertility services
  - Insulin
  - Medical equipment, such as crutches or wheelchairs
  - Mental health treatment
  - Orthodontia
  - Periodontal cleanings
  - Prescription drug copayments and coinsurance
  - Retin A (when medically necessary and not for cosmetic purposes)
  - Speech therapy
- Certain expenses that are not covered by your medical or dental plan (but can be reimbursed), such as the cost of:
  - Home modifications to accommodate a disabled person (including disabilities caused by arthritis)
  - Laser eye surgery, such as LASIK, radial keratotomy and penetrating keratoplasty
  - Removal of lead-based paint to prevent your young child who has (or had) lead poisoning from eating paint
  - Over-the-counter medicines and drugs
  - Smoking-cessation programs (does not include expenses for drugs that do not require a prescription, such as nicotine gum or patches)
  - Sterilization reversal
  - Menstrual care products
- Travel and lodging away from home for medical reasons; limitations may apply — see **IRS**

Publication 502 for details (not all items listed in Publication 502 are eligible for reimbursement — for example, premiums for coverage in the medical, dental and vision plan options)

- Tuition and tutoring for a child with severe learning disabilities, including dyslexia
- Transportation to and from your health care provider
- Vitamins by prescription
- Weight-loss programs prescribed by a physician as medically necessary treatment for a specific disease or condition
- Nursing care for a dependent (such as your dependent elderly parents) if it is not custodial nursing home care

Ineligible Health Care FSA Expenses

The Health Care FSA does not reimburse you for the following (even if your doctor recommends them):

- Cosmetic treatment (unless the treatment corrects a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease); cosmetic treatment includes, but is not limited to, teeth bleaching, laser peels, chemical peels, hair transplants and treatment for male pattern baldness
- Dance or swimming lessons
- Drugs prescribed for cosmetic purposes (such as Rogaine, a drug prescribed for hair-loss treatment)
- Electrolysis
- Expenses reimbursed through any health insurance policy or plan, such as your spouse's health plan or Medicare
- Expenses you or a family member incurred before the effective date of your Health Care FSA election or change of your Health Care FSA election
- Expenses you or a family member incurs after the end of the plan year (December 31)
- Health club dues, YMCA dues, and related expenses
- Household help
- Liposuction
- Marriage or family counseling
- Birth parent clothes, diaper service, and related expenses
- Custodial nursing home care
- Premiums for automobile insurance, including premiums to insure medical care for persons injured by or in your car
- Premiums for life, disability or accidental death and dismemberment (AD&D) insurance
- Premiums for medical, dental, and vision insurance, including COBRA premiums
- Transportation to and from work (even if your condition requires special means of transportation)

- Trips or vacations taken for relief of a condition, change in environment, improvement of morale, or general health purposes
- Tuition for a child with disciplinary problems who is enrolled in a special school
- Uniforms
- Weight-loss programs (unless prescribed by a doctor as medically necessary for the treatment of a specific disease or condition)

Health Care FSA vs. Tax Deduction

Even though the Health Care FSA reimbursements can reduce your taxable income, the federal income tax deduction might provide greater savings for some employees. To claim such a deduction, your health care expenses must exceed 10% of your adjusted gross income. Most employees find that their eligible health care expenses do not reach that amount. However, you should consult with your tax advisor to determine which method is best for your personal situation.

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT

The Dependent Day Care FSA allows you to set aside pre-tax dollars to pay for eligible dependent day care expenses while you are working. If you are married, your spouse also must work (or actively search for work), unless he or she is:

- A full-time student at least five months of the year, or
- Mentally or physically disabled and unable to care for a dependent.
- If you are divorced or legally separated, you can use the Dependent Day Care FSA if you have custody of your child for a longer period during the year than does your child's other parent. In addition, you must provide more than half of your child's financial support, and your child is claimed as a dependent on your federal income tax return.

Eligible Dependents

Dependent day care expenses that can be reimbursed through the Dependent Day Care FSA include day care for:

- Children under age 13 whom you claim as dependents on your federal income tax return
- A spouse who is incapable of caring for him- or herself
- Parents, grandparents, children age 13 or older, or other relatives or members of your household who:
  - Are claimed as a dependent on your federal income tax return,
  - Spend at least eight hours each day in your home,
  - Receive more than half of their support from you, and
  - Are physically or mentally incapable of caring for themselves.

If your spouse is incapable of caring for their own self, the expenses you incur for their care must enable you to be gainfully employed, and your spouse must:

- Have a physical or mental condition that does not allow them to take care of personal, hygienic or nutritional needs, or
- Require full-time attention for safety reasons.

The fact that your spouse is unable to engage in substantial gainful activity or perform their normal functions does not necessarily mean that expenses you incur for their care are reimbursable under the plan.

Eligible Dependent Day Care FSA Expenses

See **IRS Publication 503** for details about eligible expenses. IRS publication 503 generally provides a list of expenses eligible for reimbursement through a dependent care FSA. The publication is available:

- At your local IRS office
- From the IRS by calling 800-829-3676

- At **irs.gov**

The following expenses are eligible for reimbursement under the Dependent Day Care FSA:

- The cost of day care provided in or out of your home (including Social Security taxes you pay on behalf of your provider) by an eligible babysitter
- The cost of day care provided at a licensed day care center or kindergarten that cares for at least six people and complies with local regulations (but not services from a facility that charges no fee)
- The cost of day care provided at a summer camp (but not tuition and other fees unrelated to day care)
- The cost of day care provided at a private school (but not tuition and other fees unrelated to day care if the child is in kindergarten or above)
- Any nonrefundable fees to secure your dependent's place in a day care center

Any other expenses that would be considered eligible for a dependent care credit for federal income tax purposes. For a complete list of these expenses, see **IRS Publication 503**.

Your day care provider can be a babysitter if his or her services enable you and your spouse to work. However, please note that your day care provider cannot be any of the following:

- Your spouse
- Your child's other parent
- Your child who is under age 19 at the end of the plan year
- A person whom you or your spouse claims as a dependent for income tax purposes
- Expenses must be incurred during the plan year in order to be eligible for reimbursement. If you terminate participation in the Dependent Day Care FSA during the plan year, you may continue to use any available balance for expenses incurred during the remainder of the plan year.

Ineligible Dependent Day Care Expenses

The following expenses are not eligible for reimbursement under the Dependent Day Care FSA:

- Child support payments
- Clothing, entertainment or food expenses
- Day care expenses incurred during hours when you or your spouse is not working or works as a volunteer
- Expenses you incur while you or your spouse is away from work because of vacation, illness or leave of absence
- Expenses you or a family member incurred before the effective date of your Dependent Day Care FSA election or change of your Dependent Day Care FSA election
- Expenses that are reimbursed by another plan, such as your spouse's or a government plan
- Expenses you incur before you enroll in the Dependent Day Care FSA
- Expenses you incur during any time you cannot claim your dependent as an exemption on your federal income tax return

- Expenses you incur after the end of the plan year (December 31)
- Finder's fees for placement of an au pair or nanny
- Full-time convalescent or nursing home expenses (except care for a mentally disabled child under age 13)
- Overnight camp expenses
- Transportation expenses for your caregiver or your dependent
- Tuition, for kindergarten or higher
- Any other expenses considered not eligible for a dependent day care credit for federal income tax purposes (see **IRS Publication 503**)

Contribution Limits If You Are Married

The table below indicates the maximum allowable tax-free reimbursement from a Dependent Day Care FSA, per IRS regulations.

IF THIS IS YOUR SITUATION...	THEN YOUR MAXIMUM ANNUAL CONTRIBUTION IS...
You or your spouse earns less than $7,500	The amount the lower-paid spouse earns, up to $7,500
You and your spouse file a joint income tax return and your spouse also participates in a Dependent Day Care Flexible Spending Account	$7,500 for your spouse's account and your account combined*
You and your spouse file separate income tax returns	$3,750 under the Northrop Grumman account
Your spouse is a full-time student for at least five months of the year or Your spouse is disabled	$3,000 (or $250 for each month that your spouse is a student or is disabled) if you have one dependent $6,000 (or $500 for each month that your spouse is a student or is disabled) if you have two or more eligible dependents

* If you and your spouse are both Northrop Grumman employees, the maximum you may both elect on a combined basis is $7,500, subject to the limit for highly compensated employees.

Dependent Day Care FSA vs. Tax Credit

Another way to reduce taxes with your dependent day care expenses is to claim the child care credit on your federal income tax return.

Here is how the tax credit works: You can claim a 20% to 50% tax credit for child care expenses. The percentage that applies to you is based on your household income. If you have one dependent, the maximum expense that you can apply to the credit is $3,000 each calendar year. That means your annual tax saving when you use the credit can be up to $1,500 (50% x $3,000 = $1,500). If you have two or more eligible dependents, you can claim up to $6,000 in expenses, and your credit can be a maximum of $3,000 (50% x $6,000 = $3,000).

You have the option to use both the Dependent Day Care FSA and the tax credit approach. However, the IRS does not allow you to claim a tax credit for any expenses already reimbursed under the FSA. In other words, you cannot “double deduct” and receive a tax saving twice for the same expense.

Moreover, the amount of expenses that qualify for a tax credit are reduced — dollar for dollar — by the amount that you receive from the Dependent Day Care FSA. That means if you have one dependent and you contribute $3,000 or more to the FSA, you cannot also claim the dependent care tax credit. This rule applies even if you have additional unreimbursed expenses.

The combination of FSA reimbursements and tax credits that provides the greatest tax saving for you depends on your household income, the number of your eligible dependents and your income-tax-filing status.

USING YOUR FSA DOLLARS

When you incur an eligible expense during the plan year, you can use the pre-tax dollars in your accounts to reimburse yourself. File your request for reimbursement with Fidelity, the FSA claims administrator, and include the proper documentation substantiating the expense. You may also pay many of your eligible healthcare and dependent day care expenses directly from your FSA account. Go to **netbenefits.com/NorthropGrumman** or call Fidelity at 800-894-4194 for more information on how to file claims.

Because your bills may arrive after you receive services, you can submit claims incurred during the plan year until March 31 — after the plan year ends.

Note: The claims administrator reviews your claims. Each time you submit a claim for reimbursement from your FSA, you are deemed to certify that the expense is for an eligible individual, that you (or your spouse or other eligible individual) have not already been reimbursed for the expense, that you (and your spouse and any other eligible individual) will not seek reimbursement under any other plan for the expense and that you will acquire and retain sufficient documentation for the expense.

The following sections provide additional details about reimbursements specific to each account.

Health Care FSA

When you have an eligible healthcare expense, you may:

- Use the Fidelity health card instead of cash or credit to pay the provider or pharmacy. The amount of purchase is deducted automatically from your FSA. Save itemized receipts or other supporting documentation to substantiate your claim for FSA benefits.
- Pay the expense then file a claim for reimbursement online at **netbenefits.com/NorthropGrumman** or by mail or fax. Please note reimbursement checks for FSA expenses must be cashed or replaced no later than 12 months after the issue date or the amount is forfeited. If you do not cash or deposit a reimbursement check or obtain a replacement check before the end of the 12-month period, the amount is forfeited permanently. You will not receive a refund and the amount will not be restored to your FSA account.
- Pay the expense directly from your FSA.

You can submit health care expenses and receive reimbursement for up to the total amount you elected to contribute for the entire plan year, less any reimbursements that were already paid. Your future contributions will be credited to your account. See the example below.

If you or your dependents are enrolled in more than one health plan (such as your plan and your spouse's plan or Medicare), you first have to submit your expenses to those plans. After you receive reimbursement from all your health plans, you can submit the balance of your eligible expenses for reimbursement under the Health Care FSA. You must include the explanation of benefits (EOBs) from both plans with your claim. (You can submit expenses for your eligible dependents even if they are not covered under the health care plans.)

Here are two examples of how the Health Care FSA reimbursement process works:

	EXAMPLE 1	EXAMPLE 2
Your selected annual contribution	$600	$600
Your contributions as of February	$100	$100
Your submitted claim in February	$600	$800
Your reimbursement	$600	$600
Your account balance	($500)	($500)

- In example 1, you are reimbursed the full amount of your $600 claim in February, even though you contributed only $100 to your account so far. Your contributions during the rest of the plan year will be credited to make up the $500 negative balance in your account.
- In example 2, you submit a claim for $800, but receive reimbursement for only $600 — the total contribution you selected for the year.

Dependent Day Care FSA

When you have an eligible dependent day care expense, you may file a request for reimbursement or set up to pay your provider directly. Go to **netbenefits.com/NorthropGrumman** for more information. You will need to provide a bill or cancelled check that shows your day care provider's Social Security or tax identification number. (According to IRS rules, your expenses will not be reimbursed if you do not provide this number.)

For reimbursement of the cost of day care provided by your child's school, day care must be shown as a separate item on the tuition bill. Tuition for children in kindergarten or higher is not an eligible expense.

You can be reimbursed for eligible expenses up to the balance in your account at the time your claim is processed. If you have enough money in your account, you will be reimbursed in full. If you do not have enough money in your account to pay your entire claim, you will receive an initial reimbursement equal to your current account balance. The remainder of your claim will be paid automatically after you make additional payroll contributions to your account. Depending on how much you contribute each week, you may receive one or several reimbursement checks.

For example, let's assume you submit a claim for $400 and receive a reimbursement check for $384 (the amount in your account in February). You will be reimbursed the remaining $16 after you make additional payroll contributions to your account.

	EXAMPLE
Your selected annual contribution	$5,000
Your contributions as of February	$384
Your submitted claim in February	$400
Your reimbursement	$384
Your account balance	$0

Keep in mind that the IRS limits the pre-tax reimbursements you can receive in a single calendar year from the dependent care FSA to $7,500. (If you are married, this limit applies to any reimbursements received by you and your spouse.) If you are reimbursed for more than $7,500 in a calendar year, you will be responsible for paying taxes on the excess amount.

Please note reimbursement checks for FSA expenses must be cashed or replaced no later than 12 months after the issue date or the amount is forfeited. If you do not cash or deposit a reimbursement check or obtain a replacement check before the end of the 12-month period, the amount is forfeited permanently. You will not receive a refund and the amount will not be restored to your FSA account.

"Use It or Lose It Rule" and Other IRS Regulations

Before you enroll in an FSA, be sure to carefully estimate your health care and dependent day care expenses for the year. In exchange for the tax savings you receive, the IRS places restrictions on the amount you can contribute. Special rules pertaining to these restrictions may be communicated in additional communications.

For example, under the IRS "use-it-or-lose-it" rule, you lose any funds in your dependent day care account that you do not use by the end of plan year. That means that you will not receive a refund, and you will not be able to roll over any remaining account balances to the next year. These amounts will be forfeited.

The IRS has modified its "use-it-or-lose-it" rule for Health Care FSAs and now allows you to roll over up to $660 of unused funds at the end of the plan year to the next plan year. Please keep in mind that you must enroll in a Health Care FSA for the new plan year in order to receive the roll over. The maximum rolled over amount that may be credited to your Health Care FSA at any time is $660 (though this maximum amount may change from year to year). For example, if you rolled over $400 after year one and had only used $200 of that rolled over amount by the end of year two, the most you could roll over from unused year two contributions would be $300. Unused amounts over $660 are forfeited. The rollover amount of $660 does not impact the maximum election amount of $3,300.

In addition, IRS rules require that you:

- Cannot transfer money from one FSA to another.
- Cannot change the set amounts you choose to contribute during the plan year, unless you have a qualified life event.
- Will lose your unused account balances if you leave Northrop Grumman or lose eligibility for the Northrop Grumman Health Plan during the plan year for any reason (unless you elect to continue your Health Care FSA through **COBRA Continuation Of Coverage**); however, you can submit a claim for reimbursement of expenses that you incur before leaving Northrop Grumman or before losing eligibility for the Northrop Grumman Health Plan.
- Cannot file for an income tax deduction or tax credit for expenses reimbursed through the FSAs.
- Cannot use amounts in one FSA to cover expenses of the other FSA.

How Your Other Benefits Are Affected

Your FSA contributions will not affect your other Northrop Grumman benefits that are based on your pay. These other benefits, such as life insurance, disability, and retirement benefits, will continue to be based on your full pay before any FSA contributions are distributed.

However, your contributions to an FSA may affect your Social Security benefits. Your Social Security benefits are based on your average annual taxable income — up to the Social Security wage base —

during your entire career. Because your FSA contributions lower your taxable income, your Social Security benefits at retirement or disability may be slightly less if:

- You earn less than the Social Security wage base for the current year, or
- Your pre-tax contributions reduce your taxable income below the Social Security wage base.

If you earn more than the Social Security wage base, your Social Security benefits are not affected. For most employees, the current tax savings outweigh any possible reduction in future Social Security benefits or other government-related benefits.

When Participation Ends

Your participation in the FSAs ends and your contributions stop when the first of these events occurs:

- You no longer are eligible under the Plan
- The Plan terminates

For information about how your enrollment may be affected by certain life events, such as a leave of absence, refer to **What Happens To Your Benefits In Special Situations**.

Eligible expenses that you incur before your participation ends will be reimbursed, if you submit a reimbursement claim by March 31 — after the plan year ends.

Expenses that you incur after your Health Care FSA participation ends are not eligible for reimbursement, and you forfeit any amounts left in your accounts as of the claim submission deadline. However, under certain circumstances, when your coverage otherwise would end, you may continue participating in the Health Care FSA by making after-tax contributions through COBRA. When you elect COBRA, you can submit expenses for reimbursement and use the balance in your Health Care FSA during the plan year. See **COBRA Continuation Of Coverage** for detail.

HEALTH REIMBURSEMENT ACCOUNTS

A Health Reimbursement Account (HRA) is an employer-funded account used to reimburse eligible health care expenses. You may have an HRA associated with your past participation in the Premium Plan, Premium Plus Plan or the Anthem Consumer Driven Health Plan (CDHP), all medical plan options that are no longer available.

If on December 31, 2019, you were enrolled in the Premium Plan or Premium Plus Plan, had an HRA balance in excess of $50, and enrolled in another medical plan in the Northrop Grumman Health Plan for the 2020 plan year, your unused HRA balance was transferred to Fidelity to administer.

There are two types of HRAs:

- The **General Purpose Health Reimbursement Account (HRA)** can be used to pay medical and prescription drug expenses as well as dental and vision care expenses
- The **Limited Purpose Health Reimbursement Account (HRA)** can be used for dental and vision expenses only
- IRS rules do not allow an individual to establish or contribute to an HSA if the individual is covered by an HRA that would reimburse medical and prescription drug expenses. If you contribute to an HSA, plan to contribute to an HSA, or plan to receive the Well-being Incentive as a contribution to an HSA, be sure your HRA is limited purpose. See below under "**Electing a General Purpose or Limited Purpose HRA**" for information on how to elect a limited purpose HRA.

You will receive a Fidelity health card, which you may use to pay for your eligible expenses. Alternatively, you may submit claims for reimbursement directly to Fidelity. If you enroll in a Health Care FSA and have an HRA, your HRA funds will be used before your Health Care FSA. Once you have exhausted your HRA, you may begin using your FSA to pay eligible expenses.

Unlike an FSA, the money credited to your General Purpose or Limited Purpose HRA will not be forfeited if unused by the end of the plan year. Your balance will rollover each year as long as you remain covered under a medical plan option in the Northrop Grumman Health Plan. If you decline medical coverage at annual enrollment, your HRA balance will be forfeited. If your medical coverage ends as a result of terminating employment, a reduction in your scheduled hours, or your transfer to a benefits ineligible status, your HRA eligibility also ends unless you continue your medical coverage through COBRA. The HRA is not restored if you are rehired by Northrop Grumman. You have 90 days from the coverage end date to submit requests for reimbursement to Fidelity for eligible expenses incurred while you were covered by the medical plan.

Electing a General Purpose or Limited Purpose HRA

Your HRA may change from a General Purpose HRA to a Limited Purpose HRA (also known as an HSA-eligible HRA) or vice versa as described below.

- If you have an HRA, are enrolled in a high-deductible health plan and elect to contribute to an HSA through Fidelity during annual enrollment, your HRA will be a Limited Purpose HRA. If it's a General Purpose HRA, your HRA will change to a Limited Purpose HRA for the new plan year.
- If you have a General Purpose HRA, do not elect to contribute to an HSA through Fidelity during annual enrollment but want to remain HSA-eligible in the new plan year, you must contact Fidelity during the annual enrollment window and elect a Limited Purpose HRA for the new plan year.
- If you have a Limited Purpose HRA, do not elect to contribute to an HSA during annual enrollment, and do not want to remain HSA-eligible in the new plan year, you may elect a General Purpose

HRA for the new plan year by contacting Fidelity during the annual enrollment window.

You may not change your HRA's status from general purpose to limited purpose, or vice versa, at any time other than during annual enrollment.

Life and Accident Insurance

Financial protection from the unexpected for you and your family is an important part of the Northrop Grumman benefits program.

To provide financial support for you or your beneficiaries, you are automatically provided with basic term life,* accidental death and dismemberment (AD&D)* and business travel accident (BTA) insurance coverage at no cost. If you would like additional coverage, you can purchase optional life or AD&D insurance for yourself and your eligible dependents in various levels of coverage at favorable group rates. These plans can provide additional financial protection in the event of death or serious accidental injury.

**Independence, MO represented employees have 120-day probation period. ABL represented employees are not eligible for AD&D.*

LIFE INSURANCE

Northrop Grumman provides basic life insurance for you and optional life insurance, which you may purchase for yourself and certain dependents.

Both the basic and optional life insurance plans are known as “term insurance.” This type of insurance pays benefits in a lump sum only if you or your enrolled dependents die while you are an eligible Northrop Grumman employee or, in the case of optional life insurance, so long as you remain eligible and pay the premiums. Unlike whole life insurance, term insurance policies do not build up a cash value.

For More Information

For important additional information about the benefits described in this section, be sure to review the **Eligibility and Participation** and the **. General Plan** Administration sections of this

There are no benefit exclusions for company-paid basic life insurance or optional life insurance, which means that the plan will pay a benefit regardless of the cause of death. However, there are some exclusions for the other types of coverage.

Basic Life Insurance

Northrop Grumman provides you with basic life insurance equal to one times your annual base pay, up to $1 million, or $50,000, whichever is greater. Base pay is your pay for purposes of determining life insurance, AD&D insurance, and LTD coverage, as determined by your business unit. You are automatically covered by this insurance; you do not have to enroll in the plan. Northrop Grumman pays the full cost of basic life insurance for you.

Note: The basic life insurance coverage described in this section is not available to you if you are eligible for other life insurance coverage provided by Northrop Grumman. Also, if you a**re** an Independence, MO represented employee, your basic and optional life insurance, if elected, will be effective after you complete your 120-day probation period.

Keep in Mind

You can limit your basic life insurance coverage to $50,000 to avoid paying imputed income tax. See **Imputed Income** for details.

If you die, the plan pays benefits to the beneficiary or beneficiaries you choose. See **Beneficiary Designation** for information about designating your beneficiary.

Optional Life Insurance*

You may purchase optional life insurance for yourself, your spouse, your domestic partner and your unmarried children described below:

- Your biological child, adopted child, stepchild, child for whom you are the legal guardian, or child of your domestic partner under the age of 26
  - Adopted child: A person is treated as your child if you have legally adopted the person or the person is lawfully placed with you for legal adoption.
  - Stepchild: A stepchild is the biological child or adopted child of your spouse but not of you. If you and your spouse divorce, your former stepchild is not eligible for coverage under this provision.

**Independence, MO represented employees have a 120-day probation period.*

  - A child of a domestic partner is the biological child or adopted child of your domestic partner but not of you. If you and your domestic partner terminate your domestic partner relationship, the child of your former domestic partner is not eligible for coverage under this provision.
  - A child for whom you are the legal guardian is a child for whom you are the legally appointed guardian provided the child resides with and is supported by you.

- Your disabled biological child, adopted child, stepchild, child for whom you are the legal guardian or child of your domestic partner if the person became disabled:
  - Prior to January 1, 2011 and (i) before the person attained age 19 or (ii) while the person was at least age 19 but under age 25 and a full-time student, and was covered for optional life insurance before reaching age 26; or
  - On or after January 1, 2011 and while the person was under age 26, and was covered for optional life insurance before reaching age 26.

  For purposes of this provision, the plan considers a person to be disabled if he or she is incapable of self-sustaining employment by reason of mental or physical handicap.

For details about domestic partner optional life insurance, call the NGBC at 800-894-4194.

Important Notes About Optional Life Insurance Coverage for Children

- You may not purchase optional life insurance for your child if your child has basic or optional life coverage under the Northrop Grumman Health Plan as an active employee or optional life coverage under the Northrop Grumman Health Plan through your spouse or domestic partner
- You may not purchase optional life insurance for your child if your child is in the military of any country or international authority, except for active-duty weekend or summer training for the reserve forces of the United States, including the National Guard
- You may not purchase optional life insurance for a child placed in your home by a welfare or social service agency under an agreement where the agency retains control of the child or pays you for maintenance.

If you select optional life insurance, you pay the full cost with after-tax dollars, based on group rates negotiated by the Plan administrator.

Your cost for optional life insurance for yourself is determined by your age as of December 31 of the plan year and the coverage level selected. Your cost for optional life insurance for your spouse is generally determined by your spouse's age as of December 31 of the plan year and the coverage level selected. As your annual base pay changes, so will your coverage amount and rate for coverage for yourself and your spouse, if applicable. Your cost for child life insurance is determined as a flat rate per option.

You can select optional life insurance at the following times:

- Within 31 days of when you (and your dependents) first become eligible for coverage (which is usually your date of hire)
- Anytime during the plan year, subject to Evidence of Insurability (EOI) requirements

Depending on the amount of coverage you choose, you may need to provide satisfactory EOI. See **When Evidence of Insurability Is Required** for details.

For your optional life insurance to take effect, you must be an active employee and not on a leave of absence on the effective date of coverage. If you are on a leave of absence, and you want to increase your coverage, you must call the NGBC at 800-894-4194 when you return to work.

For your dependent's coverage to take effect, they must not be confined for medical care or treatment — either in a medical treatment facility or at home — on the effective date of the coverage. If your dependent is confined, coverage begins when he or she is released from confinement. You must not be on a leave of absence for your dependent's coverage to take effect.

You can purchase dependent life insurance regardless of whether you purchase optional life insurance for yourself, but your spouse's (or domestic partner's) life coverage cannot exceed 50% of your combined basic and optional insurance coverage.

OPTIONAL LIFE INSURANCE FOR YOURSELF*

If you select optional life insurance for yourself, your beneficiary will receive benefits under both your basic and optional life insurance in the event of your death. The optional life insurance options for employees are:

- 1 x your annual base pay up to a benefit maximum of $2.0 million
- 2 x your annual base pay up to a benefit maximum of $2.0 million
- 3 x your annual base pay up to a benefit maximum of $2.0 million
- 4 x your annual base pay up to a benefit maximum of $2.0 million
- 5 x your annual base pay up to a benefit maximum of $2.0 million
- 6 x your annual base pay up to a benefit maximum of $2.0 million
- 7 x your annual base pay up to a benefit maximum of $2.0 million
- 8 x your annual base pay up to a benefit maximum of $2.0 million
- No optional life insurance

If the amount of your annual base pay is not an even $1,000 multiple, the amount of your coverage is rounded up to the next-higher thousand-dollar amount. For example, if your annual base pay amount is $42,100 and you select the three times your annual base pay, your benefit will be: $42,100 x 3 = $126,300, rounded up to $127,000.

OPTIONAL LIFE INSURANCE FOR YOUR SPOUSE/DOMESTIC PARTNER*

The optional spouse/domestic partner life insurance options are:

- $25,000
- $50,000
- 1 x your annual base pay
- 2 x your annual base pay
- 3 x your annual base pay
- 4 x your annual base pay

**Independence, MO represented employees have a 120-day probation period.*

The amount of your spouse/domestic partner's life insurance cannot be more than the lesser of:

- 50% of the total amount of your own basic and/or optional life insurance combined amount, rounded up to the nearest $1,000
- $500,000

For example, if your annual base pay amount is $40,000, and you select optional life insurance equal to one times this amount, the total of your basic and optional life insurance is $90,000 (basic life insurance of $50,000 + optional life insurance of $40,000). You could choose optional life insurance for your spouse/domestic partner of $25,000 or one times your annual base pay. However, you could not choose any of the other options.

You do not have to purchase optional life insurance for yourself in order to buy spouse/domestic partner life insurance. If both you and your spouse/domestic partner work for Northrop Grumman, you may select optional life insurance for one another.

OPTIONAL LIFE INSURANCE FOR YOUR CHILDREN*

The optional child life insurance options are:

- $10,000 per child
- $20,000 per child
- $30,000 per child

This coverage is available for eligible children who are unmarried. If both you and your spouse/domestic partner work for Northrop Grumman, only one of you may elect optional life insurance coverage for your eligible dependent children.

**Independence, MO represented employees have a 120-day probation period.*

When Evidence of Insurability Is Required

Evidence of Insurability (EOI) refers to proof that you and/or your spouse/domestic partner are in good health at the time you enroll for optional life insurance. You must provide EOI under the following circumstances:

- When you (and your dependents) first become eligible (usually on your date of hire), and you choose:
  - Optional coverage for yourself that is greater than five times your salary or $600,000, whichever is less
  - Optional coverage for your spouse/domestic partner that is greater than $50,000
- You select or increase optional coverage for yourself (and your dependents) at any time other than within 31 days of the date you first become eligible (for instance, in the event of a qualified life event). However, if you were at an optional life insurance level of less than five times your salary and gain a new dependent through marriage, birth, or adoption, you can:
  - Select employee coverage of one times your pay or increase your current coverage by one level (if the new amount elected is less than or equal to $600,000) without EOI
  - Select spouse/domestic partner coverage up to $50,000 without EOI

  If your spouse/domestic partner loses his or her life insurance from another source, you may select spouse/domestic partner coverage up to $50,000 without EOI. Also, you may enroll in or increase child life insurance without EOI, if you experience a qualified life event.

When EOI is required, you must complete and submit your EOI form to MetLife (the life insurance company). Contact the NGBC at 800-894-4194 for information about the EOI process.

The EOI process requires information about your health, medical history, and pre-existing conditions. In addition, you may be required to undergo a paramedical examination. A medical professional will meet with you at the location of your choice to perform the exam. MetLife will pay the fee of the paramedical exam, with no cost to you.

Until your EOI is processed, your coverage will be limited to an amount allowed without EOI. For example, you enroll as a new employee and choose coverage equal to four times your annual base pay of $155,000 or $620,000. Because four times your annual base pay exceeds $600,000, the maximum amount allowed without EOI, your coverage will be limited to three times your annual base pay — $465,000 — until your EOI is processed and your coverage is approved.

Imputed Income

Federal tax law requires you to pay income taxes on the value of your employer provided group life insurance in excess of $50,000. This is called imputed income. You may choose to avoid imputed income by limiting your basic life insurance benefit to $50,000. You can limit your basic life insurance benefit during enrollment when you make your other benefit choices.

Accelerated Death Benefit Option

The Northrop Grumman basic and optional life insurance coverage includes a special feature that helps you cope with the financial difficulties often associated with terminal illness. Under the Accelerated Death Benefit Option, if you are expected to live for six months or less, you may receive up to 80% of the total life insurance (basic and optional combined) amount, up to $500,000. If your spouse/domestic partner is expected to live for six months or less, you may receive up to 80% of the total life insurance (optional spouse/domestic partner life) amount, up to $400,000. Ordinarily, this benefit would be paid to you or your spouse/domestic partner's beneficiary only upon death.

To receive this benefit, the plan requires medical documentation of your or your spouse/domestic partner's condition. The plan pays benefits when your request is approved, and in the manner that you select — for example, in a lump sum or as installment payments. After you or your spouse/domestic partner dies, the remaining life insurance benefits are paid to the beneficiary.

What Happens If Your Employment Ends

Your life insurance coverage and any optional coverage you purchase for your spouse/domestic partner and/or children ends on the date your employment ends* (unless your employment ends due to disability; see **When Employment Ends** for details). If you die within 31 days of your termination date, benefits are paid to your beneficiary for your basic life insurance, as well as any optional life insurance coverage you elected.

** You have the option to convert your life insurance to an individual policy and/or elect portability coverage (see **Continuing Your Coverage through Conversion or Portability** for details).*

What Happens If You Take a Leave of Absence?

If you take a leave of absence, your benefits will generally continue for a specified period. See **If You Take a Leave of Absence** section for more information.

Exclusions: Losses Not Covered

There are no exclusions for basic or optional life insurance — life insurance provides a benefit regardless of the cause of death.

How Benefits Are Paid

If the benefit amount payable to your beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA) with MetLife. The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty, simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if he or she wishes. Please note the TCA is not a bank account and not a checking, savings or money market account.

Assignment of Coverage

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. An assignment required by law will only be honored if approved by the plan in advance of death.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Overview

AD&D insurance pays benefits if, as a result of a covered accident, you die or lose a limb or your sight, speech, or hearing or become paralyzed within 365 days of the accident. The amount the plan pays depends on the extent of the loss.

Note: The basic and optional AD&D insurance coverage described in this section is not available to ABL (Local 261c) or ABL (Local 400) represented employees or employees eligible for other basic and optional AD&D coverage provided by Northrop Grumman. In addition, if you are an Independence, MO represented employee, your coverage will be effective after a 120-day probationary period.

Basic AD&D Insurance

Northrop Grumman provides you with basic AD&D insurance equal to one times your salary or $50,000, whichever is greater, up to $1 million. You are automatically covered by this insurance; you do not have to enroll in the plan. Northrop Grumman pays the full cost of basic AD&D insurance for you.

If you die, the plan pays benefits to the beneficiary or beneficiaries you choose. If you lose a limb or your sight, speech, or hearing or become paralyzed as a result of a covered accident, the plan pays a portion of your AD&D benefits to you.

Optional AD&D Insurance

You may purchase Optional AD&D insurance for yourself, your spouse, your domestic partner, and your unmarried children described below:

- Your biological child, adopted child, stepchild, child for whom you are the legal guardian, or child of your domestic partner under the age of 26.
  - Adopted child: A person is treated as your adopted son or daughter if you have legally adopted the person or the person is lawfully placed with you for legal adoption.
  - Stepchild: A stepchild is the biological child or adopted child of your spouse but not of you. If you and your spouse divorce, your former stepchild is not eligible for coverage under this provision.
  - A child of a domestic partner is the biological child or adopted child of your domestic partner but not of you. If you and your domestic partner terminate your domestic partner relationship, the child of your former domestic partner is not eligible for coverage under this provision.
  - A child for whom you are the legal guardian is a child for whom you are the legally appointed guardian provided the child resides with and is supported by you.

Keep in Mind

You may not purchase optional AD&D for your child if your child has basic AD&D coverage under the Northrop Grumman Health Plan as an active employee of Northrop Grumman.

- Your disabled biological child, adopted child, stepchild, child for whom you are the legal guardian or child of your domestic partner if the person became disabled:
  - Prior to January 1, 2011 and (i) before the person attained age 19 or (ii) while the person was at least age 19 but under age 25 and a full-time student and was covered for AD&D insurance before reaching age 26; or
  - On or after January 1, 2011 and while the person was under the age of 26 and was covered for AD&D insurance before reaching age 26.

  For purposes of this provision, the plan considers a person to be disabled if he or she is incapable of self-sustaining employment by reason of mental or physical handicap.

For further details about domestic partner optional life insurance, contact the NGBC at 800-894-4194.

If you select optional AD&D insurance, you pay the full cost with after-tax dollars, based on rates negotiated by the Plan administrator.

You can choose optional AD&D insurance when you are first hired and during annual enrollment. Because you pay for optional AD&D insurance with after-tax dollars, you can also enroll in optional AD&D insurance for yourself and your dependents at any time during the plan year.

If you and your spouse/domestic partner work for Northrop Grumman, only one of you may cover the entire family for AD&D insurance. The other employee may elect employee-only coverage.

OPTIONAL AD&D INSURANCE FOR YOURSELF

If you select optional coverage and suffer an eligible loss, you will receive benefits under both your basic and optional AD&D insurance.

The optional employee AD&D insurance options are:

- 1 x your annual base pay up to a benefit maximum of $2.0 million
- 2 x your annual base pay up to a benefit maximum of $2.0 million
- 3 x your annual base pay up to a benefit maximum of $2.0 million
- 4 x your annual base pay up to a benefit maximum of $2.0 million
- 5 x your annual base pay up to a benefit maximum of $2.0 million
- 6 x your annual base pay up to a benefit maximum of $2.0 million
- 7 x your annual base pay up to a benefit maximum of $2.0 million
- 8 x your annual base pay up to a benefit maximum of $2.0 million
- 9 x your annual base pay up to a benefit maximum of $2.0 million
- 10 x your annual base pay up to a benefit maximum of $2.0 million

OPTIONAL AD&D INSURANCE FOR YOUR ENTIRE FAMILY

You also may purchase optional AD&D insurance for your entire family. The insurance for your family will be a percentage of your coverage election as shown in the chart below. The optional family AD&D insurance options for you are:

- 1 x your annual base pay up to a benefit maximum of $2.0 million
- 2 x your annual base pay up to a benefit maximum of $2.0 million
- 3 x your annual base pay up to a benefit maximum of $2.0 million
- 4 x your annual base pay up to a benefit maximum of $2.0 million
- 5 x your annual base pay up to a benefit maximum of $2.0 million
- 6 x your annual base pay up to a benefit maximum of $2.0 million
- 7 x your annual base pay up to a benefit maximum of $2.0 million
- 8 x your annual base pay up to a benefit maximum of $2.0 million
- 9 x your annual base pay up to a benefit maximum of $2.0 million
- 10 x your annual base pay up to a benefit maximum of $2.0 million

If you select family coverage, your spouse/domestic partner and/or child(ren)'s coverage is based on your eligible family members at the time of the loss, as shown in this chart:

	AMOUNT OF DEPENDENT COVERAGE
Spouse/domestic partner only	75% of your optional coverage
Spouse/domestic partner and children	Spouse: 60% of your optional coverage Children: 15% of your optional coverage per child (up to $50,000)
Children only	25% of your optional coverage per child (up to $50,000)

For example, let's assume:

- Your annual base pay is $40,000
- You choose family AD&D coverage equal to 2 x your annual base pay
- You are married and have two children

In this example,

- Your AD&D coverage amount is $80,000 (2 x $40,000)
- Your spouse's coverage amount is $48,000 (60% x $80,000)
- Your children's coverage amount is $12,000 per child (15% x $80,000)

If you and your spouse/domestic partner work for Northrop Grumman, only one of you may cover the entire family for AD&D insurance.

What AD&D Insurance Pays for Specific Losses

AD&D insurance pays a percentage of the AD&D coverage amount based on the type of loss incurred, as shown in this chart:

	PERCENTAGE OF AD&D COVERAGE AMOUNT PAID		
TYPE OF LOSS*:	**If You Suffer a Loss**	**If Your Covered Spouse/Domestic Partner Suffers a Loss**	**If Your Covered Child Suffers a Loss**
Life	100%	100%	100%
Two or more (hands or feet)	100%	100%	200%
Sight in both eyes	100%	100%	200%
One hand and one foot	100%	100%	200%
One hand or one foot and sight in one eye	100%	100%	200%
Speech and hearing in both ears	100%	100%	200%
One hand or one foot	75%	75%	150%
Sight in one eye	60%	60%	120%
Speech or hearing in both ears	85%	85%	170%
Thumb and index finger of same hand	25%	25%	50%
Severance and reattachment of one hand or foot	25%	25%	50%
Maximum benefit for all losses in any one accident	100%	100%	$50,000

**A loss is defined as:*

- *For a hand or a foot: severance through or above the wrist but below the elbow or ankle but below the knee*
- *For sight: permanent and irrecoverable loss to the sight of the eye*
- *For speech: entire and irrecoverable loss of speech*
- *For hearing: entire and irrecoverable loss of hearing*
- *For thumb and index finger: permanently severed at or above the knuckles*
- *Severance means the complete and permanent separation and dismemberment of the part from the body.*

Additional Benefits Under AD&D Insurance

The following special benefits are available under AD&D and optional AD&D insurance with a few exceptions, where noted.

Rehabilitation Benefit

Under both AD&D and optional AD&D insurance, the plan will pay the benefit shown below, subject to the following conditions and exclusions, when you or an insured dependent requires rehabilitation after sustaining a covered loss resulting directly and independently of all other causes from a covered accident. The covered person must require rehabilitation within 90 days after the date of the covered loss. The benefit amount payable is 20% multiplied by the percentage of the AD&D coverage amount applicable to the covered loss, subject to a maximum of $18,000.

Common Disaster Benefit

Under optional AD&D insurance, the plan will increase the loss of life benefit payable for your insured spouse/domestic partner to 100% of your coverage amount if both you and your insured spouse/domestic partner are injured in the same accident and die within 365 days as a result of injuries from the accident.

Seatbelt and Airbag Benefit

Under both AD&D and optional AD&D insurance, the plan will pay an additional benefit if benefits were paid for loss of life, subject to the conditions and exclusions described below, when you or an insured dependent die as a result of an accidental injury while wearing a seatbelt and operating or riding as a passenger in a passenger car. The additional benefit is equal to 20% of the covered person's coverage amount subject to a minimum of $500 and a maximum of $25,000.

A police officer investigating the accident must certify that the seatbelt was properly fastened. A copy of such certification must be submitted with the claim for benefits.

An additional benefit equal to 10% of the covered person's coverage amount subject to a minimum of $250 and a maximum of $10,000 is provided if the covered person was also riding in a seat protected by an airbag and was wearing a seat belt which was properly fastened, and died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the seatbelt was properly fastened and that the passenger car in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted with the claim for benefits.

Seatbelt means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law.

Airbag means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

Passenger car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any privatecar being used for commercial purposes, or any vehicle used for recreational or professional racing.

Child Care Center Benefit

Under optional AD&D insurance, the plan will pay the benefit shown below for up to four consecutive years for the care of each surviving dependent child in a child care center if you or your spouse/domestic partner die as a result of an accidental injury and all of the following conditions are met:

- A death benefit was paid for you or your spouse/domestic partner under the plan
- Coverage for your dependent children was in force on the date of the covered accident causing your death

- One or more surviving dependent children are under age 13 and:
  - Were enrolled in a child care center on the date of the covered accident or
  - Enroll in a child care center within 12 months from the date of the covered accident

The amount of the benefit is the least of:

- The actual annual cost charged by the licensed child care center
- 10% of your or your spouse/domestic partner's optional AD&D coverage amount
- $7,500 per year

In the event that both you and your spouse die such that each death would cause a payment to be made for a child under this additional benefit, the following rules apply:

- the annual maximum will be 2 times the amount stated above;
- the overall maximum will be equal to the stated percentage applied to the sum of the amount of coverage for you and your spouse; and
- in no event will the amount paid under all child care benefits exceed the amount of child care charges incurred.

This benefit will be paid quarterly when proof that child care center charges have been paid has been received by the insurer. Payment will be made to the person who pays such charges on behalf of the child.

A child care center is a facility that:

- Is operated and licensed according to the law of the jurisdiction where it is located; and
- Provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

This benefit will not be paid for child care center charges incurred after the date the child attains age 13.

Child Education Benefit

Under optional AD&D insurance, the plan will pay the benefit shown below for each qualifying dependent child who is insured on the date you or your insured spouse/domestic partner dies as a result of an accident injury and a benefit is paid for the loss of life for you and or your spouse/domestic partner. This benefit is subject to the conditions and exclusions described below.

The benefit for each of your qualifying dependent children equals the least of:

- The actual expenses incurred
- 25% of your or your spouse/domestic partner's optional AD&D insurance coverage amount
- $15,000 per year

The benefit is payable for a period of up to 4 consecutive academic years.

In the event that both you and your spouse die such that each death would cause a payment to be made for a child under this additional benefit, the following rules apply:

- the annual maximum will be 2 times the amount stated above;

- the overall maximum will be equal to the stated percentage applied to the sum of the amount of coverage for you and your spouse; and
- in no event will the amount paid under all child care benefits exceed the amount of child care charges incurred.

A qualifying dependent child must meet all of the following conditions:

- Be enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level on the date of your or your spouse/domestic partner's death; or be at the 12th grade level on the date of your or your spouse/domestic partner's death and then enroll as a full-time student at an accredited college, university or vocational school within one year from the date of the your or your spouse/domestic partner's death.
- Proof of the child's continued enrollment as a full-time student may be required.

Benefit payments will be made semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to the person who pays the charges on behalf of the child.

Spouse/Domestic Partner Education Benefit

Under optional AD&D insurance, the plan will pay expenses incurred, as described below, to enable your insured spouse/domestic partner to obtain occupational or educational training needed for employment if you die as a result of an accidental injury and benefits were paid for the loss of your life. This benefit is subject to the conditions and exclusions described below.

Your spouse/domestic partner was enrolled as a full-time student in an accredited school at the time of your death, or enrolls as a full-time student, within 12 months after your death in any accredited school.

The amount of the benefit is the least of:

- The actual expenses incurred
- 25% of your optional AD&D insurance coverage amount
- $25,000

The benefit is payable for a period of up to one academic year and is paid semi-annually when MetLife receives proof that tuition charges have been paid.

Coma Benefit

Under both AD&D and optional AD&D insurance, if you or an insured dependent is in a coma as a result of an accidental injury, the plan will pay a coma benefit. If you or your insured dependent go into a coma within 30 days of the accidental injury and it continues for 7 consecutive days, the plan will begin to make monthly payments of 1% of the covered person's AD&D insurance coverage amount. The plan will make 11 monthly payments, provided the person remains in a coma during this period. In the 12th month the plan will pay 100%. If the person recovers, the payments will stop.

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused.

Survivor Benefit

Under AD&D insurance, the plan will pay an additional benefit if benefits were paid for loss of your life and your spouse or domestic partner survives you by at least 48 hours. The additional benefit is equal to 2% of the covered person's coverage amount payable monthly for 12 months following your death.

Under optional AD&D, the plan will pay an additional benefit if benefits were paid for loss of your life or loss of your spouse or domestic partner's life. The additional benefit is equal to 2% of the covered

person's coverage amount payable monthly for 12 months following your death. In the event of your death the benefit is payable to your spouse or domestic partner if they survive you by at least 48 hours. In the event of the death of your spouse or domestic partner the benefit is payable to you if you survive your spouse or domestic partner by at least 48 hours.

Hospital Confinement Benefit

Under both AD&D and optional AD&D insurance, the plan will pay the monthly benefit described below, subject to the following conditions and exclusions, if you or an insured dependent are confined to a hospital as a result of an accidental injury which is the direct cause of such confinement independent of other causes.

The hospital stay must begin while the covered person's insurance is in effect.

The benefit is payable beginning on the 7th day of the confinement and is 5% of the covered person's AD&D insurance coverage amount, to a maximum of $1,000 per month. The maximum benefit period is up to 12 months of continuous confinement.

If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Brain Damage Benefit

Under both AD&D and optional AD&D insurance, the plan will pay 100% of the covered person's AD&D coverage amount if you or an insured dependent suffers brain damage from an accidental injury. The benefit will be payable if all of the following conditions are met:

- Brain damage begins within 30 days from the date of the accidental injury
- The covered person is hospitalized for treatment of brain damage at least five days
- Brain damage continues for 12 consecutive months

The benefit will be paid in one lump sum at the beginning of the 13th month following the date of the covered accident if brain damage continues longer than 12 consecutive months. The amount payable will not exceed the AD&D coverage amount for the covered person whose covered accident is the basis of the claim.

Brain damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all substantial and material functions and activities normal to everyday life.

AD&D Exclusions: Losses Not Covered

Basic and optional AD&D insurance do **not** cover:

- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity
- Infection, other than infection occurring in an external accidental wound
- Intentionally self-inflicted injury
- Suicide or attempted suicide
- Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country.

- Any incident related to travel in an aircraft or device:
  - as a pilot or crew member of an Aircraft for which you are not qualified;
  - flight student or flight instructor except in the course of your job for the Policyholder;
  - for parachuting or otherwise exiting from the aircraft while the aircraft is in flight except for the purpose of self-preservation;
  - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
  - for testing or experimental purposes;
  - by or for any military authority; or
  - for travel or designed for travel beyond the earth's atmosphere
- Commission or attempt to commit a felony
- The voluntary intake or use by any means of:
  - any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician; or
    - an "over the counter" drug, medication or sedative taken as directed;
  - alcohol in combination with any drug, medication, or sedative; or
  - poison, gas, or fumes; or
- War, whether declared or undeclared

Assignment of Coverage

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. An assignment required by law will only be honored if approved by the plan in advance of death.

BUSINESS TRAVEL ACCIDENT INSURANCE

Northrop Grumman provides business travel accident insurance to you automatically — you do not have to enroll in this coverage. Business travel accident insurance is administered by AIG.

This plan pays benefits if you or any of your eligible dependents die or lose a limb, sight, speech, or hearing or become paralyzed within 365 days of and as a result of a covered accident that occurs while you are traveling on company business. If your dependents accompany you on company business, they are eligible for benefits if Northrop Grumman pays their travel expenses.

You are considered to be traveling on business when you are traveling to advance Northrop Grumman's business. Business travel accident insurance provides a benefit for a covered accident that occurs from the time you leave your home or workplace — whichever occurs last — until you return to your home or workplace, whichever occurs first. Accidents that occur during your normal course of travel to and from work are not covered. Accidental injuries you receive during a leave of absence or vacation also are not covered.

The amount of your coverage is based on the coverage description below:

COVERAGE DESCRIPTION	AMOUNT OF INSURANCE
All eligible employees, including test pilots and engineers in flight tests, flying as a pilot or crew member	4 times annual base salary up to a benefit maximum of $500,000
All eligible dependent spouses/domestic partners, provided Northrop Grumman agreed in advance to pay transportation expenses (including relocation)	$110,000
All eligible dependent children, provided Northrop Grumman agreed in advance to pay transportation expenses (including relocation)	$35,000

What Business Travel Accident Insurance Pays for Specific Losses

Business travel accident insurance pays a percentage of the business travel accident coverage amount based on the type of loss incurred, as shown in this chart:

TYPE OF LOSS*	PERCENTAGE OF BUSINESS TRAVEL ACCIDENT COVERAGE AMOUNT PAID
Life	100%
Two or more (hands or feet)	100%
Sight in both eyes	100%
One hand or one foot and sight in one eye	100%
Speech and hearing in both ears	100%
Use of four limbs (quadriplegia)	100%
Use of both lower limbs or both upper limbs (Paraplegia)	75%
Use of both limbs on the same side of the body (hemiplegia)	100%

TYPE OF LOSS*	PERCENTAGE OF BUSINESS TRAVEL ACCIDENT COVERAGE AMOUNT PAID
One hand or one foot	50%
Sight in one eye	50%
Speech or hearing in both ears	50%
Thumb and index finger of same hand	25%
Hearing in one ear	25%
Uniplegia	25%
Maximum benefit for all losses in any one accident	100%

**A loss is defined as:*

- *For a hand or a foot: severance through or above the wrist or ankle*
- *For sight: complete, total and irrecoverable loss to the sight of the eye*
- *For speech: complete, total and irrecoverable loss of speech*
- *For hearing: complete, total and irrecoverable loss of hearing*
- *For thumb and index finger: complete and total severance at or above the knuckles*
- *For quadriplegia: total paralysis of both arms and legs*
- *For paraplegia: total paralysis of both legs*
- *For hemiplegia: total paralysis of the arm and leg on the same side of the body*
- *For uniplegia: total paralysis of entire arm or leg*

Exclusions

No coverage shall be provided and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks, even if the proximate or precipitating cause of the loss is an accidental bodily injury:

1. Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or auto-eroticism.
2. Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, whether as a Passenger, pilot, operator or crew member, unless specifically provided by the policy.
3. Declared or undeclared war, or any act or declared or undeclared war, unless specifically provided by the policy.
4. Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
5. Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition, including but not limited to diabetes.
6. Full-time active duty in the armed forced, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded). (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded).

Order of Benefits Payment

The plan pays business travel accident insurance benefits to you in the event of accidental loss of limb(s), hearing, speech, or sight. If you die in a covered accident, the plan pays benefits in the following order:

- To the beneficiary or beneficiaries you have designated under your Basic AD&D coverage
- To your surviving spouse/domestic partner
- To your surviving child or children, in equal shares
- To your parents, in equal shares, or to the surviving parent
- To your surviving brothers and sisters, in equal shares, or their beneficiaries
- To your estate

If your covered dependent dies, the plan pays benefits to you.

Maximum Aggregate Business Travel Accident Benefit

In a catastrophic accident that results in significant loss to more than one covered person, the plan pays a maximum benefit for all losses of $40,000,000. If the total loss exceeds $40,000,000, each covered person or his or her beneficiary receives a proportionate share of the $40,000,000 based on the covered person's amount of insurance and determined by the insurance company.

Assignment of Coverage

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. An assignment required by law will only be honored if approved in advance of death by the plan.

GENERAL INFORMATION ABOUT LIFE AND ACCIDENT INSURANCE

Definition of Your Annual Base Pay

Your “annual base pay” for life and accident insurance purposes is your gross straight-time pay for regularly scheduled hours for a seven-day week, as determined by your business unit.

How Your Benefits Work Together

If you are injured in an accident and your injury is a covered loss, your AD&D insurance pays benefits directly to you. In the event of your accidental death, both your life insurance and AD&D insurance pay benefits to your beneficiaries. If you die while traveling on company business, your beneficiaries receive benefits from the business travel accident insurance plan, as well as the life and AD&D insurance plans.

Beneficiary Designation

Your beneficiary is the person or persons you choose to receive life and accident insurance benefits when you die. You also may choose your estate or living trust as the beneficiary of your life insurance benefits. If the beneficiary is under age 18, the insurance company may require that benefits be paid to a legal guardian on behalf of the minor.

Any benefits paid for loss of life under your life or AD&D coverage will be paid in the following order:

Making Changes

You may change your coverage amount or update your beneficiary information at any time through *NetBenefits*.

For more information on qualified changes in status see **Qualified Life Events**.

1. To the beneficiary or beneficiaries you have designated. You can designate your beneficiary online through the *NetBenefits* website at **netbenefits.com/northropgrumman**. If you do not have internet access or otherwise need assistance, please call the NGBC at 800-894-4194.
2. To your surviving spouse/domestic partner, if you have not designated a beneficiary or there is no surviving beneficiary at the time of your death
3. To your surviving child(ren) if (1) and (2) above do not apply
4. To your estate, if (1), (2), and (3) above do not apply

If you select optional insurance for your spouse/domestic partner or your children, you are automatically the beneficiary of that coverage.

Steps to Report a Death

To receive benefits under any of the life insurance plans, you or your beneficiary must report the death of the enrolled person. Here are some simple steps to follow to initiate the payment of life insurance benefits:

1. Call the NGBC at 800-894-4194 to report the death. The NGBC notifies the insurance company, gathers the necessary information, and provides you or your beneficiary with information about the payment of life insurance benefits.
2. You will be asked to provide certified copies of the death certificate, birth certificate, and marriage certificate of the deceased. These must be certified; photocopied certificates are not valid. You may also be required to provide other information, as requested by the insurance carrier.

Continuing Your Coverage through Conversion or Portability

If your (or your spouse/domestic partner's or dependents') coverage ends because your employment with Northrop Grumman ends or because you (or your spouse/domestic partner or dependents) are no longer eligible for coverage, you (and your spouse/domestic partner and dependents) may choose to either:

- Convert the terminating coverage to an individual policy of your own; or
- Use the plan's portability feature to continue the terminating life insurance coverage.

Conversion and portability are characterized as follows:

- **Conversion** allows you to convert all or a portion of the terminating life coverage to an individual policy (subject to conversion amount limitations, if applicable). Amounts you convert are no longer part of your Northrop Grumman coverage, and you are solely responsible for keeping the individual policy(ies) active. You pay the insurance company directly. Your cost is based on the insurance company's standard individual rates, which may differ from the rates you currently pay.
- **Portability** allows you to continue all or a portion of your basic and optional life and basic and optional AD&D coverage (for yourself, your spouse/domestic partner and/or your dependents) when that coverage would otherwise terminate. You pay the insurance company directly. Your cost is based on the insurance company's standard group rates, which may differ from the rates you currently pay.

The chart on the following page shows when the conversion features apply, and the conditions and limitations surrounding your choice to convert your terminating coverage.

CONVERSION	
What coverage can be converted?	• Your basic life coverage • Your optional life coverage for yourself, your spouse/domestic partner and your dependent children
When can you convert?	• When your employment ends (voluntarily or involuntarily) • When your coverage ends • When the Northrop Grumman group insurance policy terminates (life insurance only); most states limit the amount that can be converted in this case • When you retire • When your job changes and, as a result, you are no longer eligible to participate in the plan
Can a spouse/ domestic partner and dependent child(ren) convert their coverage?	• Yes, your spouse/domestic partner and child(ren) coverage can be converted
When can covered dependents convert?	• When your employment ends (voluntarily or involuntarily) • When you, the employee, retires • When you, the employee, die • When you and your spouse divorce or when you and your domestic partner terminate the domestic partnership (life coverage only) • When your child reaches age 26, if not totally disabled • When the Northrop Grumman group insurance policy terminates (life insurance only); most states limit the amount that can be converted in this case
What amount can be converted?	• You and/or your eligible dependent(s) can choose an amount to convert equal to but not greater than the amount of the group life insurance benefits being terminated or reduced • When benefits end at retirement, you can convert up to the full amount of group life insurance benefits that ended on the date of retirement less any retiree life insurance for which you may be eligible
Must I choose conversion within a certain time frame?	• If you would like to convert to an individual policy, you (or your spouse/domestic partner or dependent) must choose conversion, in writing, within 31 days of the date coverage ends • When you convert, the insurance company will issue a new policy, which becomes effective on the 32nd day after the date coverage ends
Is evidence of insurability (EOI) required?	• No, EOI is not required
What happens if I die within the first 31 days after coverage ends?	• Life insurance: If you die during the 31-day conversion period immediately after your coverage ended, your benefits are payable under the group life insurance policy

The following chart shows when the portability features apply, and the conditions and limitations surrounding your choice to port your terminating life insurance and AD&D insurance coverage.

PORTABILITY	
What coverage can be ported?	• Your basic and optional life and basic and optional AD&D coverage for yourself, your spouse/domestic partner and your dependent child(ren)
When can you port your coverage?	• When your employment ends (voluntarily or involuntarily) • When you retire and you do not have access to the same coverage through a retiree option • When your job changes and, as a result, you are no longer eligible to participate in the plan • When the Northrop Grumman group insurance policy terminates
When can you NOT port your coverage?	• When you retire and you have access to the same coverage through a retiree option
How long will the portable coverage be in effect, and what reductions apply?	• Coverage reduces 50% on January 1 of the year that you reach age 70 • Coverage terminates on January 1 of the year you reach age 100
Can a spouse/domestic partner and dependent child(ren) port their coverage?	• Yes, your spouse/domestic partner and child(ren) coverage can be ported
When can a spouse/ domestic partner and dependent child(ren) port their coverage?	• When your employment ends (voluntarily or involuntarily) • When you, the employee, retires • When your job changes and, as a result, you are no longer eligible to participate in the plan • When you, the employee, die • When you and your spouse divorce
How long will the ported dependent coverage remain in effect?	• Ported spouse/domestic partner coverage continues until your spouse/domestic partner reaches age 70 • Ported child(ren) coverage continues until the child(ren) reaches the limiting age
What amount can be ported?	• The maximum amount of coverage that can be ported is the current amount of coverage, subject to state availability, up to $2,000,000 for the employee • Up to $500,000 for the spouse/domestic partner • Up to $30,000 for dependent child(ren)
What is the minimum portable benefit?	• The minimum amount of coverage that can be ported is: • $10,000 of group term life coverage for the employee • $2,500 for the spouse/domestic partner when you port your life insurance • $10,000 for the spouse/domestic partner if you do not port your life insurance • $1,000 for dependent child(ren)

PORTABILITY	
Can ported coverage be increased or decreased?	• Yes, coverage can be increased • Coverage can be decreased; however, once coverage is decreased, you will be required to provide EOI to increase coverage
Is evidence of insurability (EOI) required?	• No, EOI is not required
Can you choose to convert your ported coverage?	• You may convert the ported amount; however, the ported coverage must terminate before a conversion policy will be issued

Choosing Conversion or Portability

You must choose conversion or portability in writing within 31 days of the date coverage ends. Your new policy becomes effective the first day after the 31-day conversion period ends.

For more information, contact the NGBC at 800-894-4194.

Short- and Long-Term Disability

A disabling sickness or injury can be financially devastating. Northrop Grumman's Short- and Long-Term Disability plans provide financial protection to help you and your family if you are unable to work due to sickness or injury.

Short-Term Disability (STD) benefits may replace part of your income if you are unable to work for an extended period of time because of a covered sickness or injury, up to 26 weeks.

Northrop Grumman also provides you with the protection of Long-Term Disability (LTD) insurance for yourself, with the option to purchase additional coverage at favorable group rates, to provide income replacement to you and your family should you become temporarily or permanently disabled.

SHORT-TERM DISABILITY (STD)

Overview

Your STD benefits are designed to provide you with income for up to 26 weeks if you are absent from work due to an eligible illness or injury. The plan administrator has engaged American Family Life Assurance Company of Columbus (AFLAC) to serve as the claims administrator for the plan. AFLAC does not insure the STD benefits provided under the plan. STD benefits are self-insured.

For More Information

For important additional information about the benefits described in this section, be sure to review the **Eligibility and Participation** and **General Plan Administration** sections of this SPD.

Note: If you are an Independence, MO represented employee, your coverage will be affected after a 120-day probationary period. Bacchus represented employees have a 365-day benefit waiting period before coverage is effective.

STD Coverage

If you are eligible for company-paid STD coverage, you are automatically enrolled. Northrop Grumman provides this coverage at no cost to you.

If you meet the plan's definition of disability, the STD plan will pay up to 100% of your base weekly earnings for the first six weeks of your disability, then 60% of your base weekly earnings for the next 20 weeks of your disability, up to a maximum benefit of $4,000 per week, with the following exceptions:

	SBUs	Sunnyvale Represented	Baltimore Salaried Represented**	Baltimore Hourly Represented	Bacchus Represented
First weekly benefit (percentage of your base weekly earnings)*	60%	70%	100%	70%	80%
Duration	26 weeks	6 weeks	6 weeks	6 weeks	26 weeks
Second weekly benefit (percentage of your base weekly earnings)*	N/A	50%	60%	60%	N/A
Duration	N/A	20 weeks	20 weeks	20 weeks	N/A
Maximum weekly benefit	$2,000	$4,000	$4,000	$4,000	N/A

*The STD benefit will be reduced to 10% base weekly earnings to a maximum benefit of $4,000 per week if you elect to retire while receiving benefits.
**If STD is approved, you may be eligible for salary continuance.

For disabilities due to sickness or pregnancy, there may be an elimination period, or waiting period, before you are eligible for benefits. If applicable, the elimination period counts against the 26 weeks of disability. This means that if an elimination period applies, you will not receive benefits under the STD plan for your first week of your disability, and then you will be entitled to 100% of your base weekly

earnings for up to five weeks, and then 60% of your base weekly earnings for the next 20 weeks of your disability, up to a maximum benefit of $4,000 per week. However, you may use Paid Time Off (PTO) to be paid during the elimination period. If you are an ABL (Local 261c) represented employee and you use PTO during the elimination period, your PTO will be reimbursed once a year if your STD is approved.

Please note: Your payment may be reduced by deductible sources of income and in some cases by the income you earn while disabled. Some disabilities may not be covered under this plan (see **How STD Benefits Integrate With Other Deductible Sources of Income** for details).

When Your Coverage Begins

You will automatically be covered at 12:01 a.m. on your date of hire. If you are an Independence, MO represented employee, your coverage begins after you complete your 120-day probationary period. Bacchus represented employees have a 365-day waiting period before coverage is effective.

If you are absent from work due to injury or sickness on the date your coverage would first begin, your coverage will begin on the date you return to active employment. If you are temporarily not working once your coverage begins, your coverage will continue in accordance with Northrop Grumman's leave of absence policy if your business unit approved your leave in writing.

When Your Coverage Ends

Your STD coverage under the plan ends on the earliest of:

- The date the plan is terminated by Northrop Grumman;
- The date the business unit that employs you ceases to offer STD benefits to employees through the plan;
- The date the plan is amended to eliminate STD benefits;
- The date you are no longer in an eligible group;
- The date your eligible group is no longer covered; or
- The last day you are in active employment.

Questions?

If you have questions not answered in this SPD, contact the NGBC.

Hours:

8:30 a.m. to midnight ET,
Monday – Friday
(except most New York Stock Exchange holidays)

Phone:

U.S.: 800-894-4194

International: Dial the AT&T out-of-country access number, then 800-894-4194

TTY: 888-343-0860

When You Are Eligible to Receive STD Benefit Payments

- You must meet the plan's definition of disability (see **How Disability Is Defined** for details)
- You must be continuously disabled through your elimination period in order to be eligible for benefits. The elimination period is:
  - 0 days for a disability due to an injury*
  - 7 days for a disability due to a sickness or pregnancy*

Note: Baltimore, Sunnyvale and Bacchus represented employees have a 0-day elimination period for a disability due to hospitalization or receipt of care at an outpatient surgical facility.

Baltimore represented employees hired or transferred after January 1, 2016 and Baltimore Hourly represented employees hospitalized or receiving care at an outpatient facility due to sickness must satisfy the 7-day elimination period for disability due to sickness.

**Bacchus represented employees have a 2-day elimination period for disabilities due to injury, sickness or pregnancy. The AS SBU employees have a 7-day elimination period for disabilities due to injury, sickness or pregnancy.*

- If you meet the definition of disability as defined below under **How Disability Is Defined**, you may satisfy your elimination period while you are working a reduced schedule or part time as long as your disability results in a loss of income equaling 20% or more or your weekly earnings. A new elimination period will be applied to each disability (see **If You Return to Work and Become**

Disabled Again for details). You must be under the regular care of a licensed physician and receiving the most appropriate treatment for your condition*.

- You must be under the regular care of a licensed physician and receiving the most appropriate treatment for your condition.
- Your disability must not have been caused by any of the exclusions that apply (see **Exclusions: Disabilities Not Covered Under the STD Plan** for details).

You will begin to receive weekly payments when your claim is approved, provided the elimination period has been met. After the elimination period, if you are disabled for less than one week, you will receive 1/7th of your weekly payment for each day of disability.

**Does not apply to AS SBU employees or Baltimore and Sunnyvale represented employees.*

How Disability Is Defined

You are disabled when the claims administrator determines that due to your sickness, injury or pregnancy-related condition:

- You are limited from performing the material and substantial duties of your regular occupation; and
- You have a 20% or more loss in weekly earnings due to that same sickness or injury.

Note: For AS SBUs and Baltimore and Sunnyvale represented employees, disability is determined by the following:

- You are unable to perform the material and substantial duties of your regular occupation; and
- You are not working in any occupation.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

The claims administrator may require you to be examined by a physician, other medical practitioner and/or vocational expert chosen by the claims administrator. This examination will be at no cost to you and can be required as often as it is reasonable to do so. The claims administrator may also require a personal interview with you.

Birth Parent STD Benefits

If you have a vaginal delivery, you will be considered disabled for a minimum period of six weeks beginning on the date of the birth, unless you are released to return to work prior to the end of six weeks. If you have a Cesarean section, you will be considered disabled for a minimum period of eight weeks beginning on the date of your Cesarean section, unless you are released to return to work prior to the end of the eight weeks. A 7-day* elimination period applies to childbirth, and this 7-day elimination period counts against the six-week (in the case of a vaginal delivery) or eight-week (in the case of a Cesarean section) period during which the plan will consider you to be disabled. Benefits may be continued beyond this initial six or eight-week period if medical complications exist that continue to meet the Plan's definition of disability.

If you are pregnant and cease working before delivery, STD benefits will be payable if the claims administrator determines that your pre-delivery absence from work is medically appropriate. In this instance, the disability would be considered a disability due to sickness and is therefore subject to a 7-day* elimination period during which no STD benefits will be paid. Refer to the **Qualified Life Events** section for information regarding how STD coverage is impacted by other qualified life events and special situations.

Bacchus represented employees have a 2-day elimination period. There is no elimination period for hospitalization due to childbirth for Bacchus, Baltimore and Sunnyvale represented employees.

Definition of Base Weekly Earnings

Your base weekly earnings is your gross weekly income just prior to your disability as defined in the plan. Your base weekly earnings may be derived from the base earnings amount column on your pay check.

If you become disabled while you are on an approved leave of absence, and your STD coverage is in effect at that time, your base weekly earnings for the purposes of this plan will be your base weekly earnings in effect just prior to the date your absence began.

Minimum Benefit*

If you are eligible to receive STD payments, the minimum weekly benefit after any deductible sources of income is $25.

Does not apply to Independence MO, Baltimore and Sunnyvale represented employees.

How and When to Claim STD Benefits

When you experience absences related to a sickness, injury or pregnancy — whether it is work-related or not — always follow your business unit's procedures for reporting time away from work. You must also notify the claims administrator of your claim as soon as possible, so that a claim decision can be made in a timely manner.

Notify your manager or supervisor of your absence from work. If you are injured at work, notify your manager or supervisor immediately, unless it is an emergency.

To file a claim, call AFLAC at 800-244-8017 and provide your claim information to AFLAC's customer care advocate or visit **mygrouplifedisability.aflac.com** and complete the registration process. As part of the disability process, you'll need to authorize AFLAC to obtain the necessary medical information from your attending physician on your behalf. You have a few ways to complete the authorization including:

- Signing the Authorization Form in AFLAC's portal through the website at **mygrouplifedisability.aflac.com**
- Printing, signing, dating and:
  - Uploading to AFLAC's portal
  - Emailing to AFLAC at **myPLADSleave@aflac.com**
  - Faxing to AFLAC at 800-206-9472

The claims administrator will notify you if they are unable to obtain your medical information. You must assist in obtaining this information. It is your responsibility to substantiate your disability.

Proof of Continuing Disability

The claims administrator may request that you send proof of continuing disability indicating that you are under the regular care of a physician. This proof, which must be provided at your expense, must be received within 45 days of a request.

Note: You must report a claim to the claims administrator within 30 days after the date your disability begins, unless you lack legal capacity to submit notice of a claim by that date. In addition, you must send the claims administrator written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be provided no later than one year after the time proof is otherwise required, except in the absence of legal capacity. If you do not provide written notice of a claim and written proof of a claim by the required dates, STD benefits will not be paid for that disability.

Your proof of claim must show:

- That you are under the regular care of a physician
- The appropriate documentation of your base earnings
- The date your disability began
- The cause of your disability
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation
- The name and address of any hospital, institution, or other establishment where you received treatment, including all attending physicians' names and addresses

You must pay any costs incurred to obtain and submit the information that is required by the claims administrator.

In some cases, you will be required to give authorization for the plan to obtain additional medical information, and to provide non-medical information as part of your proof of claim, or proof of continuing disability. If the appropriate information is not submitted, your claim may be denied or terminated.

Federal and State tax withholdings are mandatory under this plan. The claims administrator will deduct the taxes at the maximum applicable Federal tax rate and State tax, according to where you live. You may change your withholding by providing a completed W-4 form to the claims administrator to apply your applicable Federal and State tax withholdings. This form will be provided to you with your initial claim packet.

How Your STD Payments Are Determined

Benefits will be calculated at 100%* of your weekly base pay for the first 6 weeks* of disability. After 6 weeks* any benefits payable for weeks 7* through 26* will be calculated by taking your base weekly earnings multiplied by 60%.* At no point will disability benefits be paid for an amount greater than the plan's maximum weekly benefit of $4,000.* Your gross disability benefit will be reduced any deductible sources of income (see **How STD Benefits Integrate With Other Deductible Sources of Income** for details).

You will receive 1/7th of your weekly STD benefit (calculated above) for each day during the week that you qualify for disability benefits. For this purpose, the week is considered to begin on a Monday and end on the following Sunday. Please note that when you are entitled to 100% of your base weekly earnings, the amount you receive may be slightly more or slightly less than what you would have received if you had continued to receive a paycheck from Northrop Grumman. Likewise, when you are entitled to 60% of your base weekly earnings, the amount you receive may be slightly more or slightly less than 60% of what you would have received if you had continued to receive a paycheck from Northrop Grumman. This is because you are entitled to 1/7th of your STD benefit for each day in the week in which you qualify for benefits, based on a Monday through Sunday week. However, depending on your sector, the normal Northrop Grumman paycheck you receive might be based on a 5-day work week, and payroll might not be processed on a Monday through Sunday weekly basis. Thus, depending on the day of the week in which you begin your entitlement to disability benefits and the day of the week when benefits cease, the actual amount you receive under this Plan may be slightly more or slightly less than the applicable percentage (100% or 60%) of what you would have received if you had continued to receive a paycheck.

Please refer to the benefit percentages, duration of benefits and maximum weekly benefit amounts for your business unit or collective bargaining agreement (see* **STD Coverage*).*

If You Are Working While Disabled*

The claims administrator will send you your full weekly disability benefit payment if you are disabled and your weekly disability earnings, if any, are 20% or less of your weekly earnings.

**Does not apply to AS SBU represented employees or Baltimore and Sunnyvale represented employees.*

If you are disabled and your weekly disability earnings are from 20% through 80% of your weekly earnings (with the reduction being due to the same sickness or injury), your payment will be calculated as follows:

- While working, your weekly payment will not be reduced as long as your disability earnings plus your gross disability payment does not exceed 100% of your weekly earnings
    1. Add your weekly disability earnings to your disability payment
    2. Compare the answer in item 1 to your weekly earnings
- If the answer from item 1 is less than or equal to 100% of your weekly earnings, the claims

administrator will not further reduce your weekly payment

- If the answer from item 1 is more than 100% of your weekly earnings, the claims administrator will subtract the amount over 100% from your weekly payment

Consider the following example:

John began to qualify for STD benefits due to an injury (and thus not subject to an elimination period) on Wednesday, Jan. 3, 2024. He ceased to be considered disabled and returned to work on Thursday, March 14, 2024. His base weekly earnings were $700 and he had no deductible sources of income. He would be paid 100% of his base weekly earnings for the first 6 weeks of his disability (in this case, through Tuesday, Feb. 13, 2024), and then 60% of his base weekly earnings until he returned to work on March 14, 2024. John's payments would be calculated as follows:

WEEK	PAYMENT
Wednesday, Jan. 3 – Sunday, Jan. 7 (5 days)	$500 (5/7^{ths} of 100% of $700)
Monday, Jan. 8 — Sunday, Jan. 14 (7 days)	$700 (100% of $700)
Monday, Jan. 15 — Sunday, Jan. 21 (7 days)	$700 (same)
Monday, Jan. 22 — Sunday, Jan. 28 (7 days)	$700 (same)
Monday, Jan. 29 — Sunday, Feb. 4 (7 days)	$700 (same)
Monday, Feb. 5 — Sunday, Feb. 11 (7 days)	$700 (same)
Monday, Feb. 12 — Sunday, Feb. 18 (7 days)	$500 (2/7^{ths} of 100% of $700 + 5/7^{ths} of 60% of $700)*
Monday, Feb. 19 — Sunday, Feb. 25 (7 days)	$420 (60% of $700)
Monday, Feb. 26 — Sunday, March 3 (7 days)	$420 (same)
Monday March 4 — Sunday, March 10 (7 days)	$420 (same)
Monday March 11 — Wednesday, March 13 (3 days)	$180 (3/7^{ths} of 60% of $700)

**John's 6th week of disability would end on Tuesday, Feb. 16. Thus, he was entitled to 100% of his base weekly earnings for 2/7^{ths} of that week, and 60% of his base weekly earnings for the remainder (5/7^{ths}) of the week.*

You are required to send proof of your disability earnings each week. Your weekly payment will be adjusted based on your disability earnings. As part of your proof of disability earnings, you are required to send appropriate financial records necessary to substantiate your income.

If Your Claim Is Overpaid

The plan has the right to recover any overpayments due to:

- Fraud
- Any error made in processing a claim
- Any advance payments made to you by the plan while the claims administrator is collecting medical

evidence, if sufficient medical evidence supporting a disability determination is not timely provided

- Your receipt of deductible sources of income (see **How STD Benefits Integrate With Other Deductible Sources of Income** for details)

You must repay the plan for any overpayment in your claim. Alternatively, the claims administrator may reduce or eliminate future payments instead of requiring repayment or the plan administrator may collect the overpayment for the plan by deducting it from any payments due to you from Northrop Grumman, including any pay or other earnings, without your authorization.

The Plan will not recover more money than the amount that was paid to you.

How STD Benefits Integrate With Other Deductible Sources of Income*

The STD benefit payments you receive are offset dollar for dollar by other sources of income you receive (or are entitled to receive) while on disability.

Any payments you receive (or are entitled to receive) under the following sources of income will be subtracted from your gross STD benefit payments:

- Disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan including foreign government plans, for which you are eligible because of your Total Disability
- Workers' compensation, occupational disease, or similar insurance benefit payments that you receive or are eligible to receive
- State disability
- Government pension – Pension in the event it is drawn in place of Social Security
- Northrop Grumman pension – Pension payments received due to participant's retirement, including payments from any plan that is sponsored by Northrop Grumman. Whether pension payments are subject to offset under this clause shall be determined by the claims administrator. Payments received by the participant on behalf of a spouse's retirement will not be deducted.
- Northrop Grumman or business unit accumulated sick leave plan
- Payments received under the Defense Base Act (DBA)
- Payments received under Title 26, United States Code Section 688 (The Jones Act)
- Payments classified by Northrop Grumman as "sick pay" payments, including, but not limited to, payments required to be paid pursuant to a state law

Note: For Baltimore represented employees, benefits will be deducted from the End of Year Vacation Lump Sum Payout.

If the claims administrator determines that you may qualify for benefits under Social Security, state disability or workers' compensation, the claims administrator will estimate your entitlement to these benefits. The claims administrator can reduce your payment by the estimated amounts if such benefits:

- Have not been awarded; and
- Have not been denied; or
- Have been denied and the denial is being appealed.

Your STD benefit payment will not be reduced by the estimated amount if you:

- Apply for the disability payments under primary Social Security, state disability or workers' compensation and appeal your denial to all administrative levels the claims administrator feels are necessary; and
- Sign the payment option form. This form states that you promise to pay the plan any overpayment caused by an award.

If your payment has been reduced by an estimated amount, your payment will be adjusted when the claims administrator receives proof:

- Of the amount awarded; or
- That benefits have been denied and all appeals the claims administrator feels are necessary have been completed. In this case, a lump sum refund of the estimated amount will be paid to you.

If you receive your Northrop Grumman pension in a lump sum, the lump sum payment will be converted to a life only equivalent by the pension administrator, and that amount will be used by the claims administrator to determine the amount that will be deducted from your STD payments.

If you receive a lump sum payment from any other deductible sources of income, the lump sum will be prorated on a weekly basis over the time period for which the sum was given. If no time period is stated, the sum will be prorated on a weekly basis to the end of the maximum period of payment.

If subtracting deductible sources of income results in a zero benefit, you will receive the minimum weekly benefit of $25. The claims administrator may apply this amount towards an outstanding overpayment, which may result in no payment.**

***Does not apply to Independence MO, Baltimore and Sunnyvale represented employees.*

Income from the following sources will **not** be subtracted from your STD benefit payments:

- 401(k) plans
- Profit sharing plans
- Thrift plans
- Tax sheltered annuities
- Stock ownership plans
- Non-qualified plans or deferred compensation
- Pension plans for partners
- Military pension and disability income plans
- Credit disability insurance
- Franchise disability income plans
- A retirement plan from another employer except a retirement plan from another employer for which Northrop Grumman (including any division, subsidiary or affiliated company) assumed financial liability or which was merged into a Northrop Grumman (including any division, subsidiary or affiliated company) retirement plan. AFLAC may obtain additional information from Northrop Grumman to determine whether a retirement plan is a Northrop Grumman retirement plan.
- Individual retirement accounts (IRA)
- Individual disability income plans
- The amount received from any mandatory portion of a "no-fault" motor vehicle plan

- Severance benefit payments
- Vacation/PTO payments

* Please note that, if you are a union employee, how your STD benefits integrate with other sources of income will be subject to the terms of your collective bargaining agreement.

Returning to Work

You must notify AFLAC of your intent to return to work in any capacity by entering your return to work date in the AFLAC portal (**mygrouplifedisability.aflac.com**) or by calling 800-244-8014. In addition, you must follow your Sector procedures for return to work.

If You Return to Work and Become Disabled Again

If you experience a second disability within 30* consecutive days or less of your return to any occupation on a full-time basis, and the disability is related to or due to the same cause(s) as your prior disability for which STD benefits were paid, you will not have to complete another elimination period. Payments will resume up to the 26-week maximum.

If your second disability is unrelated to your prior disability for which STD benefits were paid, and it occurs less than one full day after your return to any occupation on a full-time basis, the claims administrator will treat your current disability as part of your prior claim, payments will resume up to the 26-week maximum, and you will not have to complete another elimination period.

Your disability, as outlined above, will be subject to the same terms of the plan as your prior claim.

If your second disability does not fall within the parameters described above, it will be treated as a new claim and will be subject to all of the plan provisions.

If you become entitled to payments under any other group short-term disability plan, you will not be eligible for payments under this Plan.

**14 consecutive days for Baltimore and Sunnyvale represented employees.*

When Your STD Payments End

STD benefits will be paid on a weekly basis, up to 26 weeks (the maximum period of payment including any elimination period). However, your STD benefit payments will end sooner when the first of these events occurs:

- The date you are no longer employed;
- When you are able to work in your regular occupation on a part-time basis or with an accommodation but you choose not to*;
- The date you are no longer disabled under the terms of the plan;
- The date you fail to submit proof of continuing disability, including refusal of an independent medical examination requested by the claims administrator;
- The date your disability earnings exceed the amounts allowable under the plan; or
- The date you die.

**Does not apply to AS SBU, Baltimore and Sunnyvale represented employees.*

Exclusions: Disabilities Not Covered Under the STD Plan

The plan does not cover any disabilities caused by, contributed by, or resulting from your:

- Commission of a crime for which you have been convicted under state or federal law,
- Active participation in a riot,
- Intentionally self-inflicted injuries, while sane or insane, or
- Loss of a professional license, occupational license or certification.

The plan will not pay a benefit for any period of disability during which you are incarcerated.

LONG-TERM DISABILITY (LTD)

Overview

Your long-term disability (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.

Northrop Grumman provides two kinds of LTD insurance — basic and optional. The insurance company for LTD coverage is AFLAC. AFLAC, not Northrop Grumman, is responsible for the payment of all benefits covered under the LTD insurance contract and has the sole authority, discretion and responsibility to interpret the terms of the LTD contract.

For More Information

For important additional information about the benefits described in this section, be sure to review the **Eligibility and Participation** and **General Plan Administration** sections of this SPD.

Note: The basic and optional LTD coverage described in this section is not available to you if you are eligible for other LTD coverage provided by Northrop Grumman such as the Bacchus Union Disability Wage Plan benefit.

The LTD plan does not pay benefits for a disability that is the result of an illness or injury that you had within three months of joining the plan (unless the disability begins after 12 months of continuous coverage). For details about this and other exclusions, see **Exclusions: Disabilities Not Covered Under the LTD Plan**.

Basic LTD Coverage

If you are eligible for company-paid basic LTD coverage, you are automatically enrolled in the basic LTD plan on your date of hire. If you are an Independence, MO represented employee, your LTD coverage begins after you complete your 120-day probationary period. Northrop Grumman provides this coverage at no cost to you.

The basic LTD plan pays 50% of your monthly base earnings at the time of your disability, minus any other disability benefit income you might receive, up to a maximum benefit of $15,000 per month. See **How LTD Benefits Integrate With Other Sources of Income** for details.

Optional LTD Coverage

If you are eligible for company-paid basic LTD coverage, it will replace 50% of your monthly base earnings, if you cannot work due to a disability and you qualify for LTD benefits. If you think you might need more, you have the opportunity to increase your LTD benefit by purchasing optional coverage. You may purchase:

- An additional 10%, for total LTD coverage (basic and optional) equal to 60% of your monthly base earnings*
- No optional LTD coverage

Minus any other disability benefit income you might receive, up to a benefit maximum of $15,000 per month (see* **How LTD Benefits Integrate With Other Sources of Income *for details).*

You pay the full cost of any optional LTD coverage you choose with after-tax dollars. As a result, if you become disabled, your optional LTD benefit payments are not subject to income taxes. Because the benefits attributable to your optional LTD coverage would be non-taxable to you, your actual take-home pay would be greater than if you were paid 60% of your base pay as taxable wages.

Your cost for optional LTD coverage is based on your monthly base earnings and will increase or decrease as your base earnings change.

SELECTING OR CHANGING OPTIONAL LTD COVERAGE

You can select or change your optional LTD coverage at the following times:

- Within 31 days of when you first become eligible (usually your date of hire)
- During annual enrollment
- At any other time outside of annual enrollment (for example, as a result of a qualified life event)

To select or change optional LTD coverage at any time other than when you are first hired or during annual enrollment, call the NGBC at 800-894-4194.

When You Are Eligible to Receive LTD Benefit Payments

- You must meet the plan's definition of disability (see **How Disability Is Defined**)
- You must be continuously disabled for the elimination period, which is the later of six months or the expiration of any Northrop Grumman-sponsored STD plan benefits. Your disability will be treated as continuous if your disability stops for 30 days or less during the elimination period. That means that you do not have to complete another elimination period. The days that you are not disabled will not count toward your elimination period.
- You must be under the regular care of a licensed physician and receiving the most appropriate treatment for your condition
- Your disability is not caused by any of the exclusions that apply (see **Exclusions: Disabilities Not Covered Under the LTD Plan** for details)

During your disability period, you must provide proof of your continuous disability when the insurance company requests it. Otherwise, your benefit payments end.

Before you become eligible for LTD, you may be eligible for benefits under the policies that apply to your Northrop Grumman business unit. These benefits may include paid absence, extended paid absence, and STD insurance benefits. And, if you live in California, Hawaii, New Jersey, New York, Rhode Island, or Puerto Rico, you may be eligible for mandatory state disability insurance (SDI). For more information about these disability benefits, contact AFLAC.

How Disability Is Defined

During the first 24 months of your disability, AFLAC considers you disabled if:

- You are unable to perform the material and substantial duties of your regular occupation due solely to your sickness or injury;
- You are under the regular care of a physician; and
- You have a 20% or more loss in your indexed monthly base earnings due to that sickness or injury.

After 24 months benefits have been payable, you are considered disabled when AFLAC determines that due to the same sickness or injury:

- You are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience;You are under the regular care of a physician; and
- You have a 40% or more loss in your indexed monthly earnings due to the same sickness or injury.

AFLAC considers your regular occupation as it is normally performed on a national economy basis, not how it is performed for Northrop Grumman or at a specific location. AFLAC will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from your physicians, and physicians and medical practitioners or vocational experts of AFLAC's choice.

Definition of Base Earnings

Your cost for optional LTD coverage is based on your monthly base earnings, as defined by your business unit. The amount of your LTD benefit is based on your monthly base earnings on your last day of work. Contact AFLAC for details.

For the purpose of determining your LTD benefit payments, the plan uses your monthly base earnings. Your benefit payment from the plan will not be adjusted for cost of living increases, inflation, or any other similar adjustment factor.

Minimum Benefit

If you qualify for LTD benefits, the minimum monthly benefit is the greater of:

- $100
- 10% of your gross disability payment

If necessary, AFLAC may apply this amount toward an outstanding overpayment.

How and When to Claim LTD Benefits

When you experience an illness or injury — whether it is work-related or not — always follow your business unit's procedures for reporting illnesses and injuries. Also, you should notify AFLAC of a claim for LTD benefits as soon as possible to ensure that a claim decision can be made in a timely manner. Contact AFLAC within 90 days after the start of your disability.

To ensure that your claim is processed in a timely and confidential manner, call AFLAC at 800-244-8017, and a customer care advocate will start the claim process for you. You will be asked to sign an authorization form, allowing AFLAC to obtain the appropriate medical information from your doctor. If AFLAC is unable to obtain your medical information, you will receive a letter and the appropriate forms, which you should complete and return by the date provided.

You must notify AFLAC immediately if you return to work in any capacity.

How LTD Benefits Integrate With Other Sources of Income

The benefit payments you receive under the basic and optional LTD plans are offset dollar-for-dollar by other disability income benefits that you, your spouse and children receive — or are entitled to receive — for the same disability.

For example, let's assume your LTD coverage is 50% of your monthly base earnings, which is $3,000. Your monthly LTD benefit payment is $1,500 (50% x $3,000). If you and your family members are

eligible for a monthly Social Security benefit of $500 based on your disability, your adjusted monthly LTD benefit payment will be $1,000 ($1,500 - $500).

These types of benefit payments may be subtracted from your LTD benefit payments:

- Workers' compensation, occupational disease, or similar insurance benefit payments that you receive or are eligible to receive.
- Benefit payments under a state compulsory benefit act or law or another group insurance plan.
- Benefit payments under a government retirement system as a result of your job with Northrop Grumman.
- Retirement benefit payments you voluntarily elect to receive under your Northrop Grumman retirement plan or receive when you reach the later of age 62 or the normal retirement age, as defined under your Northrop Grumman retirement plan:
  - Northrop Grumman's retirement plans include any retirement plan for which Northrop Grumman (including any division, subsidiary or affiliated company) assumed financial liability or which was merged into a Northrop Grumman retirement plan. AFLAC may obtain additional information from Northrop Grumman to determine whether a retirement plan is a Northrop Grumman retirement plan.
  - Disability benefit payments from a retirement plan that reduce the retirement benefit under the retirement plan will be considered a retirement benefit for purposes of this provision and such payment amounts will be subtracted from your LTD benefit payments.
  - Retirement benefit payments attributable to your contributions to the retirement plan are not subtracted from your LTD benefit payments. Regardless of how you receive retirement benefit distributions, for purposes of determining the portion of any retirement benefit payment that is attributable to your contributions, AFLAC will consider your and Northrop Grumman's contributions to be distributed simultaneously throughout your lifetime.
  - Amounts received include amounts rolled over or transferred to any eligible retirement plan. AFLAC will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code, including any future amendments which affect the definition.
- Disability benefit payments you receive under your Northrop Grumman retirement plan, if applicable. Disability benefit payments include payments under your retirement plan that are paid due to disability and do not reduce the retirement benefit that would have been paid without a disability.
- The amount that you, your spouse and your children receive or are entitled to receive as disability payments because of your disability under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act:
  - The amount that you receive as retirement payments or the amount your spouse and children receive as retirement payments because you are receiving retirement payments under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act. However, if you were age 65 or older when you became disabled and you were already receiving Social Security retirement payments, the offset does not apply to this income.

Your LTD benefit is not offset by any Social Security disability or retirement payments that your spouse and/or children receive based on their own disabilities or under their own retirement plans.

- The amount that you receive under Title 46, United States Code Section 688 (the Jones Act)
- The amount that you receive under a salary continuation or accumulated sick leave plan

Your benefit will be reduced only by income that is payable as a result of the same disability, with the exception of retirement payments.

Income from the following sources will **not** be subtracted from your LTD benefit payments:

- 401(k) plans
- Profit sharing plans
- Thrift plans
- Tax-sheltered annuities
- Stock ownership plans
- Non-qualified plans of deferred compensation
- Pension plans for partners
- Military pension and disability income plans
- Credit disability insurance
- Franchise disability income plans
- A retirement plan from another employer except a retirement plan from another employer for which Northrop Grumman (including any division, subsidiary or affiliated company) assumed financial liability or which was merged into a Northrop Grumman (including any division, subsidiary or affiliated company) retirement plan. AFLAC may obtain additional information from Northrop Grumman to determine whether a retirement plan is a Northrop Grumman retirement plan.
- Individual retirement accounts (IRA)
- Severance benefit payments
- Individual disability income plans
- The amount received from any mandatory portion of a “no-fault” motor vehicle plan

Social Security Disability Benefits

The LTD plan coordinates its payments with the income you receive (or are eligible to receive) from Social Security, as described in the **How LTD Benefits Integrate With Other Sources of Income** section. AFLAC can provide assistance with your Social Security application process or any appeal.

Social Security benefit payments can begin after you are disabled for five consecutive calendar months if your disability is permanent or expected to last at least 12 consecutive months. Benefit payments continue during your disability, up to your normal retirement date. Your normal retirement date under Social Security depends on your year of birth, as shown in the following chart.

SOCIAL SECURITY NORMAL RETIREMENT DATE	
Your Year of Birth	**Your Social Security Normal Retirement Date**
Before 1938	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-1954	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
After 1959	67

It is your responsibility to apply for Social Security disability benefits.

Rehabilitation: Transitioning Back to Work

The Northrop Grumman long-term disability program includes rehabilitation to ease your transition back to work. You can continue to receive LTD benefit payments while you work in a job that is tailored to fit your abilities and the limitations created by your disability.

Rehabilitation work may be in your previous position, a different position at Northrop Grumman or, if necessary, a position with another employer. Northrop Grumman also considers your requests for reasonable accommodations and evaluates each request on a case-by-case basis.

If you are eligible for the vocational rehabilitation program, the claims administrator may assign a rehabilitation counselor to you. Your counselor will try to arrange a suitable job that you are able and qualified to perform. This may involve customizing a position and work setting to fit your individual needs. If your disability is work-related, your rehabilitation counselor coordinates his or her efforts with your workers' compensation rehabilitation counselor. While you participate in the vocational rehabilitation program, you may receive an additional benefit of 10% of your gross disability benefit to a maximum of $5,000. Please contact AFLAC, the claims administrator, for more information about this additional benefit.

Your disability benefit payments will not be offset by any return-to-work earnings you receive for the first 12 months of an attempted return to work, unless your gross benefit combined with your return-to-work earnings exceeds 100% of your indexed pre-disability base earnings.

After benefits have been payable for 12 months, while working, the amount of your monthly benefit will change and a portion of your disability earnings will be considered a deductible source of income. Fifty percent of your disability earnings will be added to your other deductible sources of income, if any. The sum will be deducted from your gross disability benefit. This amount will be your monthly benefit. For more information about indexed pay, see **Definition of Base Earnings**.

If You Return to Work and Become Disabled Again

If you experience a second disability within six months of your return to full-time work, and it is caused by the same medical condition as the first, then the two are considered a single disability and you do not have to complete a new elimination period.

If the second disability occurs after six months of returning to work, or is caused by a different condition, it is considered a separate disability. In this case, you must complete a new elimination period before you are eligible to reapply for LTD benefit payments.

For example, assume in January 2021 you experience an illness or injury, and the insurance company approves your LTD benefit payment. On August. 1, 2021, you return to work after seven months of disability. At that point, you received one month of LTD benefit payments after completing the elimination period.

- If this illness or injury disables you again **within** six months after you return to work (or by the end of January 2021), the insurance company considers this the same condition as the first. You do not have to complete a new elimination period, your LTD benefit payments, if approved, can begin immediately.
- However, if this illness or injury disables you again **after** six months after you return to work (on or after February 1, 2021), this is considered a separate disability. In this case, you must complete a new elimination period before you are eligible to reapply for LTD benefit payments.
- If an entirely different illness or injury disables you again at any time after you return to work, this is considered a separate disability. In this case, you must complete a new elimination period before you are eligible to reapply for LTD benefit payments.

Disabilities Based on Self-Reported Symptoms or Mental Illness

You may be eligible for LTD benefit payments for up to 24 months per lifetime for a disability based on self-reported symptoms or a disability due to a mental, nervous, or emotional disease or disorder.

If at the end of 24 months you are hospitalized or institutionalized due to your mental, nervous, or emotional disease or disorder, then your LTD benefits may continue until the first of the following occurs:

- You are released from the hospital or institution. If you are still disabled when you are discharged, you will continue to receive payments for a recovery period of 90 days.
  - If you are reconfined at any time during the 90-day recovery period and remain confined for at least 14 consecutive days, you will receive payments during that additional confinement and for one additional recovery period of up to 90 days
  - If you continue to be disabled and are reconfined after the 90-day recovery period for at least 14 consecutive days, you will receive payments during the length of the reconfinement
- Your benefit payments otherwise would end, as described in **When Your LTD Benefit Payments End**.

Self-reported symptoms refer to manifestations of your condition that are not verifiable using tests, procedures, or clinical examinations standard in the medical practice. Examples include, but are not limited to, headaches, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness and loss of energy.

Under the LTD plan, mental illness is defined as a psychiatric or psychological condition regardless of cause, such as schizophrenia, depression, manic-depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders, and other conditions. These conditions are usually treated by a mental health provider or other qualified provider.

When Your LTD Benefit Payments End

If your disability begins before age 60, your LTD benefit payments will end at age 65. If your disability begins at age 60 or older, your LTD benefit payments will end as shown here:

IF YOUR DISABILITY BEGINS AT AGE:	YOUR PAYMENTS MAY CONTINUE WHILE YOU ARE DISABLED FOR:
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 or older	12 months

However, your LTD benefit payments will end sooner when the first of these events occurs (see the exception for pilots below):

- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you choose not to (see **How Disability Is Defined**)
- After the first 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to (see **How Disability Is Defined**)
- The end of the maximum period of payment
- The date your disability earnings exceed the amount allowable under the plan
- The date you are no longer disabled under the terms of the plan
- The date you fail to submit proof of continuing disability
- The date you die

If you were employed as a pilot at the time you became disabled, your LTD benefit payments will end sooner when the first of these events occurs:

- When you are able to work in your regular occupation on a part-time basis but you choose not to (see **How Disability Is Defined**)
- The end of the maximum period of payment
- The date you are no longer disabled under the terms of the plan
- If you are working the date your monthly disability earnings exceed 80% of your indexed monthly earnings
- The date you fail to submit proof of continuing disability
- The date you die

Exclusions: Disabilities Not Covered Under the LTD Plan

The LTD plan does not pay benefits if your disability results from, is caused by, or is contributed by any of the following:

- Intentionally self-inflicted injuries
- Active participation in a riot
- Loss of a professional license, occupational license, or certification
- Commission of a crime for which you have been convicted under state or federal law
- A pre-existing condition when you apply for coverage when you first become eligible. You have a pre-existing condition if you received medical treatment, consultation, care, or other services, including diagnostic measures, or took prescribed drugs or medicines in the three months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage. In addition, the LTD plan will not cover an increase in your coverage made during an annual enrollment period or any other time during the plan year if you have a pre-existing condition. You have a pre-existing condition if you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the three months prior to the date your coverage increased; and the disability begins in the 12 months after your coverage increased.

You will not receive a benefit for any period of disability during which you are incarcerated.

If You Die While Receiving LTD Benefits

If you die while receiving LTD benefits, your eligible survivor may receive a lump sum benefit equal to three months of your gross disability benefit. This benefit will be provided if, on the date of your death, you:

- Had been continuously disabled for 180 or more consecutive days, and
- Were receiving — or were entitled to receive — LTD benefit payments under the Plan.

Your eligible survivor is your spouse or your domestic partner; otherwise, your children under age 25. Your eligible survivor does not actually need to be covered under the Northrop Grumman Health Plan.

If you have no eligible survivors, payment will be made to your estate, unless there is none. If there is no estate, no payment will be made.

When Employment Ends

If you are approved for a disability claim and are later terminated from employment, your termination does not affect your LTD benefit payments, provided you remain disabled as determined by the insurance company. When your employment ends, Northrop Grumman notifies you and sends information to you about your benefit options.

Other Benefits

In addition to providing the benefits described in other sections of this SPD, Northrop Grumman offers other benefits designed to assist you in personal and professional areas of your life.

Following is a brief overview of some of the available benefits and programs, including:

- **NGCare/Employee Assistance Program**
- **Group Legal Plan**
- **Travel Protection**
- **Voluntary Benefits**

NGCare/EMPLOYEE ASSISTANCE PROGRAM

NGCare, Northrop Grumman's Employee Assistance Program (EAP) is a free, professional, and confidential counseling and referral program that is available to you and your family members who are eligible to enroll in the Northrop Grumman Health Plan. The EAP is separate from the mental health and substance abuse program described under the medical plan options. Employees and family members can use the EAP services, even if they are not enrolled in a Northrop Grumman medical plan option or HMO.

The EAP provides eight free counseling sessions for each participating individual per issue per year, including marriage, family and bereavement counseling. If you are identified as being on an international work assignment, a frequent international traveler, or on a rotational international assignment, you are eligible for the International Employee Assistance Program (IEAP) which includes six free counseling sessions for each participating individual per issue per year.

The EAP also provides telephonic assistance to include information on a variety of behavioral health topics, community resources and referrals. Assistance required beyond your EAP benefit is coordinated with the mental health benefits under your medical plan option, if applicable. EAP services do not include inpatient treatment for mental health or chemical dependency or other intensive or specialty services designed to treat acute and chronic mental illness or chemical dependency diagnoses.

Work/Life Solutions are additional benefits provided under the EAP, and include 24/7 confidential assistance in balancing work and life commitments. Work/Life services offers information, resources and referrals for many everyday issues included but not limited to ongoing or emergency child and elder care, help for care givers, school and college information, assistance for children with special needs, adoption resources, housing options, assistance with relocation, and resources to assist in preparing for retirement. The program can also help you locate community resources for financial counseling or debt management.

The EAP is insured by ComPsych. For more information about the EAP and Work/Life Solutions, access the Employee Assistance Program link at Total Rewards Gateway at **totalrewards.northropgrumman.com** or by calling ComPsych by using the NGCare number at 1-800-982-8161.

GROUP LEGAL PLAN

Overview

The Group Legal Plan, through MetLife Legal Plans, provides you and your eligible dependents access to legal assistance. You pay for your Group Legal Plan coverage through automatic after-tax payroll deductions. Once you elect this coverage, you can change your election only during the next annual enrollment period. Your coverage continues for the entire plan year and remains in effect until you change your election (in other words, your coverage rolls over each plan year unless you change your election).

The level of benefit you receive depends on the option you choose —Basic or Advantage. When you face a situation that has legal implications, the MetLife Legal Plans' website, **legalplans.com**, provides instant access to information about your legal plan benefits and more. You can locate attorneys, obtain a case number and contact an attorney by e-mail. You will need your Membership Number to access the website.

Keep in Mind

Once you select group legal coverage, you can change your election only during the next annual enrollment period. Your coverage automatically will roll over in the next plan year, unless you change your election. There are no exceptions.

You may also call MetLife Legal Plans' Client Service Center at 800-821-6400, Monday through Friday 8 am to 8 pm, Eastern time. A Client Service Representative will assist you in locating a Plan Attorney near your home or workplace and will answer any questions you may have about the plan.

When you use an attorney outside the network, the plan will reimburse your legal fees up to a maximum amount.

Eligibility

There are two Group Legal Plan options to choose from: the Basic Plan and the Advantage Plan. You can choose to participate in the Group Legal Plan each year during annual enrollment. When you select group legal coverage, you automatically cover yourself and your eligible dependents. Your eligible dependents include:

- Your spouse
- Your domestic partner
- Your unmarried children under age 26

The level of benefit you receive depends on the option you choose: Basic or Advantage.

What Services Are Covered

The Group Legal Plan entitles you and your eligible dependents to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions, which must be met. A complete description of benefits available to you can be found at the MetLife microsite available at **metlife.com/info/ngc**. Please take time for yourself and your family to read the description of benefits carefully.

When Coverage Ends

Your ability to receive legal services under the plan ends if you are no longer an eligible employee or if you choose not to enroll during future annual enrollment periods.

If you cease to be eligible to participate in the plan or your employment with the Company ends, the plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. Of course, no new matters may be started after you become ineligible.

For More Information

The IMG Travel Assistance Services customer service center is available 24 hours a day, 365 days a year. For more information call 317-669-9478.

Amendment or Termination

While your employer expects to continue to offer participation in the Legal Service Plan, it reserves the right to amend, or terminate the plan at any time. If the plan is terminated, all covered services then in process will be handled to their conclusion under the plan.

Administration and Funding

The Legal Service Plan is provided for and administered through a contract with MetLife Legal Plans, Inc. MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to MetLife Legal Plans, Inc.

Cost of the Plan

You pay the cost of the plan through after-tax payroll deductions, based on your enrollment choice.

Plan Confidentiality, Ethics and Independent Judgment

Your use of the plan and the legal services is confidential. The Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal problems or the services you use under the plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the plan.

No one will interfere with your Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife Legal Plans, Inc., or the law firm providing services under the plan is responsible for all services provided by their attorneys.

You should understand that the plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at 800-821-6400. Your complaint will be reviewed and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the plan.

Other Special Rules

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you? If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents? You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the Plan Attorney. Your dependent will not be covered under the plan.

What if you are involved in a legal dispute with another employee? If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the plan must be repaid from this award to the extent that it paid the fee for your attorney.

TRAVEL PROTECTION

Emergencies can happen while traveling, and Northrop Grumman provides you with access to travel assistance when you travel for business at least 100 miles from home. The service is administered by IMG Travel Assistance Services and you do not have to enroll to have coverage.

Through IMG Travel Assistance Services, you receive special assistance for emergency medical, financial, legal and communication assistance when you travel.

This program provides the following:

Emergency Medical Transport Services	
Dispatch of a Physician	Repatriation of Remains
Emergency Medical Evaluation	Return of Travel Companion
Services for Medical Repatriation	Visit of Family Member or Friend
Return of Dependent Children	Vehicle Return Services

Medical Assistance Services	
Convalescence Arrangements	Medical Referrals
Outpatient Services	Dental Referrals
Interpretation Services	Medical Monitoring
Replacement of Medical Devices	Cost Management
Direct Billing	General Medical Advice
Pre-Authorization	Prescription Transfer

Travel Assistance Services	
Emergency Cash/Bail Assistance	Pre-Trip and Cultural Information
Lost Luggage and/or Document Assistance	Legal Referrals
Consulate and Embassy Location	Urgent Message Relay

The IMG Travel Assistance customer service center is available 24 hours a day, 365 days a year. For more information call 317-669-9478.

VOLUNTARY BENEFITS*

You can enroll yourself and eligible dependents. The premiums for these benefits will come out of your paycheck on an after-tax basis. For company couples where both the employee and spouse/domestic partner work for Northrop Grumman, dual coverage is not allowed for spouse/domestic partner and/or children. You must be actively at work for coverage to be effective. If you go on a leave of absence, you may keep coverage if you are already enrolled as long as you continue paying premiums.

***Note:** Baltimore and Sunnyvale represented employees are not eligible.

The Benefits available to you are as follows:

Accident Insurance

When unexpected injuries lead to unexpected expenses, your accident insurance can provide money to help pay for expenses such as medical bills, transportation costs and childcare expenses.

- You'll receive a lump sum payment to use as you see fit, paid directly to you.
- The Plan pays no matter what your medical insurance covers.
- May cover accident-related events, such as: sports injuries, auto accidents, bicycle accidents, broken bones, knee injuries and falls

You have the choice between two plans: Low Plan and High Plan, that provide payments in addition to any other insurance payments you receive.

For more information, including a complete description of covered benefits, please visit **metlife.com/info/ngc** or contact MetLife directly at 1-800-438-6388.

Critical Illness Insurance

You can fill the financial coverage gaps caused by unexpected health issues with Critical Illness Insurance*, which provides a lump sum payment to help you and your family with financial support in a difficult time. Here's how the benefit works:

- You'll receive a lump sum payment upon verified diagnosis to use as you see fit
- Use it for prescriptions, deductibles, co-payments, experimental/non-traditional treatments and even non-medical expenses like everyday bills
- Pays out regardless of what your medical insurance covers
- Payments are paid directly to you, not to the doctors, to the hospitals or to the healthcare providers

Refer to **metlife.com/info/ngc** or contact MetLife directly at 1-800-438-6388 for more information about Critical Illness Insurance and covered conditions.

**Baltimore and Sunnyvale represented employees are not eligible.*

Hospital Indemnity Insurance

You can be financially prepared for an unexpected hospital stay with Hospital Indemnity Insurance. MetLife will help pay for out-of-pocket costs related to a hospital stay.

- You'll receive a lump sum payment to use as you see fit

- Pays on top of what your medical insurance covers
- Coverage for hospital admission, stays and accident-related rehab (accidents only)

MetLife offers you a choice of two comprehensive plans, Low Plan and High Plan, which provide you lump sum cash payments for covered events regardless of any other payments you may receive from your medical plan.

Please visit **metlife.com/info/ngc** or contact MetLife directly at 1-800-438-6388 for detailed definitions and state variations of covered benefits.

General Plan Administration

The Northrop Grumman benefits program is broad, complex and regulated by a number of federal laws.

As a result, there are administrative provisions with which you should be familiar, particularly if a special circumstance arises.

This section includes important information about the structure and administration of the Northrop Grumman benefit Plans. It also includes an explanation of your rights as a Plan participant.

GENERAL PLAN ADMINISTRATION

This section contains information on the administration of the Plan, as well as your rights as a participant. You probably do not need this information on a day-to-day basis; however, it is important for you to understand your rights and the procedures you need to follow in certain situations.

The Benefit Plans Administrative Committee, as the Plan Administrator, is responsible for the general administration of the Plan, and will be the named fiduciary to the extent not otherwise specified in this SPD, the Plan document or in an insurance contract. The Benefit Plans Administrative Committee has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and the Benefit Plans Administrative Committee (or its delegate) will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Benefit Plans Administrative Committee nor Northrop Grumman will be liable in any manner for any determination made in good faith.

The Benefit Plans Administrative Committee may designate other organizations or persons to carry out specific fiduciary responsibilities in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as claims administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator has not been delegated such authority.

The Benefit Plans Administrative Committee (or its delegate) will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

A NOTE ABOUT FRAUD

If you or one of your dependents make a claim that you know contains or is based on false, incomplete, or misleading information, with the intention of obtaining benefits that you are not entitled to, the Plan may terminate your eligibility for benefits or may demand that you repay benefits or offset future benefits, and you may be subject to prosecution under state and federal law.

POWER AND AUTHORITY OF THE HMO

Benefits may be provided under a group insurance contract entered into between the Plan and an HMO. With respect to fully insured benefits, claims for benefits are sent to the HMO. The HMO is responsible for paying claims — not Northrop Grumman.

The HMO is also responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan

The HMO also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the benefits provided through the HMO.

Claim procedures are set forth in the next section.

Questions?

If you have any questions about this information, call the NGBC at 800-894-4194 or contact the nearest regional office of the Employee Benefits Security Administration, an agency of the U.S. Department of Labor.

AUTHORITY AND LIABILITY OF INSURER OR HMO

For benefits that are provided on an insured basis (not self-insured by Northrop Grumman), the insurance carrier or health maintenance organization (HMO) through which coverage is provided is solely responsible for the payment of benefits and has the sole authority, discretion and responsibility to interpret the terms of the insurance or HMO coverage contract, including eligibility for benefits. Northrop Grumman does not guarantee the payment of any benefit described in an insurance or HMO coverage contract, and you must look solely to the insurance carrier or HMO for the payment of benefits.

CLAIMS

Health Care Claims

MEDICAL, DENTAL OR VISION

When you receive medical (including prescription drugs or mental health and/or chemical dependency care), dental, or vision care from an in-network provider, your provider should automatically file a claim for you.

If you receive care or treatment from an out-of-network provider (if applicable), you will usually need to pay the provider directly at the time you receive care and then file a claim with the claims administrator for reimbursement of your eligible expenses. Your claim must include the appropriate paperwork and receipts. If you receive reimbursement from another source, such as your spouse's plan, your claim must include the explanation of benefits from that plan. You must submit your claim to the address of the claims administrator as indicated in the chart entitled "Claims and Appeals Contact Information." Be sure to keep a copy of the claim submission for your records.

If you are enrolled in Plan 1: High Premium/Low Deductible Plan, Plan 2: Medium Premium/Medium Deductible Plan, Plan 3: Low Premium/High Deductible Plan, Plan 4: Medium Premium/Deductible Utah Extended Network Plan, Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan, or Sunnyvale Value Plan you must submit medical claims that you incur during the plan year to Anthem within 12 months after the plan year ends. Prescription drug coverage available under these medical plan options is administered by CVS/caremark, and in-network

pharmacies should file claims for you within 90 days from date of service. If you have to file a claim with CVS/caremark — for example, if you go to an out-of-network pharmacy and pay the pharmacist directly — you must file your claim for reimbursement within 12 months from the date of service.

If you are enrolled in another medical plan option, you must submit claims you incur during the plan year within 12 months after the plan year ends.

Delta Dental claims must be filed no more than 12 months after the date the dental service was provided. Vision claims must be submitted within 365 calendar days from the date services are rendered and/or materials provided.

The medical, dental, and vision plan options do not pay claims that are submitted after these deadlines.

If you do not file a claim by the applicable deadline and in the proper manner, your claim will expire and be automatically denied if it is subsequently filed. You will not be able to proceed with a lawsuit based on that claim.

Timeframes for Determinations: Medical, Dental and Vision

The timeframes for benefit determination for medical, dental and vision benefits vary depending on the type of claim.

TYPE OF CLAIM	INITIAL DEADLINE FOR CLAIMS REVIEW	TIME FOR YOU TO PROVIDE ADDITIONAL INFORMATION	EXTENSIONS FOR CLAIMS REVIEW, IF NECESSARY
Urgent	72 hours	48 hours	None
Urgent, Concurrent Care	24 hours*	48 hours	None
Pre-Service	15 days	45 days	15 days
Post-Service	30 days	45 days	15 days

**Applies only when claim is submitted at least 24 hours before end of approved treatment.*

Urgent claims: Medical care is “urgent” if a longer time could seriously jeopardize the participant’s life, health, or ability to regain maximum function. Also, care may be urgent if, in a doctor’s opinion, it would subject the participant to severe pain if care or treatment were not provided. If you require care that is classified as urgent, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 24 hours. You have 48 hours after that time to supply any additional information. Until you supply this information, the time limits that apply for the review are suspended (or “tolled”).

Concurrent care decisions: These are decisions involving an ongoing course of treatment over a period of time or a number of treatments. If you or your dependent is undergoing a course of treatment, or is nearing the end of a prescribed number of treatments, you may request extended treatment or benefits. If the course of treatment involves urgent care and you request at least 24 hours before the expiration of the authorized treatments, the claims administrator will respond to your claim within 24 hours. If you reach the end of a pre-approved course of treatment before requesting additional benefits, the normal “pre-service” or “post-service” time limits will apply, as described below.

Pre-service determinations: A “pre-service” determination requires the receipt of approval of those benefits in advance of obtaining the medical care. If you request a review for pre-service benefits, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 15 days. You have 45 days after that to supply any additional information. Until you supply this information, the time limits that apply to the claims administrator are tolled.

Post-service claims: A “post-service” determination is made for benefits after you have already received care or treatment. A “post-service” determination does not require advance approval of benefits.

In the case of pre-service determinations and urgent claims, if you fail to follow the specified procedure for filing your claim, the claims administrator will notify you of the failure and of the proper procedure. This notice will be provided to you no later than five days after your incorrectly filed claim is received (24 hours in the case of an urgent claim). The notice from the claims administrator may be an oral notice, unless you specifically request written notice.

Example: If you have an urgent medical situation, the claims administrator must respond to your initial request for benefits within 72 hours, and no extensions are permitted. If the administrator needs more information from you to make a determination, you will have 48 hours from the time you are notified to supply that information. The time period during which you are gathering that additional information does not count toward the time limits that apply to the claims administrator.

If Your Claim Is Denied: Medical, Dental and Vision

If your claim is denied (either in whole or in part), the claims administrator will send you a written explanation of why the claim was denied. In the case of an urgent claim, this can include oral notification, as long as you are provided with a written notice within three days following the oral notification.

This explanation will contain the following information to the extent required by law:

- The specific reasons for the denial
- References to the specific Plan provisions on which the denial is based
- If a medical claim, information sufficient to identify the claim involved, including the date of service, name of the health care provider, and claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with their corresponding meanings)
- If a medical claim, the denial code (if applicable) and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim
- A description of additional material or information that you may need to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan’s review procedures (including any available external review process) and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal
- If a medical claim, a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and external review processes
- If a denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims
- If the denial is based on an internal rule, guideline, protocol, or standard, the denial will either include a copy of such rule, guideline, protocol, or standard, or else state that you can obtain a copy of the rule, guideline, or protocol, free of charge upon request
- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge

Appealing a Denied Claim: Medical, Dental and Vision

If your claim is denied, you have the right to make an appeal:

- You may call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- If you cannot correct the problem by phone, or if you choose not to call the claims administrator, you have the right to file a level 1 appeal by writing directly to the claims administrator at the address indicated in the chart entitled "**Claims and Appeals Contact Information**". Be sure to explain why you think your claim should be paid and provide all relevant details.
- A second level of appeal is available for pre-service (other than urgent care) medical, dental, and vision health claims, and for post-service health claims (other than non-clinical prescription drug claims). For these claims, if your claim is denied by the level 1 appeals review committee, you may file a second level appeal by writing to the address as indicated in the chart entitled "**Claims and Appeals Contact Information**".
- In deciding appeals, the claims administrator acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations as to whether you are entitled to benefits.

Appealing a Rescission of Coverage: Medical Only

A Rescission of Coverage is a cancellation or discontinuance of medical coverage that is effective retroactively and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a Rescission of Coverage. If you are notified by the Plan Administrator or its delegate that your coverage under the Plan is being rescinded, that notification is considered to be a claim denial. You may appeal a Rescission of Coverage by writing to the claims administrator. There is only one level of appeal for Rescissions of Coverage. See the chart entitled "**Claims and Appeals Contact Information**" for the contact information of the claims administrator. The claims administrator identified in the chart acts as the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the plan and to make factual determinations.

Timing of Your Appeal: Medical, Dental and Vision

If you make a claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see **Employee Retirement Income Security Act Of 1974 (ERISA)** for details).

In the case of medical (including prescription drug, mental health and substance abuse treatment), dental and vision, you have 180 days* from the time that you receive a claim denial from the claims administrator to file an appeal.

TYPE OF CLAIM	TIME TO APPEAL FROM DATE CLAIM IS DENIED	TIME FOR DECISION ON APPEAL	EXTENSIONS FOR CLAIMS ADMINISTRATOR, IF NECESSARY
Urgent claims	180 days	72 hours	None
Pre-Service claims	180 days for each level of appeal	Two levels of appeal: 15 days from the receipt of the appeal for each level	None
Post-Service claims	180 days* for each level of appeal	Two levels of appeal: 30 days from the receipt of the appeal for each level **	None
Rescissions of Coverage	180 days from the date of receipt of the Rescission of Coverage	One level of appeal: 60 days from the receipt of the appeal	60 days

**A second level appeal for a vision claim must be submitted within 60 days after receipt of VSP's response to the initial appeal.*

***There is only one level of appeal for dental claims and non-clinical prescription drug claims (claims that do not involve a determination of clinical appropriateness or medical necessity) to CVS/caremark under the Plan 1: High Premium/Low Deductible, Plan 2: Medium Premium/Medium Deductible, Plan 3: Low Premium/High Deductible Plan, Plan 4: Medium Premium/Deductible Utah Extended Network Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan, and Sunnyvale Value Plan medical plan options. The time frame for a decision on appeal is 60 days. See Post-Service Claims below.*

Urgent Claims. There is only one level of appeal that is required for urgent claims. You may file an urgent claim appeal with the claims administrator within 180 days if your initial claim for benefits is denied. Your appeal must be considered within 72 hours, with no extensions. You may file a lawsuit under ERISA if your appeal of an urgent claim is denied. However, if you wish, you may file a voluntary level 2 appeal of an urgent claim denial with the claims administrator within 180 days, and your appeal will be considered within 72 hours, with no extensions. For urgent claims, the level 2 appeal is voluntary — it is your choice to request it or not — and you are not required to file a voluntary level 2 appeal in order to file a lawsuit. If you would like additional information to help you decide whether to file a voluntary level 2 appeal of an urgent claim denial, please call the claim administrator. Your decision as to whether to file a voluntary level 2 appeal of an urgent claim denial will have no effect on any of your other rights under the plan, and the same rules and procedures apply to a voluntary level 2 appeal of an urgent claim denial as for all other level 2 appeals.

Pre-Service Claims (other than urgent claims). There are two levels of appeal.

- Level 1 appeal: You may file a level 1 appeal with the claims administrator within 180 days after you receive the claim denial. Your appeal must be considered within 15 days, with no extensions.
- Level 2 appeal: If your first appeal is denied by the claims administrator, you may file a level 2 appeal with the claims administrator within 180 days after you receive the denial of your level 1 appeal. Your appeal must be considered within 15 days, with no extensions.

Post-Service Claims. There are two levels of appeal, except that there is only one level of appeal for non-clinical prescription drug claims (claims that do not involve a determination of clinical appropriateness or medical necessity) to CVS/caremark under the Plan 1: High Premium/Low Deductible Plan, Plan 2: Medium Premium/Medium Deductible Plan, Plan 3: Low Premium/High Deductible Plan, Plan 4: Medium Premium/Deductible Utah Extended Network Plan, Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan, and Sunnyvale Value Plan options. Your claim denial letter from CVS/caremark will inform you whether there is one level or two levels of appeal.

- Level 1 appeal**:** You may file a level 1 appeal with the claims administrator within 180 days after you receive the claim denial. Your appeal must be considered within 30 days (60 days for dental claims and when there is 1 level of appeal for prescription drug claims under the Plan 1: High Premium/Low Deductible Plan, Plan 2: Medium Premium/Medium Deductible Plan, Plan 3: Low Premium/High Deductible Plan, Plan 4: Medium Premium/Deductible Utah Extended Network Plan, Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan , and Sunnyvale Value Plan options), with no extensions.
- Level 2 appeal: If your first appeal is denied by the claims administrator, you may file a level 2 appeal with the claims administrator within 180 days (60 days in the case of vision) after you receive the denial of your level 1 appeal. Your appeal must be considered within an additional 30 days, with no extensions.

Please see **Additional Information About the Appeals Process (Other than LTD and STD Appeals)**.

FSA AND HRA

Please see **Using Your FSA Dollars** to learn how to file a Health Care and Dependent Day Care FSA claim. For information about filing HRA claims, see **Health Reimbursement Accounts.**

Timeframes for Determinations: Health Care FSA and HRA

The timeframes for benefit determination for Health Care FSA and HRA is outlined below.

TYPE OF CLAIM	INITIAL DEADLINE FOR CLAIMS REVIEW	TIME FOR YOU TO PROVIDE ADDITIONAL INFORMATION	EXTENSIONS FOR CLAIMS REVIEW, IF NECESSARY
FSA and HRA	30 days	45 days	15 days

If Your Claim Is Denied: Health Care FSA and HRA

If your claim is denied (either in whole or in part), the claims administrator will send you a written explanation of why the claim was denied.

This explanation will contain the following information as well as any other additional information to the extent required by law:

- The specific reasons for the denial
- References to the specific Plan provisions on which the denial is based
- A description of additional material or information that you may need to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures (including any available external review process) and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal

Appealing a Denied Claim: Health Care FSA and HRA

If your claim is denied, you have the right to make an appeal:

- You may call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- If you cannot correct the problem by phone, or if you choose not to call the claims administrator, you have the right to file an appeal by writing directly to the claims administrator at the address indicated in the chart entitled "**Claims and Appeals Contact Information**". Be sure to explain why you think your claim should be paid and provide all relevant details.
- In deciding appeals, the claims administrator acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations as to whether you are entitled to benefits.

Timing of Your Appeal: Health Care FSA and HRA

If you make a claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see **Employee Retirement Income Security Act Of 1974 (ERISA)** for details).

In the case of Health Care FSA and HRA claims, you have 180 days from the time that you receive a claim denial from the claims administrator to file an appeal. You do not have the right to make an appeal of a Dependent Care FSA claim. The Health Care FSA or HRA administrator will have 60 days from the date of the receipt of your appeal to render its decision.

Please see **Additional Information About the Appeals Process (Other than LTD and STD Appeals)**.

Disability Claims

SHORT-TERM DISABILITY AND LONG-TERM DISABILITY

To learn how to file an STD claim, see **How and When to Claim STD Benefits.** For LTD claim filing information, see **How and When to Claim LTD Benefits**.

Timeframes for Determinations: STD and LTD

The timeframes for benefit determination for disability benefits may vary depending on the type of claim as shown in the table below:

TYPE OF CLAIM	INITIAL DEADLINE FOR CLAIMS REVIEW	TIME FOR YOU TO PROVIDE ADDITIONAL INFORMATION	EXTENSIONS FOR CLAIMS REVIEW, IF NECESSARY
Short-term Disability	45 days	45 days	Two 30-day extensions
Long-term Disability	45 days	45 days	Two 30-day extensions

The claims administrator must respond within 45 days, and may take up to two 30-day extensions, if circumstances warrant. The claims administrator will notify you in writing of the circumstances requiring an extension and the date by which it expects to make a decision on your claim. Any notice of extension that it provides to you will specifically explain the standards on which entitlement to a disability benefit is based; the unresolved issues that prevent it from making a decision on the claim; and what additional information is needed by the claims administrator to resolve those issues. You have 45 days to supply any additional information from the date you are notified that your claim is incomplete.

If Your Claim Is Denied: STD and LTD

If your claim is denied (either in whole or in part), the claims administrator will send you a written explanation of why the claim was denied.

This explanation will contain the following information to the extent required by law:

- The specific reasons for the denial
- References to the specific Plan provisions on which the denial is based
- A description of additional material or information that you may need to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures (including any available external review process) and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to the claims administrator of health care professionals treating you and vocational professionals who evaluated you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether the advice was relied upon by the claims administrator in denying your claim

- A determination of disability by the Social Security Administration presented by you to the claims administrator
- If the decision to deny the claim is based on medical necessity or experimental treatment, or any similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that you may request a copy of the explanation free of charge
- A copy of any internal rules, guidelines, protocols, standards, or other similar criteria relied upon in denying the claim, or a statement that such criteria do not exist
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim

Appealing a Denied Claim: STD and LTD

AFLAC is the decision-maker for short-term and long-term disability claims and appeals, with full delegated authority for such decisions. You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. A retroactive cancellation or discontinuance of coverage will be considered a claim denial that you may appeal, unless your coverage is retroactively cancelled due to failure to pay premiums. Requests for appeal should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If AFLAC determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). AFLAC will notify you in writing if an additional 45-day extension is needed.

If AFLAC considers, relies upon or generates new or additional evidence in the process of considering your claim, such evidence will be provided to you as soon as possible in advance of the date by which AFLAC is required to provide notice of its final decision on appeal. If AFLAC intends to issue an adverse final decision on appeal (deny your appeal in whole or part) based on a new or additional rationale, AFLAC will provide you with the rationale as soon as possible in advance of the date by which AFLAC is required to provide notice of its final decision on appeal.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by AFLAC and will be made by a person different from the person who made the initial determination, and such person will not be the original decision-maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, AFLAC will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination, or a subordinate.

If your claim denial is upheld, AFLAC will send you notice that contains the following information to the extent required by law:

- The specific reason(s) for the determination
- A reference to the specific Plan provision(s) on which the determination is based
- A statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision
- The statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination
- A description of any applicable contractual limitations period that applies to your right to bring an action under Section 502(a) of ERISA and the calendar date on which the contractual limitations period expires for your claim

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by you to AFLAC of health care professionals treating you and vocational professionals who evaluated you
  - The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the claim denial, without regard to whether the advice was relied upon by AFLAC in denying your claim
  - A determination of disability by the Social Security Administration presented by you to AFLAC
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion, or a statement that that such rule, guideline, protocol, or other criterion was relied upon and that it will be provided free of charge upon request
- If the denial was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or statement that such an explanation will be provided free of charge upon request

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

Timing of Your Appeal: STD and LTD

If you submit a claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see **Employee Retirement Income Security Act Of 1974 (ERISA)** for details).

In the case of disability claims, there is one level of appeal. If your initial claim for disability benefits was denied, you may appeal that denial within 180 days after you receive the claim denial. Your appeal must be considered within 45 days, with a 45-day extension permitted, if necessary. For complete details on disability claim appeals, see the preceding section, **Appealing a Denied Claim: STD and LTD**.

Other Benefit Claims

LIFE, AD&D, GROUP LEGAL, ACCIDENT, HOSPITAL INDEMNITY, CRITICAL ILLNESS AND BUSINESS TRAVEL ACCIDENT

See **General Information about Life and Accident Insurance** for information about receiving benefits under any of the life insurance plans.

Timeframes for Determinations: Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA

The timeframes for benefit determination for Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA are outlined below.

INITIAL DEADLINE FOR CLAIMS REVIEW	EXTENSIONS FOR CLAIMS REVIEW, IF NECESSARY
90 days	90 days

If Your Claim Is Denied: Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA

If your claim is denied (either in whole or in part), the claims administrator will send you a written explanation of why the claim was denied.

This explanation will contain the following information to the extent required by law:

- The specific reasons for the denial
- References to the specific Plan provisions on which the denial is based
- A description of additional material or information that you may need to perfect the claim and an explanation of why such material or information is necessary
- A description of the Plan's review procedures and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal

Appealing a Denied Claim: Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA

If your claim is denied, you have the right to make an appeal:

- You may call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- If you cannot correct the problem by phone, or if you choose not to call the claims administrator, you have the right to file a level 1 appeal by writing directly to the claims administrator at the address indicated in the chart entitled "**Claims and Appeals Contact Information**". Be sure to explain why you think your claim should be paid and provide all relevant details.

In deciding appeals, the claims administrator acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations as to whether you are entitled to benefits.

Timing of Your Appeal: Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA

If you submit a claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see **Employee Retirement Income Security Act Of 1974 (ERISA)** for details).

In the case of Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA claims, you have 60 days from the time that you receive a claim denial from the claims administrator to file an appeal. The Life, AD&D, Group Legal, Accident, Hospital Indemnity, Critical Illness and BTA administrator will have 60 days from the date of the receipt of your appeal to render its decision, with a 60-day extension permitted, if necessary.

Please see **Additional Information About the Appeals Process (Other than LTD and STD Appeals)**.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Your NGCare or EAP provider will submit your EAP claims directly to ComPsych on your behalf. If your benefit claim is denied, you will receive written notification of the denial within 30 days, with the possibility of one 15-day extension. The notice of denial will include, to the extent required by law, the reason for the denial, the specific Plan provision on which the denial is based, a description of any additional material or information necessary to perfect the claim and a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a lawsuit under section 502(a) of ERISA should your appeal be denied.

Appealing a Denied Claim: EAP

If your claim is denied, you have the right to make an appeal:

You may call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.

If you cannot correct the problem by phone, or if you choose not to call the claims administrator, you have the right to file an appeal by writing directly to the claims administrator at the address indicated in the chart entitled "**Claims and Appeals Contact Information**". Be sure to explain why you think your claim should be paid and provide all relevant details.

Timing of Your Appeal: EAP

If you make a claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see **Employee Retirement Income Security Act of 1974 (ERISA)** for details). In the case of EAP claims, you have 180 days from the time that you receive a claim denial from the claims administrator to file an appeal. The EAP administrator will have 60 days from the date of the receipt of your appeal to render its decision.

In deciding appeals, the claims administrator acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations as to whether you are entitled to benefits.

Please see **Additional Information About the Appeals Process (Other than LTD and STD Appeals).**

Administrative Claims

A claim that relates to the payment of a specific benefit under the Plan is called a "Benefit Claim." For example, when you receive medical care and the provider submits a claim to the Plan to be paid for the service that is considered a Benefit Claim. Claims that are not a claim for a specific benefit under the Plan are called "Administrative Claims." For example, you believe that you are being charged too much for the benefit coverage you have elected and file a claim. Because your claim is not for the payment of a specific benefit under the Plan, your claim is treated as an Administrative Claim.

Administrative Claims must be submitted to the claims administrator within 65 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the Plan. If a claim involves a Plan change or amendment, you are considered to know about your claim when the change or amendment is first communicated to participants in the Plan, and the 65-day period for filing a claim begins on the date the change is first communicated, whether or not the change or amendment has become effective by that date.

If you do not file an Administrative Claim by the applicable deadline and in the proper manner, your claim will expire and be automatically denied if it is subsequently filed. You will not be able to proceed with an appeal or lawsuit based on that claim.

Timeframes for Determinations: Administrative

The timeframe for benefit determination for Administrative Claims is outlined below.

TYPE OF CLAIM	INITIAL DEADLINE FOR CLAIMS REVIEW	TIME FOR YOU TO PROVIDE ADDITIONAL INFORMATION	EXTENSIONS FOR CLAIMS REVIEW, IF NECESSARY
Administrative	90 days	45 days	90 days

Appealing a Denied Claim: Administrative

If your Administrative Claim is denied, you have the right to make an appeal by writing to the claims administrator at the address indicated in the chart entitled "**Claims and Appeals Contact Information**". There are no appeal rights for denied Administrative Claims relating to a wellness incentive program, including the Well-being Incentive Program* or Annual Physical Incentive for Baltimore and Sunnyvale represented employees. Be sure to explain why you think your Administrative Claim should be approved and provide all relevant details. There is only one level of appeal for

Administrative Claims. See the chart entitled **Claims and Appeals Contact Information** for the contact information of the claims administrator. The claims administrator identified in the chart acts as the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations.

**Baltimore and Sunnyvale represented employees are not eligible.*

Timing of Your Appeal: Administrative

If you make a claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see **Employee Retirement Income Security Act Of 1974 (ERISA)** for details).

In the case of Administrative Claims, you have 65 days from the time that you receive a claim denial from the claims administrator to file an appeal. Below are the timeframes that apply when you file an appeal.

TYPE OF CLAIM	TIME TO APPEAL FROM DATE CLAIM IS DENIED	TIME FOR DECISION ON APPEAL	EXTENSIONS FOR CLAIMS ADMINISTRATOR, IF NECESSARY
Administrative	65 days	One level of appeal: 60 days from the receipt of the appeal	60 days

Please see **Additional Information About the Appeals Process (Other than LTD and STD Appeals).**

Authorized Representative: All claims

At both the initial claim level, and on appeal, you may have an authorized representative submit your claim for you. To designate an authorized representative, you must follow the process established by the claims administrator or insurance carrier. Contact the claims administrator or insurance carrier for information about what you need to do. The claim administrator or insurance carrier may require you to certify that the representative has permission to act for you. The representative may be a health care or other professional. If you designate an authorized representative, all communications from the claims administrator or insurance carrier regarding your claim will be made to your authorized representative, not to you. You may withdraw your designation of an authorized representative by following the process established by the claims administrator or insurance carrier.

Assignment of Benefits and Other Rights

The Plan prohibits assignments of benefits that are self-insured. All rights to benefits under the Plan are personal to the participant or beneficiary. Your rights and benefits under the Plan cannot be assigned, sold, pledged, or transferred to a third party, including your health care provider. This includes your right to payment or reimbursement for benefits under the Plan and your right to file a lawsuit to recover benefits due to you under the Plan. Any purported assignment of rights or benefits is void and will not be recognized by the Plan. Please be aware that when you visit a provider or facility, the provider or facility may ask you to sign a form that states that you assign your right to benefits to the provider or facility. If this happens, it is your responsibility to notify your provider or facility that you are unable to assign benefits due to the Plan's prohibition on assignments.

The claims administrator may communicate with your provider or facility about your claim and/or issue payments directly to your providers/facilities for covered services you receive (whether or not pursuant to an authorization). The claims administrator's doing so, however, does not create an assignment of benefits and it will not constitute a waiver of the application of this provision.

The prohibition of assignments does not take away your ability to designate an authorized representative (described earlier) to file claims for benefits or to file appeals as part of the Plan's internal claims as appeals process. In order to appoint an authorized representative, you must follow the process described previously. Signing a provider form will not be sufficient.

The Plan also prohibits assignments of any other rights a participant or beneficiary may have under ERISA, including, without limitation, the right to request documents under section 104 of ERISA and the right to file a lawsuit to:

- Enforce rights under the terms of the Plan
- To clarify rights to future benefits under the terms of the Plan
- Obtain relief for a breach of fiduciary duty
- Enjoin any act or practice which violates ERISA or the terms of the Plan or to obtain other equitable relief to redress such violations or enforce any provisions of ERISA or the Plan
- Obtain relief based on the Plan Administrator's failure to provide information or other documentation to which a participant or beneficiary may be entitled under ERISA

Claims and Appeals Contact Information

CLAIMS ADMINISTRATOR	CLAIMS	LEVEL 1 APPEALS	LEVEL 2 APPEALS
Quantum Health	Non-behavioral health claims that are urgent care, concurrent care, or pre-service claims must be submitted to Quantum Health at: Quantum Health 5240 Blazer Parkway Dublin, OH 43107 Fax: 1-877-498-3681	Level 1 non-behavioral health medical appeals that require the exercise of medical judgment should be submitted to Quantum Health at: Quantum Health 5240 Blazer Parkway Dublin, OH 43107 Fax: 1-877-498-3681	Level 2 non- behavioral health medical appeals that require the exercise of medical judgment should be submitted to Quantum Health at: Quantum Health 5240 Blazer Parkway Dublin, OH 43107 Fax: 1-877-498-3681
Anthem Blue Cross Plan 1: High Premium/Low Deductible Plan Plan 2: Medium Premium/Medium Deductible Plan Plan 3: Low Premium/High Deductible Plan Plan 4: Medium Premium/Deductible Utah Extended Network Plan Baltimore Premium Plus Plan Baltimore Premium Plan Baltimore Value Plan Sunnyvale Premium Plan	All behavioral health medical claims and all post-service medical claims* must be submitted to your local Blue Cross Blue Shield Plan. For pharmacy claims, see CVS/caremark below. *The local Blue Cross Blue Shield Plan will forward post-service non-behavioral health medical claims requiring the exercise of medical judgment to Quantum Health to adjudicate the claim.	Level 1 behavioral health medical appeals and appeals of non-behavioral health medical claims that do not require the exercise of medical judgment should be submitted to Anthem at: Anthem Blue Cross PO Box 54159 Los Angeles, CA 90054	Level 2 behavioral health medical appeals and appeals of non-behavioral health medical claims that do not require the exercise of medical judgment should be submitted to Anthem at: Anthem Blue Cross PO Box 54159 Los Angeles, CA 90054

CLAIMS ADMINISTRATOR	CLAIMS	LEVEL 1 APPEALS	LEVEL 2 APPEALS
Sunnyvale Value Plan			
CVS/caremark (Prescription drugs for Plan 1, Plan 2, Plan 3, and Plan 4 Options)	CVS/caremark Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136	CVS/caremark Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866-443-1172	CVS/caremark Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 Fax: 866-443-1172
Delta Dental (PPO dental plan options)	Delta Dental of California Claims Services P.O. Box 997330 Sacramento, CA 95899-7330	Delta Dental of California Member Appeals P.O. Box 997330 Sacramento, CA 95899-7330	Delta Dental of California Member Appeals P.O. Box 997330 Sacramento, CA 95899-7330
Vision Service Plan	Vision Service Plan Attention: Claims Services P.O. Box 385018 Birmingham, AL 35238-5018	Vision Service Plan Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95741	Vision Service Plan Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95741
American Family Life Assurance Company of Columbus (AFLAC) (Short-term Disability, Long-Term Disability, and Rescissions of Disability Coverage)	AFLAC Administrative Office P.O. Box 1725 Grand Rapids, MI 49501	AFLAC Administrative Office P.O. Box 1725 Grand Rapids, MI 49501	No Level 2 appeals. LTD benefit claims have only one level of appeal.
MetLife (Life and AD&D Insurance)	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	N/A
MetLife (Critical Illness, Hospital Indemnity, Accident Insurance)	Metropolitan Life Insurance Company P.O. Box 80826 Lincoln, NE 68501-0826	Metropolitan Life Insurance Company P.O. Box 80826 Lincoln, NE 68501-0826	N/A
National Union Fire Insurance Company of Pittsburgh, PA (AIG) (Business Travel Accident)	National Union Fire Insurance Company of Pittsburgh PO Box 25987 Shawnee Mission, KS 66225	National Union Fire Insurance Company of Pittsburgh PO Box 25987 Shawnee Mission, KS 66225	National Union Fire Insurance Company of Pittsburgh PO Box 25987 Shawnee Mission, KS 66225
ComPsych (NGCare/EAP)	EAP Providers submit claims to ComPsych for EAP services: ComPsych Corporation 455 N. Cityfront Plaza Dr., 13th floor Chicago, IL 60611	ComPsych Corporation 455 N. Cityfront Plaza Dr., 13th floor Chicago, IL 60611	N/A
Fidelity (FSAs and HRA)	Fidelity Investments Fidelity Flexible Spending and Reimbursement Accounts PO Box 2703 Fargo, ND 58108	Fidelity Investments Fidelity Flexible Spending and Reimbursement Accounts PO Box 2703 Fargo, ND 58108 There are no appeal rights for Dependent Care FSA claim denials.	N/A
GENERAL PLAN ADMINISTRATION **MetLife** (Group Legal)	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2407	MetLife Legal Plans, Inc. 1111 Superior Avenue Cleveland, OH 44114-2407	N/A

CLAIMS ADMINISTRATOR	CLAIMS	LEVEL 1 APPEALS	LEVEL 2 APPEALS
Benefit Plans Administrative Committee Administrative Claims	Plan Administrator - Northrop Grumman Health Plan Northrop Grumman Corporation P.O. Box 77003 Cincinnati, OH 45277-1060	For Eligible Administrative Claims: Benefit Plans Administrative Committee - Northrop Grumman Health Plan Northrop Grumman Corporation P.O. Box 77003 Cincinnati, OH 45277-1060	N/A
Benefit Plans Administrative Committee Rescissions of Coverage for Health Coverage	N/A	Benefit Plans Administrative Committee - Northrop Grumman Health Plan Northrop Grumman Corporation P.O. Box 77003 Cincinnati, OH 45277-1060	N/A

For all other claims administrators, refer to your medical plan ID card for contact information.

Additional Information About the Appeals Process (Other than LTD and STD Appeals)

To the extent required by law, in filing an appeal, you have the opportunity to:

- Submit written comments, documents, records and other information relating to your claim for benefits
- Have reasonable access to and review, upon request and free of charge, copies of all documents, records and other information relevant to your claim, including the name of any medical or vocational expert whose advice was obtained in connection with your initial claim
- Have all relevant information considered on appeal, even if it wasn't submitted or considered in your initial claim.

To the extent required by law, in the case of appeals of medical, dental, vision, EAP, HRA, and Health Care FSA benefit claims:

- The decision on the appeal will be made by a person or persons at the claim administrator who is not the person who made the initial claim decision and who is not a subordinate of that person
- The decision will be made in a manner designed to ensure the independence and impartiality of the persons involved in making the decision
- In making the decision on the appeal, the claims administrator will give no deference to the initial claim decision
- If the determination is based in whole or in part on a medical judgment, the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same individual who was consulted (if one was consulted) with regard to the initial claim decision and will not be a subordinate of that person. The claims administrator will identify the medical or vocational experts whose advice was obtained on behalf of the Plan.

In the case of health (excluding dental, vision, EAP, and Health Care FSA claims):

- If the claims administrator considers, relies upon or generates new or additional evidence in the process of considering your claim, such evidence will be provided to you as soon as possible in advance of the date by which the claims administrator is required to provide notice of its final decision on appeal
- If the claims administrator intends to issue an adverse final decision on appeal (deny your appeal in whole or part) based on a new or additional rationale, the claims administrator will provide you with the rationale as soon as possible in advance of the date by which the claims administrator is required to provide notice of its final decision on appeal

If benefits are still denied on appeal, you will receive a written notice of the denial. The notice will contain, to the extent required by law:

- The specific reasons for the decision
- Reference to the specific Plan provisions on which the decision was based
- If a health (excluding dental, vision, EAP and FSA) claim, information sufficient to identify the claim involved, including the date of the service, name of the health care provider, and claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with their corresponding meanings)
- If a health (excluding dental, vision, EAP and FSA) claim, the denial code (if applicable) and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the appeal, including a discussion of the decision
- If a health (excluding dental, vision, EAP and FSA) claim or Rescission of Coverage, a description of any available external review process and how to initiate an external review
- A statement that you may receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim
- A statement describing any additional appeal procedures, and a statement of your rights to bring suit under ERISA. (See **Employee Retirement Income Security Act Of 1974 (ERISA)** for details.)
- If a health (excluding dental, vision, EAP and FSA) claim, a statement disclosing the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman that can assist you with the internal claims and appeals and external review processes

Depending on the type of claim, the notice that you receive from the final review level will also contain the following information, to the extent required by law:

- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the rule, free of charge upon request
- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge

EXTERNAL REVIEW

If your appeal relating to a health claim (excluding dental, vision, EAP and FSA claims) is denied after the final level of appeal, you may have the right to request an external review. External review is available if the denial involves medical judgment (such as requirements for medical necessity, appropriateness, health care setting, and level of care, effectiveness, or a determination that a treatment is experimental or investigational) or for a medical claim or air ambulance claim required to be subject to external review under the No Surprises Act. External review is not available for medical claims that involve only contractual or legal interpretation without any use of medical judgment. Denials

of appeals of Rescissions of Coverage are also eligible for external review. Denials of Benefit Claims based on a determination that you were not covered under the Plan or that you were not eligible for coverage under the Plan at the time you incurred the medical claim, and Administrative Claims are not eligible for external review. The U.S. Department of Labor or other appropriate federal agency may further limit or broaden the scope of external appeals. The Plan will provide an external appeals process in accordance with any such additional guidance.

Your request for external review must be filed in accordance with the instructions contained in your appeal denial notice and must be received no later than four months after the date you receive the appeal denial notice. If there is no corresponding date four months after the date of the appeal denial notice, then the request must be filed by the first day of the fifth month following receipt of the notice. For example, if the date of the denial notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last fling date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Within five business days after receiving your external review request, the claims administrator will complete a preliminary review to determine whether your request is complete and eligible for external review. That preliminary review will determine: whether you were covered under the Plan at the time the item or service was requested or provided; whether the final denial of your appeal related to your failure to meet the Plan's eligibility requirements; whether you exhausted the Plan's internal appeal process (or are not required to exhaust the process); and whether you have provided all the information and forms required to process an external review. Within one business day after the claims administrator completes its preliminary review, it will issue you a written notification. If your request is complete, but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration. If your request is not complete, the notification will describe the information or materials needed to make the request complete and you will be allowed to perfect your request for external review within the original four month filing period or, if later, the 48-hour period following your receipt of the notification.

If your request for external review is complete and eligible, the claims administrator will assign a qualified independent review organization (IRO) to conduct the external review and within five business days after making the assignment will provide the IRO with the documents and information the claims administrator considered in making its final appeal denial.

The IRO will review all of the information and documents received and will not be bound by any decisions or conclusions reached by the claims administrator during the Plan's internal claim and appeal process. The IRO may also consider the following in reaching its decision: your medical records; the attending health care professional's recommendation; reports from the appropriate health care professionals and other documents submitted by the claims administrator, you or your treating provider; the terms of the Plan, to ensure that the IRO's decision is not contrary to the terms of the Plan; appropriate practice guidelines; any applicable clinical review criteria developed and used by the Plan; and the opinion of the IRO's clinical reviewer(s).

The IRO will provide written notice to you and the claims administrator of the final external review decision within 45 days after the IRO receives the request for external review. The IRO's notice will contain, to the extent required by law: a general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning and the reason for the previous denial; the date the IRO received the assignment and the date of the IRO's decision; references to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards; a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision; a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or you; a statement that judicial review may be available to you; and, if applicable, current contact information for any applicable office of health insurance consumer assistance or ombudsman.

Under the following circumstances, you may be eligible to file for an expedited external review:

- If you receive a claim denial that involves a medical condition for which the timeframe for completion of an expedited internal appeal with the claims administrator would seriously jeopardize your life or health, or that would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- If you receive a final claim denial from the claims administrator and:
  - you have a medical condition for which the timeframe for completion of a standard external appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or
  - if the final claim denial concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of the request for an expedited external review, the claims administrator will complete a preliminary review of your request in order to determine your eligibility for an external review. Immediately after completion of the preliminary review, the claims administrator will issue you a written notification of your eligibility for an external review. If your request is complete but not eligible for external review, the notice will include the reasons for ineligibility. If your request in incomplete, the notice will describe the information or materials needed to make the request complete and you will have an opportunity to complete the request.

Upon a determination that a request is eligible for an expedited external review, the claims administrator will assign an IRO for review and transmit all necessary documents and information to the IRO. The IRO will provide notice to you and the claims administrator of the final external review decision as expeditiously as possible, but in no event later than 72 hours after the IRO receives the request for the expedited external review. The notice will contain the information described above.

Limits On Legal Actions

If your Benefit or Administrative Claim is denied after you have exhausted the internal claims and appeals process, you generally may file a lawsuit under ERISA regarding your claim, provided that you comply with the deadlines for filing a lawsuit described in this section and you exhaust the internal claims and appeals process. If you wish to file a lawsuit, you must do so by the earlier of the date that is 12 months after the date your claim was denied on appeal or the date that is 12 months from the date a cause of action accrued (except in the case of an LTD claim which must be brought within 3 years from the time proof of claim is required). A cause of action “accrues” when you know or should know that the claims administrator, the Plan Administrator, or Northrop Grumman as Plan Sponsor has clearly denied or otherwise repudiated your claim.

- **Example 1:** If your claim for payment of a medical expense (other than an urgent claim) is denied after a second level of appeal, the 12-month period begins on the date of the denial of the second level of appeal.
- **Example 2:** If your urgent claim is denied, and you file suit after the first level appeal, the 12-month period begins on the date of the denial of the first level appeal. If you file a voluntary level 2 appeal of an urgent claim denial, the 12-month period begins on the date of the denial of the level 2 appeal.
- **Example 3:** If you are in the first year of a medical leave of absence, under current Plan terms, your medical, dental and vision benefits could continue at active employee rates for up to one year. If Northrop Grumman amends the Plan so that coverage at active employee rates continues for six months, then Northrop Grumman has clearly denied your right to continued coverage at active employee rates after that six-month period ends, and the 12-month period for filing a lawsuit begins when the amendment is first communicated to Plan participants. Note that if you file a claim regarding the amendment and follow the procedure through the second level of appeal, the 12-

month period for filing a lawsuit will begin on the date of the denial of the second level of appeal.

EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

What Is ERISA?

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs employee plans.

What ERISA Means to You

ERISA sets standards that a plan sponsor must follow if it maintains a covered employee plan. With some exceptions, covered employee plans include plans sponsored by an employer to provide employees with certain pension, savings, and health and welfare benefits.

ERISA does not require any company to offer an employee plan and generally does not specify the benefits you should receive. However, if a plan is offered, ERISA provides you with certain rights as a participant, and requires that employers who offer covered employee plans follow certain standards related to the Plan's operation.

What ERISA Does

You and your beneficiaries have basic rights and protections under ERISA, which:

- Requires the plan administrator to provide you with information about the plans, including important information about the plans' features and how they are funded. In certain circumstances, the plan administrator may request a small fee to cover copying costs.
- Requires that fiduciaries of your plans operate the plans prudently and in the interest of all plan participants
- Gives you the right to sue for benefits or for breaches of fiduciary duty

What Is a Fiduciary?

A fiduciary is a person or organization whose duty is to operate your plans prudently and in the interest of all plan participants and beneficiaries. Fiduciaries may include employees who make certain discretionary decisions about the management or administration of a plan, or employees who make decisions about funding plan benefits. They also may include outside investment advisors, trustees, and certain others.

Your ERISA Rights

As a plan participant under ERISA, you have the right to:

- Examine all plan documents without charge at the plan administrator's office or at other specified locations. This includes plan documents, trust agreements, insurance contracts and collective bargaining agreements. Copies of all documents filed on behalf of the plan with the U.S. Department of Labor, such as annual reports and plan descriptions, are also available for you to review at the plan administrator's office.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the

latest annual report and updated summary plan description. The plan administrator may charge a reasonable fee for the copies. Requests for documents should be submitted to the NGBC at: PO Box 770003, Cincinnati, OH 45277-0071.

- Receive a summary of the plan's annual financial reports. You do not have to ask for your copy of the summary; the plan administrator sends you a Summary Annual Report (SAR) each year.
- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review **COBRA Continuation Of Coverage** and the documents governing the plan for the rules governing your COBRA continuation of coverage rights.
- Receive a reduction or elimination of the exclusionary periods of coverage for preexisting conditions under your group health plan.

In addition to creating rights for plan participants, ERISA imposes duties on the plan fiduciaries — the people responsible for operating the plan. Plan fiduciaries may include employees who make certain discretionary decisions about the management or administration of the plan. Fiduciaries also may include outside investment advisors and trustees.

Questions?

If you have any questions about your rights under ERISA or about this statement outlining your rights, you should contact the nearest regional office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. You also may contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administrator (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Fiduciaries have a duty to operate the plan prudently and in the sole interest of plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and/or required to reimburse the plan for losses that they have caused.

No one, including Northrop Grumman or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing Your ERISA Rights

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request plan materials and you do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for a reason beyond the control of the plan administrator or the plan administrator otherwise had a reasonable basis for not providing them.

If you have a claim for benefits that is denied or ignored — in whole or in part — and you have satisfied all of the plan's appeals procedures, then you may file suit in a state or federal court. If a fiduciary misuses the plan's assets, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

In addition to deciding what damages, if any, should be awarded, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay them. If you lose, the court may order you to pay these costs and fees (for example, your claim is frivolous).

As described earlier, the Plan prohibits assignments of self-insured benefits. All rights to benefits under the Plan are personal to the participant or beneficiary. Your rights and benefits under the Plan cannot be assigned, sold, pledged, or transferred to a third party, including your health care provider. This includes your right to payment or reimbursement for benefits under the Plan and your right to file a lawsuit to recover benefits due to you under the Plan. Any purported assignment of rights or benefits is void and will not be recognized by the Plan.

The claims administrator may issue payments directly to your providers for covered services you receive (whether or not pursuant to an authorization). The claims administrator's doing so, however, does not create an assignment of benefits and it will not constitute a waiver of the application of this provision.

The prohibition of assignments does not take away your ability to designate an authorized representative (described earlier) to file claims for benefits or to file appeals as part of the Plan's internal claims as appeals process. In order to appoint an authorized representative, you must follow the process described previously. Signing a provider form will not be sufficient.

The Plan also prohibits assignments of any other rights a participant or beneficiary may have under ERISA, including, without limitation, the right to request documents under section 104 of ERISA and the right to file a lawsuit to:

- Enforce rights under the terms of the Plan;
- To clarify rights to future benefits under the terms of the Plan;
- Obtain relief for a breach of fiduciary duty;
- Enjoin any act or practice which violates ERISA or the terms of the Plan or to obtain other equitable relief to redress such violations or enforce any provisions of ERISA or the Plan; and
- Obtain relief based on the Plan Administrator's failure to provide information or other documentation to which a participant or beneficiary may be entitled under ERISA.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

What Is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets standards for employee plans —specifically related to your ability to obtain new coverage, the opportunity to select or change coverage after certain qualified life events, and health information privacy.

Special Enrollment Periods Provided Under HIPAA

If you waive medical coverage for yourself or your spouse or eligible dependents during enrollment because you or they have other health insurance coverage, and then you or they lose that coverage, you **may** be able to enroll yourself or your dependents in a Northrop Grumman medical plan option before the next annual enrollment. Specifically, you may enroll in a Northrop Grumman medical plan option within 31 days of the date you or your dependents:

- Lose eligibility for coverage under another group health plan,
- Lose the employer contribution toward another group plan's coverage, or
- Exhaust COBRA coverage (your COBRA coverage ends, but not because you failed to make the premium payment or because employer-subsidized COBRA has ended).
- Once you enroll, your coverage is effective retroactive to the date you lost coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Coverage for new dependents due to marriage will be effective no later than the first month following the date of enrollment. Coverage for new dependents as a result of birth, adoption, or placement for adoption will be effective on the date of the event.

You may elect medical, dental and/or vision coverage at a time other than the annual enrollment period in the following situations:

- If you (and/or your eligible dependent) are not enrolled in medical, dental and/or vision coverage and are covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act and your (and/or your eligible dependent's) coverage under that Medicaid or State child health plan terminates because you (and/or your dependent) lose eligibility for that coverage, you may elect medical, dental and/or vision coverage if you request enrollment within 60 days after coverage under the Medicaid plan or State child health plan terminates.
- If you (and/or your eligible dependent) are not enrolled in medical, dental and/or vision coverage and become eligible for assistance with the cost of medical, dental and/or vision coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, you may elect medical, dental and/or vision coverage if you request enrollment within 60 days after the date you (and/or your eligible dependent) are determined to be eligible for such assistance.

In the case of both of the above special enrollment events, coverage will be effective as of the date specified in regulations or other guidance issued by the Internal Revenue Service or U.S. Department of Labor.

HIPAA Privacy Rights

Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on employer health plans concerning the use and disclosure of protected health information. The Northrop Grumman Health Plan is a hybrid entity. This means that certain components of the Plan are subject to the HIPAA privacy rules, while others are not. The components of the Plan that are subject to the HIPAA privacy rules are the medical, dental, vision, employee assistance program (EAP), health reimbursement account (HRA), and the health care flexible spending account (HCFSA) components of the Plan. All other components of the Plan are not subject to the HIPAA privacy rules.

Protected health information includes all individually identifiable health information held by the components of the Northrop Grumman Health Plan subject to the HIPAA privacy rules — whether received in writing, in an electronic medium, or as an oral communication. Enrollment information collected by Northrop Grumman or the Plan's recordkeeper is employer information and not protected health information subject to HIPAA.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The HIPAA privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. 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 Northrop Grumman Health Plan has been amended to permit authorized Northrop Grumman workforce members to use and disclose protected health information for functions permissible under HIPAA. This means that the Northrop Grumman Health Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Northrop Grumman workforce members for plan administration purposes, and that authorized Northrop Grumman workforce members may use or disclose your health information to administer benefits under the Plan. Authorized Northrop Grumman workforce members may not use or disclose your health information other than as permitted or required by the plan documents and by law. Personnel within the following areas of responsibility are the only Northrop Grumman workforce members who will have access to your health information for plan administration and other functions permissible under HIPAA:

- HIPAA Privacy Official and HIPAA Security Official
- Directors, managers, supervisors, and similar leadership positions (or their designees) related to the Plan and/or other Northrop Grumman health and welfare benefit programs
- Benefits personnel addressing operations, administration, analytics, strategy, and design of the Plan and/or other Northrop Grumman health and welfare benefit programs
- Benefit services personnel
- Executive services personnel
- Employee Assistance Plan administrative personnel
- Payroll, Human Resources, and Accounting personnel
- Information Technology personnel
- Compliance managers and others who are responsible for legal compliance relating to the Plan
- General counsel, assistant general counsel, and other counsel acting on behalf of the Plan
- Such other persons designated by the Privacy official (or his or her designee)

Here's how additional information may be shared between the Northrop Grumman Health Plan and authorized Northrop Grumman workforce members, as allowed under the HIPAA rules:

- The Northrop Grumman Health Plan, or its Insurer or HMO, may disclose "summary health information" to authorized Northrop Grumman workforce members 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 Northrop Grumman Health Plan, or its Insurer or HMO, may disclose to authorized Northrop Grumman workforce members information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

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

In certain cases, your health information can 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 opportunity to agree or object to these disclosures (although exceptions may be made: for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

Except as described in the Northrop Grumman Health Plan Privacy Notice ("Privacy Notice") and plan document, 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 cannot revoke your authorization if the Plan has taken action relying on it.

DEFAULT PROCEDURE

For self-insured medical benefits administered by Anthem, it is the Plan's procedure, upon request for assistance, to disclose your health information to your spouse or your domestic partner (if applicable), and his or her health information to you, and to disclose the health information of your over-age enrolled dependent (for example, your child who is over age 21) to you or your spouse or your domestic partner (if applicable), unless the person whose health information would otherwise be disclosed chooses to opt out of this default procedure. You may request the Plan not share your health information with your spouse or your domestic partner (if applicable) by opting out of this default procedure. To opt out, you must contact Anthem at 800-894-1374. Your spouse, domestic partner (if applicable) and/or your over-age enrolled dependent may also opt out of this procedure by contacting the Anthem. Once an individual has opted out of this default, the Plan generally will not disclose any of his or her health information to family members, unless some other part of the HIPAA regulations permits or requires it (for example, that individual becomes incapacitated). Any individual may change his or her opt-out election at any time by contacting Anthem.

YOUR RIGHTS UNDER HIPAA

You have the following rights with respect to your health information the Northrop Grumman Health Plan maintains. These rights are subject to certain limitations, as discussed below.

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. In addition, you have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

- The Plan is not required to agree to a requested restriction. However, 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

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 (for example, 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

Note about Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and or with the Plan. You will not be retaliated against if you file a complaint. To file a complaint with respect to a violation of your privacy rights, please contact the Privacy Official or its designee.

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 Privacy Notice.

- If you want to exercise this right, your request to the Plan must be in writing

Right to be notified of a breach of your unsecured protected health information.

COBRA CONTINUATION OF COVERAGE

What Is COBRA?

According to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, you and your enrolled family members are eligible to pay for continued group health care coverage if you lose your benefits under certain circumstances, including termination of employment (unless due to gross misconduct). Continued coverage rights apply only to health care coverage (medical, dental, vision, and health care flexible spending account), not to other types of benefits (Dependent Day Care Flexible Spending Account, life insurance and long-term disability insurance).

You and your enrolled family members will be considered qualified beneficiaries and can continue coverage for a maximum of 18, 29, or 36 months, depending on the reason your coverage ended, as shown in the chart below. If multiple circumstances occur, the maximum period is a total of 36 months. For the Health Care Flexible Spending Account (FSA), you can continue participation until the end of the plan year in which you lose your benefits.

You and your eligible dependents have 60 days from the date coverage ends or the date of receipt of your COBRA notice, whichever is later, to elect continued participation under COBRA. (Each family member who is a qualified beneficiary may make a separate COBRA election.) You normally have 45 days from your COBRA election to make the first premium payment, and subsequent monthly payments must be made within a 31-day grace period that starts at the beginning of each coverage month. If you do not make a timely election, COBRA rights are waived.

If you elect COBRA continuation:

- Initially, you and your dependents will keep the same type of plan coverage you were enrolled in under the Northrop Grumman Health Plan while an active employee
- You may keep the same coverage category you had as an active employee or choose a different category. For example, if your spouse and all of your dependents were enrolled under the Northrop Grumman medical plan, you could choose to enroll all, some or none under COBRA.
- Coverage is effective on the date of the event that qualified you for COBRA coverage, unless you waive COBRA coverage and subsequently revoke your waiver within the 60-day election period. In that case, your coverage begins on the date you revoke your waiver.
- You may change plan coverage and coverage category (including adding eligible dependents) during the annual enrollment period or if you have a qualified life event
- You may add newly acquired dependents during the plan year
- You can enroll your newly eligible spouse or child under the same guidelines that apply to active employees

If you or a covered dependent is Medicare eligible, the Plan will pay secondary to Medicare for that individual, regardless of whether the individual enrolls in Medicare Parts A and/or B.

COBRA-like coverage is also available for eligible domestic partners. For details, call the NGBC at 800-894-4194.

COBRA Continuation Period

QUALIFYING EVENT	MAXIMUM CONTINUATION PERIOD		
	EMPLOYEE	SPOUSE	CHILD
You lose coverage because you reduce your work hours or take unpaid leave	18 months	18 months	18 months
You terminate employment for any reason (except gross misconduct)	18 months	18 months	18 months
You or your dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days after COBRA begins	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your spouse divorce	N/A	36 months	36 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

Newly Eligible Child

If you, the former Northrop Grumman employee, elect continuation coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Northrop Grumman-sponsored group health plan and the requirement of the federal law, these qualified beneficiaries can be added to COBRA coverage by providing the NGBC with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 31 days of birth, adoption, placement for adoption, or appointment as a legal guardian. The notice must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the NGBC in a timely fashion regarding your newly acquired child, you will not be offered the option to elect COBRA coverage for that child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

Cost of COBRA

COBRA participants pay monthly premiums for their coverage on the following basis:

- For health care coverage (medical, dental, vision, and EAP), premiums are based on the full group rate per enrolled person set at the beginning of the plan year, plus 2% for administrative costs. Your spouse or child who is a qualified beneficiary making a separate election is charged the same rate as a single employee.
- Health Care Flexible Spending Account (FSA) contributions can be continued through the end of the plan year on an after-tax basis.

If you or your enrolled dependent is disabled, as defined by Social Security, COBRA premiums for months 19 through 29 may be increased to reflect 150% of the full group cost per person.

Notification

You are notified by mail of your COBRA election rights and enrollment instructions when you qualify due to a reduction in hours or termination of employment (other than for gross misconduct). Your spouse and dependent children are notified of their COBRA election rights when they lose health coverage under the Plan as a result of your death or Medicare entitlement.

If your dependents lose coverage due to divorce or loss of dependent status, you (or a family member) must notify the NGBC at 800-894-4194 within 60 days of the event so that COBRA can be offered and information on election rights can be mailed. Also, to extend coverage beyond 18 months because of disability, you must provide notice of the Social Security Administration's determination during the initial 18-month period and within 60 days of the date you receive your determination letter.

Your Duties Upon a Second Qualifying Event

If an employee or covered family member experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the NGBC. This notice must be provided in writing and must include the name of the employee, the name of the qualified beneficiary receiving COBRA coverage, and the type and date of second qualifying event.

This notice must be provided within 60 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the employee or covered family member may also be required to provide a copy of a death certificate, divorce decree, separation agreement, and dependent child(ren)'s birth certificate(s).

When the NGBC is notified that one of these events has happened, the covered family member will automatically be entitled to the extended period of continuation coverage. If an employee or covered family member fails to provide the appropriate notice and supporting documentation to the NGBC during this 60-day notice period, the covered family member will not be entitled to extended continuation coverage.

Special Rules for Disability

If the qualifying event is a termination of employment or reduction in hours of employment, the 18-month COBRA continuation period may be extended to 29 months if a qualified beneficiary is determined by Social Security to be disabled at any time before the 60th day of the COBRA continuation period. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment. To be granted this extension, the qualified beneficiary must, before the end of the 18-month period: (1) notify the Plan Administrator of such disability determination by the later of (a) 60 days after coverage is lost due to the qualifying event, (b) 60 days after the qualifying event, or (c) 60 days after the Social Security Administration determines the individual to be disabled; and (2) provide a copy of the determination of disability notification from the Social Security Administration.

You must notify the Plan Administrator of any final determination by the Social Security Administration that a qualified beneficiary is no longer disabled, within 30 days of such determination.

The cost for this 11-month extension will be:

- 150% of the applicable premium for all qualified beneficiaries if the disabled qualified beneficiary is covered; or
- 102% of the applicable premium if only non-disabled qualified beneficiaries are covered.

Medicare

If you experience a qualifying event due to termination of employment or reduction of hours within 18 months after you have enrolled in Medicare, your spouse and dependent children who are qualified beneficiaries may elect COBRA for medical and/or dental/vision coverage for up to 36 months measured from the date of your Medicare enrollment.

Questions about COBRA?

If you have any questions about COBRA coverage or the application of the law, please contact the NGBC or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **dol.gov/ebsa**.

Trade Reform Act of 2002

The Trade Reform Act of 2002 created a special COBRA right applicable to employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

When COBRA Ends

COBRA coverage ends before the maximum continuation period ends if one of the following occurs:

- You or your dependent becomes covered under another group health plan not offered by Northrop Grumman after the date of your COBRA election (unless the Plan has pre-existing condition limitations that affect the enrolled person)
- You or your dependent first becomes enrolled in Medicare after the date of your COBRA election (if you or your dependent is not entitled to or enrolled in Medicare, you or your dependent can continue coverage under COBRA until the maximum continuation period ends)
- You or your dependent fails to make a timely monthly payment. After the initial COBRA premium payment, payments are due on the first day of each month. If your payment is not received within 30 days after the first day of the month (the "grace period"), coverage will be terminated effective as of the last day of the period for which payment was made. For example, if payment for May coverage is due May 1, and you fail to make the applicable payment by May 31, your coverage will be terminated retroactive to April 30. After your initial 18-month period, you or your dependent ceases to be considered disabled for Social Security purposes and is not otherwise eligible for a longer continuation coverage period.
- Northrop Grumman ceases to provide medical benefits to any employee

COBRA and FMLA

For purposes of a Family and Medical Leave Act (FMLA) leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave begins (of you or your dependent becomes covered during the FMLA leave); and
- You do not return to employment at the end of the FMLA leave.

A leave that qualifies under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you are still eligible for COBRA on the last day of the FMLA leave if you decide not to return to active employment. Your COBRA continuation coverage will begin on the earliest of the following to occur:

- When you definitively inform Northrop Grumman that you are not returning at the end of the leave, or
- The end of the leave, assuming you do not return to work.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should update your address in Workday (or contact the HRSC) informed of any changes in your or your family members' addresses. You should also keep a copy, for your records, of any notices you send.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA)

If you have taken leave to perform service in the uniformed services, you may also qualify to purchase continuation coverage for yourself and any covered dependents pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Continuation coverage rights under USERRA are similar to COBRA continuation coverage rights.

In order to qualify for USERRA continuation coverage, you must be performing duty on a voluntary or involuntary basis in a uniformed service (see below) under competent authority. Service includes active duty, active and inactive duty for training, National Guard duty under federal law and a period for which you are absent for an examination to determine your fitness to perform those duties. Service also includes a period for which you are absent to perform funeral honors duty as authorized by law and services as an intermittent disaster-response appointee of the National Disaster Medical System. Uniformed services means the following: Armed Forces; Army National Guard; Air National Guard when engaged in active duty for training, inactive duty training, or fulltime National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the president in time of war or national emergency.

Duration of Coverage

If you qualify to continue coverage under USERRA, you may continue coverage for yourself and any covered dependents for whom you elect coverage for up to 24 months from the date your coverage would end because of your leave. Your USERRA coverage will end earlier than the end of the 24-month period if:

- You fail to pay the required premiums on a timely basis as described in the **COBRA Continuation Of Coverage** section of this summary plan description and the COBRA election and payment materials that will be provided to you when you experience a COBRA qualifying event
- You fail to return to work within the time required under USERRA
- You lose your USERRA rights because you are dishonorably discharged or because of other conduct specified in USERRA

COBRA coverage and USERRA coverage begin at the same time and run concurrently. As noted in the **COBRA Continuation Of Coverage** section, COBRA coverage can continue for up to 18 months and is subject to extension and early termination in certain circumstances that do not apply under USERRA.

If you elect COBRA coverage on a timely basis and are eligible for USERRA continuation coverage, your COBRA election will also be treated as an election of USERRA. All of the rules and procedures regarding COBRA coverage apply to USERRA coverage, except that the deadline for electing continuation coverage will not apply to USERRA coverage if under the circumstances it was unreasonable or impossible for you to make a timely election of coverage (for example, emergency military deployment). Also, if your military leave is for less than 31 days, you will be required to pay only the normal employee contribution for the level of coverage you continue.

Keep in Mind

If you qualify for USERRA leave, you most likely will be entitled to benefits continuation as described in the section titled **If You Take a Leave of Absence**.

FUTURE OF THE PLAN

Northrop Grumman has the absolute right in its sole discretion to amend or terminate the Plan or any Plan provision in whole or in part at any time, including any cost sharing arrangements.

Amendments to or termination of the Plan may apply to active, inactive or former employees. A Plan change may transfer Plan assets to another plan, or split the Plan into two or more parts. The Plan Administrator notifies you if an amendment or termination substantially affects your benefits.

Any amendment, termination, or other action by Northrop Grumman with respect to the Plan shall be duly authorized by the committee or person(s) authorized to take such action. An amendment to the Plan may be effectuated by Northrop Grumman causing the Plan Administrator to publish a Summary of Material Modifications or a revised Summary Plan Description describing the change.

If all or part of the Plan is terminated, you have no further rights other than payment of claims for eligible expenses that you incurred before the Plan or portion of the Plan terminated. The amount and form of any final benefit you may receive under the Plan depend on Plan assets, any contract or insurance provisions affecting the Plan, and decisions made by Northrop Grumman.

If the Plan is terminated, retired employees and beneficiaries who are receiving coverage or benefits under the Plan stop their participation and receive no additional benefits. Claims for expenses incurred before the termination date, however, are processed in accordance with Plan terms.

After all benefits are paid and legal requirements are met, the Plan assets will become the sole property of Northrop Grumman, to the extent permitted by law.

ADMINISTRATIVE INFORMATION

General Plan Facts

Employer/Plan Sponsor	Northrop Grumman Corporation 2980 Fairview Park Drive Falls Church, VA 22042
Employer Identification Number (EIN)	80-0640649
Type of Plan	Welfare plan
Type of Administration	Insured and self-insured
Plan Administrator	Benefit Plans Administrative Committee Northrop Grumman Health Plan Northrop Grumman Corporation 2980 Fairview Park Drive Falls Church, VA 22042
Agent for Service of Legal Process	Northrop Grumman Corporation c/o Corporate Secretary Northrop Grumman Corporation 2980 Fairview Park Drive Falls Church, VA 22042 Service of process may also be made to the plan trustee or the Plan Administrator identified below.
Plan Year	January 1 to December 31
Plan Name and Number	The Northrop Grumman Health Plan is a component plan under the Northrop Grumman Corporation Group Benefits Plan; plan 501

Specific Plan Facts

MEDICAL PLAN	
Insured by:	Northrop Grumman self-insures Plan 1: High Premium/Low Deductible, Plan 2: Medium Premium/Medium Deductible, Plan 3: Low Premium/High Deductible, Plan 4: Medium Premium/Deductible Utah Extended Network, Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan, and Sunnyvale Value Plan medical plan options. All medical plan options administered by Anthem utilize the Utah state benchmark plan for purposes of identifying essential health benefits. All other medical plan options are fully insured under contracts with insurers.
Claims administered by:	Refer to the claims administrators and addresses provided in the chart under Claims and Appeals Contact Information in the Claims section. For all other plan options, refer to your medical ID card for claims administration details.
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Sources of contributions:	Depending on the benefits selected by the employee, the cost of benefits will either be covered by contributions from Northrop Grumman or shared by Northrop Grumman and the employee.

PRESCRIPTION DRUG PLAN IN THE MEDICAL PLAN OPTIONS	
Insured by:	Northrop Grumman self-insures the prescription drug benefits in the Plan 1: High Premium/Low Deductible, Plan 2: Medium Premium/Medium Deductible, Plan 3: Low Premium/High Deductible, Plan 4: Medium Premium/Deductible Utah Extended Network, Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan, and Sunnyvale Value Plan medical plan options. Prescription drug benefits under all other medical plan options are provided under contracts between the medical plan and prescription drug providers.
Claims administered by:	For prescription drug benefits in the Plan 1: High Premium/Low Deductible, Plan 2: Medium Premium/Medium Deductible, Plan 3: Low Premium/High Deductible, Plan 4: Medium Premium/Deductible Utah Extended Network, Baltimore Premium Plus Plan, Baltimore Premium Plan, Baltimore Value Plan, Sunnyvale Premium Plan, and Sunnyvale Value Plan medical plan options, claims are administered by: CVS/caremark (initial claim determinations) Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 CVS/caremark (appeals determinations) Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 For all other plan options, refer to the claims administrators and addresses provided in the chart found under Claims and Appeals Contact Information in the Claims section of this SPD, or refer to your medical ID card for claims administration details.
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman and participant contributions
DENTAL PLAN	
Insured by:	The dental plan options are self-insured by Northrop Grumman, with the exception of the CIGNA Dental Care Access plan option (formerly, CIGNA DHMO) and the CIGNA Global Dental plan available to eligible expatriates. These plan options are insured by the following entities: CIGNA Dental Health P.O. Box 189060 Plantation, FL 33318-9060 800-244-6224 CIGNA Global Cigna International PO Box 15964 Wilmington, Delaware 19850 800-441-2668
Claims administered by:	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 415-972-8300 CIGNA Dental Health P.O. Box 189060 Plantation, FL 33318-9060 800-244-6224
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman and participant contributions

VISION PLAN	
Insured by:	Vision Service Plan
Claims administered by:	Vision Service Plan 3333 Quality Drive Rancho Cordova, CA 95670 800-877-7195
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman and participant contributions
EMPLOYEE ASSISTANCE PROGRAM (EAPI)	
Insured by:	ComPsych Corporation
Claims administered by:	ComPsych Corporation 455 N. Cityfront Plaza Dr., 13th Fl. Chicago, IL 60611
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman
BASIC AND OPTIONAL LIFE INSURANCE AND BASIC AND OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE	
Insured by:	MetLife 200 Park Avenue New York, NY 10168
Claims administered by:	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100
Trustee[2]:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	For basic: Northrop Grumman; for optional: participant contributions
BUSINESS TRAVEL ACCIDENT INSURANCE	
Insured by:	AIG (National Union Fire Insurance Company of Pittsburgh, PA) PO Box 25987 Shawnee Mission, KS 66225
Claims administered by:	LINA (Life Insurance Company of North America) P.O. Box 25987 Shawnee Mission, KS 66225
Trustee[2]:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman
GROUP LEGAL PLAN	
Insured by:	MetLife Legal Plans, Inc.

Claims administered by:	MetLife Legal Plans, Inc 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 (800) 438-6388
Trustee[2]:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Participant contributions
CRITICAL ILLNESS	
Insured by:	MetLife Legal Plans, Inc.
Claims administered by:	MetLife Legal Plans, Inc 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 (800) 438-6388
Trustee[2]:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Participant contributions
ACCIDENT	
Insured by:	MetLife Legal Plans, Inc.
Claims administered by:	MetLife Legal Plans, Inc 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 (800) 438-6388
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Participant contributions
HOSPITAL INDEMNITY	
Insured by:	MetLife Legal Plans, Inc.
Claims administered by:	MetLife Legal Plans, Inc 1111 Superior Avenue, Suite 800 Cleveland, OH 44114 (800) 438-6388
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Participant contributions
LONG-TERM DISABILITY PLAN	
Insured by:	American Family Life Assurance Company of Columbus (AFLAC)

Claims administered by:	American Family Life Assurance Company of Columbus (AFLAC) Administrative Office P.O. Box 1725 Grand Rapids, MI 49501
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman
HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLANS	
Insured by:	Northrop Grumman self-insures the Health Care and Dependent Care Flexible Spending Account Plans.
Claims administered by:	Fidelity Investments (Fidelity Flexible Spending and Reimbursement Account Services) P.O. Box 2703 Fargo, ND 58108
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman
GENERAL PURPOSE AND LIMITED PURPOSE HEALTH REIMBURSEMENT ACCOUNTS PLANS	
Insured by:	Northrop Grumman self-insures the General Purpose and Limited Purpose Health Reimbursement Account Plans
Claims administered by:	Fidelity Investments (Fidelity Flexible Spending and Reimbursement Account Services) P.O. Box 2703 Fargo, ND 58108
Trustee:	State Street Bank and Trust Company Master Trust Division 1200 Crown Colony Drive Quincy, MA 02169
Funded by[1]:	Northrop Grumman

[1] The Northrop Grumman and participant contributions may be held in a type of trust called a Voluntary Employee Beneficiary Association (VEBA).
[2] Northrop Grumman and participant contributions are deposited into the trust, and the trust pays the premiums.