

NORTHROP GRUMMAN



Summary Plan Description

Northrop Grumman Health Plan

January 2017

(For Eligible Sunnyvale Represented Employees)

A Guide to Your Northrop Grumman Health Plan

The Northrop Grumman Health Plan gives you access to meaningful benefit choices at competitive rates. You have the flexibility to choose the benefits and coverage levels that are right for you — based on your personal situation.

This guide provides information about the Northrop Grumman Health Plan. If you have questions not answered in this guide, contact the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. Benefits Center service representatives are available to answer your questions Monday through Friday (except most New York Stock Exchange holidays), 8:30 a.m. to 8:30 p.m. Eastern time. If you are calling from outside of the U.S., dial the AT&T out-of-country access number followed by 800-894-4194. TTY service is available at 1-888-343-0860.

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 or this guide will govern, even if inconsistent with information provided by the NGBC.

This guide is the Summary Plan Description (SPD) for the Northrop Grumman Health Plan (also referred to as the “Health Plan” or “Plan”), effective January 1, 2017. The benefits described in this guide are offered to certain hourly and salaried employees of Northrop Grumman Corporation and its affiliates (“Northrop Grumman”). Several medical and dental benefits, and all short term disability 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, EAP, 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.

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 self-insured medical, dental, and prescription drug benefits and insured vision and group legal benefits provided under the Plan are described in detail in this document. The insured medical and dental 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

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SUMMARY PLAN DESCRIPTION
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administration and other important information regarding the Plan that applies to all benefits, whether self-insured or insured.

Northrop Grumman (also referred to as the “Company” in this guide) refers to Northrop Grumman Corporation and related employers that participate in the Plan. The “Plan” is a component plan under the Northrop Grumman Corporation Group Benefits Plan.

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Northrop Grumman Health Plan General Information and Overview of Options

January 2017

GENERAL INFORMATION

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the Plan if you meet all of 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.

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
- 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 are eligible for the Northrop Grumman Health Plan, you also might be able to cover other persons described below.

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 Northrop Grumman by calling the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194
- You understand that Northrop Grumman 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 Northrop Grumman
- 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 Northrop Grumman 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 a person does not meet the eligibility requirements at the time of enrollment, Northrop Grumman will cancel that person's coverage
- If a person ceases to meet the eligibility requirements at a time after enrollment, Northrop Grumman will cancel that person's coverage
- If you refuse or fail to timely provide required proof of eligibility for a person, Northrop Grumman will cancel that person's coverage as of the date of enrollment or such other date as Northrop Grumman determines, in its sole discretion, to be appropriate
- If you enroll a person who does not meet the eligibility requirements, or if you fail to notify Northrop Grumman 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, and criminal charges.

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 residency. You will be required to submit a Declaration of Informal Marriage, an affidavit, marriage certificate, or other documents as required by Northrop Grumman.
- 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 "General Plan Administration: COBRA" section.
- If your spouse works, please read "Special Provisions for Working Spouses." If your spouse is retired, read "Special Provisions for Retired Spouses."

■ 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;
 - 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.

Domestic partner tax note: For domestic partner benefits, the IRS treats Company contributions (as applicable) as taxable. The value of the benefit will be imputed as income to you. It is important that you understand the tax and legal implications of creating a domestic partner relationship and covering your domestic partner and/or your partner's eligible children. Therefore, you may want to consult your tax and legal advisors to determine the impact on you.

Other Eligible Dependents

The following people are eligible for medical, dental and vision coverage as your dependents if they meet the requirements stated. For information on when their coverage ends, see the chart titled "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 section.

■ Your Children

- Your biological child to the end of the month in which he/she turns age 26
- Your adopted child to the end of the month in which he/she turns age 26. 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.
- Your stepson or stepdaughter to the end of the month in which he/she turns age 26, but only while you are married to the child's biological or adoptive parent. A stepson or stepdaughter 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 he/she turns 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 before January 1, 2011;
 - The child became disabled before the age of 19, or while at least the age of 19 but under 25 and while a full-time student;
 - You claim the child as a dependent on your federal tax return.
- 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 on or after January 1, 2011;
 - 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.

■ **Your Brothers or Sisters**

- Your brother or sister that you claim as a dependent on your federal tax return and for whom you are the legal guardian, up to the end of the month in which they turn age 26
- Your unmarried and disabled brother or sister who is age 26 or older and meets all of the following requirements:
 - Your brother or sister became disabled before January 1, 2016;
 - Your brother or sister became disabled before the age of 19, or while at least the age of 19 and before 25 and while a full-time student;
 - You claim your brother or sister sibling as a dependent on your federal tax return; and
 - You are the legal guardian of your brother or sister.
- Your unmarried and disabled brother or sister who is age 26 or older and meets all of the following requirements:
 - Your brother or sister became disabled on or after January 1, 2016;
 - Your brother or sister became disabled before the age of 26;
 - You claim your brother or sister as a dependent on your federal tax return; and
 - You are the legal guardian of your brother or sister.

■ **Your Grandchildren**

- Your grandchild (i.e., the child of your biological or adopted child) that you claim as a dependent on your federal tax return and for whom you are the legal guardian, up to the end of the month in which they turn 26
- Your unmarried and disabled grandchild who is age 26 or older and meets all of the following requirements:
 - Your grandchild became disabled before January 1, 2016;
 - Your grandchild became disabled before the age of 19, or while at least the age of 19 and before 25 and while a full-time student;
 - You claim the grandchild as a dependent on your federal tax return; and
 - You are the legal guardian of your grandchild.
- Your unmarried and disabled grandchild who is age 26 or older and meets all of the following requirements:
 - Your grandchild became disabled on or after January 1, 2016;
 - Your grandchild became disabled before the age of 26;
 - You claim the grandchild as a dependent on your federal tax return; and
 - You are the legal guardian of your grandchild.

■ 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, Northrop Grumman 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 Northrop Grumman verifies that an order is a QMCSO, Northrop Grumman enrolls the child according to the terms of the order.

Judgment, Decree, or Order Including QMCSO

If a judgment, decree or order including a Qualified Medical Child Support Order (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 judgment, decree, or order 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 statement from the treating physician or other documents as required by Northrop Grumman to confirm a disability. The Plan considers a person to be disabled only if all of the following are true:

- he or she is 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
- he or she is dependent on you for financial support.

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

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 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 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 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 Works for a Company Other than Northrop Grumman

If you have a working spouse (or eligible domestic partner) who has medical coverage available through his or her employer, you can enroll your spouse in a Northrop Grumman medical plan option. However, claims for your spouse'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 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 plan is an HMO but your spouse 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 is

strongly encouraged to obtain and utilize medical care through the plan provided by his or her employer.

Special Provisions for Retired Spouses

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

If Your Spouse Is a Northrop Grumman Retiree

If your spouse is a Northrop Grumman retiree, you have two options for your active employee medical coverage:

- You may cover your spouse 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 can be covered under his or her retiree medical plan option. (You may enroll your spouse 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 retiree medical plan option.

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 Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

HOW THE PLAN WORKS

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 Northrop Grumman has your current address. If your address changes, you must contact the Human Resources Service Center (HRSC) or your local human resources representative immediately to report the change.

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, which are:

- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance
- Basic long-term disability (LTD) insurance
- Basic short-term disability (STD) insurance
- Business travel accident insurance.

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 and Northrop Grumman share the cost of these optional benefits:

- Medical
- Dental.

You pay the entire cost of these optional benefits at Northrop Grumman group rates:

- Optional life insurance
- Optional long-term disability (LTD) insurance
- Optional accidental death and dismemberment (AD&D) insurance
- Vision
- Group legal.

You can also choose to set aside pre-tax dollars in the flexible spending accounts (FSAs):

- Health care FSA
- Dependent day care FSA.

You can also choose to set aside pre-tax dollars in a Health Savings Account (HSA) if you enroll in the Value plan medical plan option as described in the “Health Savings Account” section of this SPD.

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/domestic partner
- You + family (employee, child[ren], and spouse/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.

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 monthly employee contribution amount plus a percentage of your base salary over \$100,000.
- For medical, whether you and your current family members do or do not use tobacco products.
- For certain medical plans, whether you and your spouse or domestic partner complete an annual physical.

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.

Non-Tobacco Usage Credit

Employees who attest that they and their covered family members are tobacco-free will receive a \$25 per month credit (\$15 for Sunnyvale represented employees) on their required contribution for medical plan coverage. The credit will be applied to your per pay period medical deduction, and is the same regardless of the number of covered dependents you have. It is not a cash payment and is available only to employees enrolled in an eligible Northrop Grumman Health Plan medical option.

To receive the credit, you must complete the 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 uses tobacco products, you can receive the premium credit if the tobacco user(s) enroll in any tobacco cessation program, including Quit for Life or any program recommended by your doctor. If the tobacco user(s) enroll in a tobacco cessation program by the date specified in enrollment materials, the credit will be available and will continue as long as the tobacco user completes the tobacco cessation program (whether or not he or she succeeds in ceasing tobacco use). The credit will cease to be available if the tobacco user does not complete the program. More information regarding the Quit for Life program may be obtained by calling 1-800-894-4194. Certain restrictions apply.

You will have the opportunity to make or change your tobacco usage attestation at any point during the Plan Year. If you attest to being a non-tobacco user after Annual Enrollment, the non-tobacco use credit will be applied as soon as administratively possible on a prospective basis – retroactive credits are not permitted under any circumstances. This rule also applies to new hires and employees newly-enrolling in medical coverage as a result of a qualifying life event election change.

The following are considered tobacco products: cigarettes, pipes, cigars, and chewing tobacco. E-cigarettes are not included.

The non-tobacco usage credit does not apply to certain COBRA participants, individuals enrolled in the TRICARE Supplement, and the following medical plan options: Aetna International Benefits Plan, HMSA HMO, HMSA PPO, and Kaiser Hawaii.

Annual Physical Incentive

If you (and your spouse or domestic partner, if enrolled) complete an annual physical, you may be eligible for a premium credit applied toward your Northrop Grumman Health Plan medical plan option. You may receive a credit of up to \$100 per month for five months depending on your coverage level. You must complete the annual physical within a specified time period in order to receive the credit. The credit does not apply to individuals enrolled in TRICARE Supplement or who reside in Hawaii.

In accordance with privacy and security rules under HIPAA, the results of your annual physical — as well as any other health services you receive — are never shared with Northrop Grumman. Safeguards are in place to protect the privacy and security of your medical information. The Company will only receive aggregated data, which will help with the development of future programs that reflect the health needs of participants and beneficiaries.

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 constitutes 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 will 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 30 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 Plan Administrator 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.

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

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 some 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 the COBRA section)
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 the COBRA section)
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 the COBRA section)
Your dependent covered by reason of a QMSCO is no longer required to be covered by the QMSCO	If the dependent was covered only by the QMSCO 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 QMSCO. If the dependent was covered at the time the QMSCO 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/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

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If you or your dependents are no longer eligible for participation because:	Then coverage will end:
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 Coverage may be reinstated on the date the required documentation is submitted to the Northrop Grumman Benefits Center or at the next Annual Enrollment.
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 the "COBRA" section)

Note: Northrop Grumman 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 Northrop Grumman.

You and your dependents may continue coverage under certain circumstances when coverage otherwise would end, as described in the "General Plan Administration: COBRA" section.

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.

In addition, you may change your elections during the plan year (outside of the annual enrollment period):

- For pre-tax benefits (medical, dental, vision, and flexible spending accounts), when you have a qualified life event (see “Qualified Life Events” later in this section)
- For after-tax benefits (Life, AD&D, and LTD), when and how permitted by those plans (subject to evidence of insurability and/or pre-existing condition exclusions, as applicable). Refer to those sections of this summary plan description for details.
- For Group Legal, you can change your election only during the annual enrollment period each year.

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” later in this section). 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 and 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.

For after-tax benefits (optional life and AD&D): You may enroll your dependents in optional life and AD&D coverage at any time, as permitted by those plans and subject to evidence of insurability, as applicable. Refer to those sections of this summary plan description for details.

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*® available through *Benefits and You OnLine* or directly at www.netbenefits.com/northropgrumman to make your enrollment choices.

You must make your benefit elections within 31 days after your date of hire. 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, AD&D, and long-term disability insurance 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.)

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” later in this section.

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.

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, Northrop Grumman 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 including your flexible spending account elections (if available) will carry over to the following plan year. 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 or optional LTD insurance. If you wish to make changes to your flexible spending accounts (FSAs), or increase your basic or optional life insurance, optional AD&D insurance, or optional LTD insurance coverage, you may do so only *when you return to work on a regular basis (as a benefits-eligible employee)* by calling the Northrop Grumman Benefits Center (NGBC) within 31 days of your return to work.

If you are on an unpaid leave of absence during the annual enrollment period, you may call the NGBC to enroll. New benefit elections must be made prior to January 1 either by calling the NGBC or logging on to the enrollment website.

If you are on a leave of absence after the end of annual enrollment but at the start of the 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
- If you enroll in optional life insurance, optional AD&D insurance, optional LTD insurance, or Group Legal coverage, call the NGBC when your return to work to make new elections.

Changing Your Benefits Outside of 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, 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 Northrop Grumman or the date you make a new election. See “Qualified Life Events” later in this section for details. The pre-tax benefits are:
 - Medical
 - Dental
 - Vision
 - Health care flexible spending account (FSA)
 - Dependent day care FSA.
- For your after-tax benefits, you can make changes during the plan year when and as permitted by the terms of the particular plan. Evidence of insurability and/or pre-existing condition exclusions should be considered prior to changing your elections.

For details, call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. The after-tax benefits are:

- Optional long-term disability (LTD) insurance
- Optional life insurance [employee, spouse, child(ren)]
- Optional accidental death and dismemberment (AD&D) insurance (employee, family).

For Group Legal, you may change your election only during the annual enrollment period each year.

You may adjust your HSA contributions at any time, and the change will be effective the first of the following month.

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.

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.

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. 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.

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 his or her employer, you are allowed to **discontinue** his or her 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 www.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 www.netbenefits.com/northropgrumman or by calling the NGBC at 1-800-894-4194. 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.

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 1-800-494-4194.

For information about qualified life events that affect domestic partner coverage, call the NGBC at 1-800-894-4194.

The chart below describes, in general terms, the changes you might be able to make or must make to your **pre-tax** benefits when you experience a qualified life event. For your after-tax benefits, you can make changes during the plan year when and as permitted by the terms of the particular plan.

Qualified Life Event	Benefit Option	Changes You Can or Must Make
Marriage	Medical, Dental, Vision	Within 31 days after the marriage, you can: <ul style="list-style-type: none"> ■ 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

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Qualified Life Event	Benefit Option	Changes You Can or Must Make
	Health Care Flexible Spending Account	Within 31 days after the marriage, you can: <ul style="list-style-type: none"> ■ Increase or start contributions
	Dependent Day Care Flexible Spending Account	Within 31 days after the marriage, you can: <ul style="list-style-type: none"> ■ 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
Divorce or annulment	Medical, Dental, Vision	Within 31 days after the divorce or annulment, you must drop your ex-spouse and former stepchild(ren) from coverage. You can also: <ul style="list-style-type: none"> ■ 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: <ul style="list-style-type: none"> ■ 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: <ul style="list-style-type: none"> ■ Increase or start contributions ■ Decrease or stop contributions Change must be consistent with the event. For example, if employee now has financial responsibility for child care, he or she can newly elect or increase contributions
Birth or adoption of a child	Medical, Dental, Vision	Within 31 days after the birth or adoption, you can: <ul style="list-style-type: none"> ■ 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 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: <ul style="list-style-type: none"> ■ Increase or start contributions
	Dependent Day Care Flexible Spending Account	Within 31 days after the birth or adoption, you can: <ul style="list-style-type: none"> ■ 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)

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Qualified Life Event	Benefit Option	Changes You Can or Must Make
Spouse gains benefits through his or her employer	Medical, Dental, Vision	Within 31 days after your spouse gains benefits, you can: <ul style="list-style-type: none"> ■ Remove your spouse from benefits ■ Remove your dependents from benefits under certain conditions ■ Stop coverage under certain conditions
	Health Care Flexible Spending Account	No change allowed
	Dependent Day Care Flexible Spending Account	No changes allowed
Spouse loses benefits	Medical, Dental, Vision	Within 31 days after your spouse loses benefits, you can: <ul style="list-style-type: none"> ■ Start coverage for yourself if you lose coverage provided by your spouse's employer ■ Add coverage for your spouse and/or child(ren)
	Health Care Flexible Spending Account	Within 31 days after your spouse loses benefits, you can: <ul style="list-style-type: none"> ■ Increase or start contributions if your spouse can no longer contribute
	Dependent Day Care Flexible Spending Account	Within 31 days after your spouse loses benefits, you can: <ul style="list-style-type: none"> ■ Increase or start contributions if your spouse can no longer contribute
Death of a dependent or spouse	All	There are many benefit changes that you may need to consider after the death of a dependent or spouse. Call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 and speak with a Benefits Center service representative.
Change in home address	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, access the Employee Self-Service website. Or, contact the HRSC and payroll departments immediately. Until your address is updated, you will not be able to make any benefit changes.

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 also access the Employee Self-Service website and contact the HRSC and payroll department. After you change your address, you will receive the materials necessary to select benefits at your new location.

Election Mistakes

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.

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
- If you are on a temporary off-site assignment.

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:

- Medical leave of absence
- Personal or educational leave of absence
- Family leave of absence
- Military leave of absence/military mobilization.

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. (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 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 must 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, and Group Legal coverage when you return to work on a regular basis. (Note: 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 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 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 twelve 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, Vision	Coverage continues for the duration of your approved leave, up to the twelve-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 (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 unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred during the plan year.
Basic and Optional Long-Term Disability (LTD)	Coverage continues for the duration of your approved leave, up to the twelve-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.
Basic Short-Term Disability (STD) (if offered by your business unit)	Coverage continues for the duration of your approved leave, up to six months.
Basic Life Insurance	Coverage continues for the duration of your approved leave, up to the twelve-month maximum*. When coverage ends, you may choose to convert to an individual policy within 31 days.
Optional Life Insurance (employee, spouse, child)	Coverage continues for the duration of your approved leave, up to the twelve-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 twelve-month maximum*. When coverage ends, you may choose to convert to an individual policy within 62 days.
Optional Accidental Death and Dismemberment (AD&D)	Coverage continues for the duration of your approved leave, up to the twelve-month maximum*, provided you make required contributions. When coverage ends, you may choose to convert to an individual policy within 62 days.

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Benefit Option	What Happens During a Medical Leave of Absence
Group Legal	Coverage continues for the duration of your approved leave up to the twelve-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 Hyatt Legal within 30 days of your coverage end date.
Health Savings Account (HSA)**	Your contributions continue as long as you are receiving a paycheck from Northrop Grumman.

**Twenty four-month maximum if a represented Baltimore or Sunnyvale employee*

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

If You Take a Personal or Educational Leave of Absence

If you take 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, 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 the "General Plan Administration: COBRA" section).
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 (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. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses during the plan year.
Basic Long-Term Disability (LTD)	Coverage continues to the end of 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.
Basic Short-Term Disability (STD)	Coverage continues to the end of 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 to convert to an individual policy 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 to convert to an individual policy within 62 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 to convert to an individual policy within 62 days.

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Benefit Option	What Happens During a Personal or Educational Leave of Absence
Group Legal	<p>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.</p> <p>If you are on unpaid leave, coverage continues to end of month plus one month provided you make any required contributions.</p> <p>You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact Hyatt Legal within 30 days of your coverage end date.</p>
Health Savings Account (HSA)*	<p>Your contributions continue as long as you are receiving a paycheck from Northrop Grumman.</p>

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

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, 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 the “General Plan Administration: COBRA” section).
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 (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 begin If you are on unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred during the balance of the plan year.
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.
Basic 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 to convert to an individual policy 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.
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 to convert to an individual policy within 62 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 to convert to an individual policy within 62 days.

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Benefit Option	What Happens During a Family Leave of Absence
Group Legal	<p>Coverage continues to end of the month plus four additional months from the day your leave begins provided you make the required payroll deductions or direct bill.</p> <p>You may be able to continue coverage thereafter by making payments directly to the carrier. You must contact Hyatt Legal within 30 days of your coverage end date.</p>
Health Savings Account (HSA)*	<p>Your contributions continue as long as you are receiving a paycheck from Northrop Grumman.</p>

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

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

Northrop Grumman 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, 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.
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, <i>on a taxable basis</i> , 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.
Basic and Optional Long-Term Disability (LTD)	Coverage stops on the day your leave begins.
Basic Short-Term Disability (STD)	Coverage stops on the day your leave begins.
Basic Life Insurance	Coverage continues.
Optional Life Insurance (employee, spouse, child)	Coverage continues as long as you make the required contributions.
Basic Accidental Death and Dismemberment (AD&D)	Coverage stops on the day your leave begins. When coverage ends, you may choose to convert to an individual policy within 62 days.
Optional Accidental Death and Dismemberment (AD&D)	Coverage stops on the day your leave begins. When coverage ends, you may choose to convert to an individual policy within 62 days.
Group Legal	Coverage continues as long as you make the required contributions.
Health Savings Account (HSA)**	Your contributions continue as long as you are receiving a paycheck from Northrop Grumman.

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** 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.*

Note: if you are on a military LOA, coverage continues for a maximum of five years. For more information about a military leave of absence, contact the Human Resources Service Center (HRSC) at 1-855-737-8364.

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, 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, 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 Accounts (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 contributions stop on your transfer date.
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 convert your life insurance (basic and optional) and 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 coverage by making payments directly to the carrier. You must contact Hyatt Legal within 31 days of your coverage end date.

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

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 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 \$2,500 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 the “Flexible Spending Accounts” section of this SPD 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:

- You voluntarily quit or are discharged
- Your employment ends due to a layoff/reduction in force
- You retire
- 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 select 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 continuation 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.
Basic Short-Term Disability (STD)	Coverage stops on your termination date.
Basic Life Insurance	Coverage stops on your termination date. You may choose to convert to an individual policy 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 to convert to an individual policy within 62 days after your termination date.
Optional Accidental Death and Dismemberment (AD&D)	Coverage stops on your termination date. You may choose to convert to an individual policy within 62 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 Hyatt Legal within 31 days of your coverage end date.
Health Savings Account (HSA)*	Your contributions stop on your termination date.

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

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 section).

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.
Basic Short-Term Disability (STD)	Coverage stops on your termination date.
Basic Life Insurance	Coverage stops on your termination date. You may choose to convert to an individual policy 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 with 31 days after your termination date.
Basic Accidental Death and Dismemberment (AD&D)	Coverage stops on your termination date. You may choose to convert to an individual policy with 62 days after your termination date.
Optional Accidental Death and Dismemberment (AD&D)	Coverage stops on your termination date. You may choose to convert to an individual policy with 62 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 Hyatt Legal within 31 days of your coverage date.
Health Savings Account (HSA)*	Your contributions stop on your termination date.

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

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If You Retire

If your employment terminates at a time when you are eligible for retiree benefits and the Human Resources Service Center codes your termination 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.
Basic Short-Term Disability (STD)	Coverage stops on your termination date.
Basic Life Insurance	Coverage stops on your termination date. You may choose to convert to an individual policy 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 to convert to an individual policy within 62 days after your termination date.
Optional Accidental Death and Dismemberment (AD&D)	Coverage stops on your termination date. You may choose to convert to an individual policy within 62 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 Hyatt Legal within 31 days of your coverage end date.
Health Savings Account (HSA)*	Your contributions stop on your termination date.

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

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/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.
Basic 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) can convert to an individual policy.
Basic Accidental Death and Dismemberment	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	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, which continues for your eligible dependents to the end of the month plus one year from the date of your death.
Group Legal	Coverage stops on the date of your death.
Health Savings Account (HSA)**	Your contributions stop 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.*

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

If your death is due to a job-related accident or illness while you are actively employed, your spouse/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 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/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

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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 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: Your prior benefit choices are reinstated on the date you return to work. Please call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 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.

MEDICAL

OVERVIEW

Having access to quality health care is important to everyone. It gives you peace of mind to know that you have the coverage you need.

The Plan offers a variety of medical plan options, so you can choose coverage that best fits your and your family's needs.

Medical Plan Options

The Plan offers the following medical plan options:

- Premium Plan Option
- Premium Plus Plan Option
- Premium Plan Option for Sunnyvale Represented Employees
- Value Plan Option
- Regional Health Maintenance Organization (HMO) Medical Plan Options, if offered in your home ZIP code area
- Aetna International Benefits Plan option (if you work and live outside the United States or are a frequent traveler abroad or on a regular rotational assignment)

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 and during annual enrollment. Your choice is effective for the entire plan year as long as you remain eligible, and you cannot make changes until the next annual enrollment, unless you experience a qualified life event.

The specific benefits provided under the Premium, Premium Plus, and Value plan medical plan options are described in detail in this summary plan description, and in the coverage certificates and subscriber contracts for the Aetna International Benefits Plan and HMO options. The coverage certificates and subscriber contracts are considered part of and must be read together with this summary plan description.

As described in the "TRICARE Supplement Plan" section below, Northrop Grumman also facilitates access to coverage that supplements TRICARE coverage for employees who are eligible for TRICARE. The TRICARE Supplement coverage is not part of the Northrop Grumman Health Plan.

The Plan also offers the Quit for Life[®] program at no cost, for employees, spouses or domestic partners and covered dependents over 18 enrolled in a Northrop Grumman Health Plan medical plan option. Quit for Life[®] provides one-on-one telephone based treatment sessions to help tobacco users quit tobacco. More information is available at *Benefits & You OnLine*.

PREMIUM PLAN AND PREMIUM PLUS PLAN OPTIONS

The Premium and Premium Plus plan options are offered nationwide. The Premium and Premium Plus offer the same provider network and covered services. Their deductible and out-of-pocket maximum amounts differ. Here is an overview of how the Premium and Premium Plus plan options work:

- Preventive Care is 100% covered through in-network providers. You and your covered dependents pay nothing for eligible expenses.
- The plan has a deductible, which is the amount paid by the participant for health care services before the plan begins to pay. The deductible does not apply to prescription drugs.
- After you meet the deductible, the plan pays a majority of the cost of services, and you pay a percentage of the cost (called coinsurance) up to a plan year out-of-pocket maximum.
- After you reach the annual out-of-pocket maximum, the plan pays 100% of your eligible expenses for the remainder of the plan year.

For additional information about the Premium and Premium Plus plans, refer to the Premium and Premium Plus Plans section of the SPD. Eligible represented Sunnyvale employees should refer to the Premium Plan – Sunnyvale Represented section.

VALUE PLAN OPTION

The Value plan option is a “high deductible health plan” as defined in Internal Revenue Code section 223 that may be paired with a health savings account (HSA) to help you offset the cost of eligible medical expenses.

Here is an overview of how the Value plan works.

- Preventive Care is 100% covered through an in-network provider. You pay nothing for eligible expenses.
- The plan has a deductible, which is the amount paid by the participant and covered dependents for health care services before the plan begins to pay.
- After you meet the deductible, the plan pays a majority of the cost of services, and you pay a percentage of the cost (called coinsurance) up to an annual out-of-pocket maximum.
- After you reach the annual out-of-pocket maximum, the plan pays 100% of your and your covered dependent’s eligible expenses for the remainder of the plan year.
- The deductible and out-of-pocket maximum amounts include medical and prescription drugs. In other words, you do not have to meet separate deductibles or out-of-pocket maximums for medical and prescription drug expenses.

A Health Savings Account (HSA) is an employee-owned account that can be used to reimburse eligible health care expenses on a tax-advantaged basis. The HSA is funded by your own pre-tax contributions, up to a certain annual limit. (You may also contribute post-tax money to your HSA and take a tax deduction as long as you do not exceed the IRS limit.)

You own the HSA, and it’s designed to help you save and budget for eligible expenses. Money in your HSA can be used toward your deductible and other out-of-pocket costs.

For additional information about the Value plan medical plan option and the HSA, refer to the Value plan section of the SPD.

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 primary care providers (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.

HMOs generally pay 100% of your eligible expenses after you pay a copayment. You pay no deductibles, and there are no claim forms.

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.

For more information about the HMO plan options, you can contact the HMO's member services directly. If you are currently enrolled in an HMO, you can find member services contact information in your HMO member materials and on your medical plan ID card.

AETNA INTERNATIONAL BENEFITS PLAN OPTION

The Aetna International Benefits Plan medical option 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 Aetna International Benefits Plan dental option provides dental coverage.

To ensure employees working overseas have adequate health insurance, Aetna International medical coverage is mandatory for employees who are on an:

- Overseas assignment of 6 months duration or longer (may be less for certain countries for certain countries such as Australia, Kingdom of Saudi Arabia and the United Arab Emirates) or
- Rotational assignment where 50% or more of their time is spent outside of the U.S.

You may opt out of the Aetna International Benefits Plan medical coverage by providing proof of other international medical coverage. Domestic coverage will not satisfy this requirement. Waiving the Aetna International Medical Benefit Plan is not an option in some countries including Australia, The Netherlands, Saudi Arabia and the United Arab Emirates. If you are a retired military service member and enrolled in TRICARE coverage, you may be eligible to opt out of the Aetna International Benefits Plan medical plan option. Please call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 for information on opting out of coverage.

If your assignment is for 90 to 180 days, you may voluntarily enroll in the Aetna International Benefits Plan. Please contact the NGBC for more information.

For employees with dependents that remain in the United States, the Aetna International Plan medical and dental plan options provide domestic coverage through an Aetna network of providers.

For details about the coverage provided by the Aetna International Benefits Plan option, refer to your plan material or call Aetna toll-free at 888-506-2278 or collect at 813-775-0189.

Aetna, 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.

IF YOU CHOOSE NO MEDICAL COVERAGE

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) 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 can still participate in other benefits under the Northrop Grumman Health Plan, including dental and vision. In addition, you are still eligible for the employee assistance program (EAP).

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 Standard, Extra, or Prime, and
- Under age 65 and not Medicare-eligible.

The TRICARE Supplement Plan provides additional benefits to your TRICARE Standard, Extra, or Prime 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 (Standard, Extra, or Prime).

For more information about the TRICARE Supplement including dependent eligibility, please call Selman & Company at 1-800-638-2610 or call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

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 (Premium, Premium Plus, Sunnyvale Represented Premium and Value) 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.

For information about maximums in the Premium, Premium Plus, Sunnyvale Represented Premium and Value plan options, 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 percent 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 or other specified damages. The plan has the right of first recovery, regardless of whether the covered person has been made whole. This means 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.

You must notify your 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 rights are not dependent on having a signed agreement.

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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
- Prosthesis 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 Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

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 Northrop Grumman 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 Northrop Grumman 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, Northrop Grumman 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 "pending" 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. 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 of an active employee).

When your active employment ends, you and/or any Medicare eligible dependent must 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 (Supplementary Medical Insurance) 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, the Premium, Premium Plus, Sunnyvale Represented Premium or Value plan option — rather than an HMO — may be the best choice for you.

If you enroll in the Premium, Premium Plus, Sunnyvale Represented Premium or Value plan option, your dependents can visit a physician in the Anthem Bluecard network, also known as the Anthem PPO network in some states, 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.

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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 Aetna International Benefits Plan option, any covered dependents who are living in the United States will receive coverage through that plan option.

DENTAL

OVERVIEW

Dental Plan Options

The Plan offers the following dental plan options:

- Dental Care PPO Plan option
- Dental Care Plus PPO Plan option
- Preventive Care PPO Plan option
- CIGNA Dental Maintenance Organization (DMO) option, if offered in your ZIP code area
- Aetna International Dental Plan option (for employees working outside of the U.S.)

The options differ by which services are covered, the cost of coverage, and the way you receive dental care.

You can choose dental coverage for yourself and your eligible dependents when you are first hired and during annual enrollment. Your choices remain in effect for the entire plan year, and you cannot make changes until the next annual enrollment, unless you experience a qualified life event. (See “Qualified Life Events” for details.)

PREFERRED PROVIDER ORGANIZATION (PPO) DENTAL PLAN OPTIONS

The PPO dental plan options 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 PPO network providers. Delta Dental administers the PPO dental plans and provides the PPO network of dental providers.

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.

- 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 PPO network. This same network applies to all four of the PPO dental plan options. To find a PPO dentist, visit Delta's website, which is accessible from the *Provider* icon at *Benefits & You OnLine* (select "Delta Dental PPO" to search the provider list for all four PPO dental plan options) or call Delta Dental at 1-800-765-6003.
- Delta dentists who do not participate in the PPO network are called Delta 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..
- In the Dental Care and Dental Care Plus dental plan options only (not Preventive Care): If you live in an area where you do not have access to at least two Delta general dentists* in the Delta Premier network within a 30-mile radius, you may be eligible to receive in-network coverage — meaning you pay the same coinsurance you would pay if you used a PPO dentist, up to the in-network benefit maximums — even if you use a non-Delta Dental dentist.

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.

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 (June 30). You will be notified by Delta Dental if you are eligible for this out-of-area feature.

* *General dentists are non-specialist dentists.*

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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 **Dental Care PPO Plan** option is 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.
- The **Dental Care Plus PPO Plan** option provides the same coverage as the Dental Care PPO Plan option **and** also covers eligible orthodontia expenses.
- The **Preventive Care PPO Plan** option covers preventive and diagnostic care only and has the lowest contribution for coverage.

The chart below compares the key similarities and differences between the Dental Care and Dental Care Plus PPO plan options. The Preventive Care PPO option covers preventive and diagnostic care up to an annual maximum of \$500 per person.

	Dental Care PPO Plan			Dental Care Plus PPO Plan		
What the plan covers:	Preventive and diagnostic Basic and major restorative			Preventive and diagnostic Basic and major restorative Orthodontia		
	<i>In-network</i>	<i>Reduced in-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Reduced in-network</i>	<i>Out-of-network</i>
Deductible						
Individual	\$100	\$150	\$200	\$100	\$150	\$200
Family	\$200	\$300	\$400	\$200	\$300	\$400
Annual maximum per person (in- and out-of-network combined) <i>Please see note for additional restrictions</i>	\$1,500	\$1,250	\$1,000	\$2,500	\$2,000	\$1,500
Orthodontia lifetime maximum per person (in- and out-of-network combined)	Not covered	Not covered	Not covered	\$3,000	\$2,000	\$1,500
Non-surgical treatment of TMJ Subject to an annual or lifetime maximum per person (in- and out-of-network combined)	\$500 Lifetime Maximum	\$300 Lifetime Maximum	\$250 Lifetime Maximum	\$500 Lifetime Maximum	\$300 Lifetime Maximum	\$250 Lifetime Maximum
Implants Subject to an annual or lifetime maximum per person (in- and out-of-network combined)	\$1,000 Lifetime Maximum	\$750 Lifetime Maximum	\$500 Lifetime Maximum	Subject to plan year maximum	Subject to plan year maximum	Subject to plan year maximum
	<i>In-network</i>	<i>Reduced in-network</i>	<i>Out-of-network</i>	<i>In-network</i>	<i>Reduced in-network</i>	<i>Out-of-network</i>
Preventive and diagnostic care (up to two cleanings, exams, and bite-wing X-rays each plan year)* Deductible does not apply.	0%	0%	0%)	0%	0%	0%

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	Dental Care PPO Plan			Dental Care Plus PPO Plan		
Basic restorative care (for example, fillings, crowns, extractions)*	20%	30%	50%	20%	30%	50%
Major restorative care (for example, bridges, TMJ treatment, implants, dentures)*	50%	50%	50%	50%	50%	50%
Orthodontia*	Not covered	Not covered	Not covered	50%	50%	50%

*See "Eligible Dental Expenses" for details.

Note: There is one lifetime maximum regardless if you change to another PPO dental plan option. Annual maximums apply regardless of whether services are in or out-of-network. For example, if you are in the Dental Care PPO plan and incur \$1,000 of in-network expenses, you will have exhausted the annual maximum for out-of-network benefits.

When you receive care from a dentist outside the Delta Dental network, you also pay any expenses that exceed the plan allowance for dentists in your area, as determined by Delta.

The deductible is the amount you must pay each plan 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 care.

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

The annual maximum is the maximum benefit amount your plan option will pay each plan year. If you visit an in-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.

For more information, including eligible dental expenses, refer to "A Closer Look: How the PPO Dental Plan Options Work" later in this section.

CIGNA DENTAL MAINTENANCE ORGANIZATION (DMO) OPTION

Depending on your ZIP code area, you may have access to the CIGNA Dental Care Dental Health Maintenance Organization DMO Plan option.

The CIGNA Dental Care DMO Plan 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 1-800-244-6224 or search the CIGNA Dental Health website, which is accessible from *Provider* icon at *Benefits & You OnLine*.

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 1-800-244-6224 or go to their website, which is accessible from the *Providers* link at *Benefits & You OnLine*.

When you enroll in the DMO, you agree to resolve all differences between you or your dependents and the DMO through binding arbitration. Binding arbitration is a legal method used to efficiently resolve disputes outside the court system.

Additional details about how the plan works, including eligible expenses, are provided in "A Closer Look: How the CIGNA Dental Care DMO Option Works," later in this section.

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.

Network or Non-Network in the Dental PPO Plan Options: It Is Up to You!

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 or a provider outside the PPO 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 in-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 1-800-765-6003 or visit the Delta Dental website at www.deltadentalins.com/ngc, which is also accessible from the *Providers* icon at *Benefits & You OnLine* (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:

	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 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*

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	In-Network (Delta Dental PPO Providers)	In-Network (Delta Premier Providers)	Non-Network (Non-Delta Dental Providers)
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 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%.*

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 since 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.

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 “General Plan Administration: COBRA” 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).

Below 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 1-800-765-6003. If you do not find an expense listed under “Eligible Dental Expenses” or “Ineligible and Limited Dental Expenses,” call Delta Dental at 1-800-765-6003 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 to age 19
- 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 PPO 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
- 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 bicuspid. 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 PPO 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 lifetime or plan year 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 nightguards, splints, occlusal orthotic devices, and equilibration (subject to lifetime maximum).

Orthodontic Services

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

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

The in-network lifetime maximum for orthodontia is \$3,000 in the Dental Care Plus PPO plan option. There is one lifetime maximum, regardless if you change to another PPO plan option.

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 1-800-765-6003 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 and Dental Care Platinum PPO plans
- Applications of fluoride or other anti-cavity substance to adult teeth
- 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 or Dental Care Platinum PPO Plan option
- 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 1-800-765-6003 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 in any plan year for children up to age 19, and once in any plan 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 films(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 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 (e.g., 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.

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

Selecting a CIGNA Dental Provider

If you select the CIGNA Dental Care DMO 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 1-800-244-6224 to request network dentist information, or go to the CIGNA website, which is accessible from the *Providers* link at *Benefits & You OnLine*.

Changing Your CIGNA Dental Provider

If you decide to change your dental office, simply call CIGNA at 1-800-244-6224. 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.

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 DMO 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 1-800-244-6224 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 1-800-244-6224 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	<ul style="list-style-type: none"> ■ X-rays, as needed
Preventive	<ul style="list-style-type: none"> ■ Prophylaxis (routine cleaning) ■ Sealants (per tooth up to age 19) ■ Fluoride treatments (once every six months up to age 19)
Restorative (fillings)	<ul style="list-style-type: none"> ■ Amalgam (primary or permanent) ■ Resin/composite (anterior primary or permanent) ■ Resin or composite one surface (posterior primary or permanent) ■ Sedative filling
Oral Surgery	<ul style="list-style-type: none"> ■ Simple extraction, first tooth ■ Additional extractions (per tooth) ■ Soft tissue impaction ■ Full bony impaction
Endodontics	<ul style="list-style-type: none"> ■ Root canal treatment: anterior, bicuspid, molar
Prosthetics (dentures)	<ul style="list-style-type: none"> ■ 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)	<ul style="list-style-type: none"> ■ Replacement bridge ■ Ceramic or porcelain crowns or bridges ■ Stainless steel crowns, each ■ Crown, abutment ■ Pontic, full cast metal
Orthodontic Services (braces)	<ul style="list-style-type: none"> ■ 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	<ul style="list-style-type: none"> ■ Canceling appointments with less than a 24-hour notice

Ineligible Dental Expenses in the CIGNA Plan

The DMO Plan 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 1-800-244-6224 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

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- 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.

ADDITIONAL INFORMATION ABOUT YOUR DENTAL BENEFITS

If You Have Other Dental Coverage

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 1-800-765-6003 or CIGNA Dental Health at 1-800-244-6224.

VISION

OVERVIEW

From routine vision exams to eyeglasses and contact lenses, the costs of eye care can really add up. If you and your family need regular eye care, you might want to consider vision coverage. Northrop Grumman vision coverage provides benefits to help you pay some of your routine vision care costs. Expenses related to eye disease, such as cataracts or glaucoma, would be covered under your medical plan coverage option.

The Plan offers two vision plan options:

- Vision plan option
- Vision Care Plus plan option

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. (See “Qualified Life Events” for details.)

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 1-888-463-9954 or go to the VSP website, which is accessible from the *Provider* icon at *Benefits & You OnLine*. 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.

THE NORTHROP GRUMMAN VISION PLAN OPTIONS

Vision Plan

Here is how the Vision plan option provides coverage:

Service	In-Network (Choice Network)	Out-of-Network ¹
Exam (1 every plan year)	After you pay a \$10 copay, then the plan pays 100%	You pay the full cost, and the plan will reimburse up to \$50
Prescription eyeglass lenses ² (1 pair every plan year)	After you pay a \$10 copay ³ , the plan pays 100% for single vision, bifocals or trifocal lenses, and blended and progressive lenses. Average 20-25% off non-covered lens options Scratch resistant coating is not covered	You pay the full cost, and the plan will reimburse: <ul style="list-style-type: none"> ■ Up to \$50 for single vision ■ Up to \$75 for lined bifocals and blended ■ Up to \$100 for lined trifocals and progressives Scratch resistant coating is not covered
Eyeglass frame ² (Covered once every other plan year)	After you pay a \$10 copay ³ , the plan pays up to \$120 (you receive 20% discount on remaining cost, if any)	You pay the full cost, and the plan will reimburse up to \$70
Prescription contact lenses ² (every plan year)	\$105 allowance available for contact lenses. The contact lens exam (fitting and evaluation) is covered in full after a copay of up to \$60. Special rebates available on select brands of contacts lenses on www.vsp.com	You pay the full cost, and the plan will reimburse up to \$105 if elected instead of glasses
Low vision care ⁴ <ul style="list-style-type: none"> ■ Supplementary testing ■ Supplemental care aids 	<ul style="list-style-type: none"> ■ You pay 25% of the approved cost, and the plan pays 75%, up to \$1,000 ■ Two Supplemental Eye Exams allowed every 2 years. VSP will pay up to \$125 for each eye exam 	<ul style="list-style-type: none"> ■ You pay the full cost, and the plan will reimburse up to \$125 for Supplemental Eye Exam ■ You pay 25% of the approved cost, and the plan pays 75%, up to \$1,000 ■ Reimbursement will only be made if the benefit criteria is met
Additional complete sets of eyeglasses	20% off unlimited additional pairs of prescription glasses and non-prescription sunglasses (when purchased from a VSP provider)	Not applicable
Laser VisionCare Program (PRK and LASIK)	You receive an average 15% discount on contracted laser center's fees or 5% on promotional prices, whichever gives you the lesser cost	Not applicable
Primary EyeCare Plan	Visit your VSP provider as often as needed for treatment of eye pain, pink eye, management of glaucoma and diabetic eye disease, or exams to monitor cataracts. You pay a \$10 copay for exam services only.	Not applicable

¹ Out-of-network benefits do not guarantee full payment. Services obtained through out-of-network providers are subject to the same timeframes and copayments as services obtained through VSP providers.

² You may choose coverage for either eyeglasses or contact lenses, but not both, during any plan year. If you choose contacts, you will be eligible for eyeglass lenses and frames the next plan year.

³ You pay one \$10 copay for lenses or frames, but not both.

⁴ Low vision is visual impairment not correctable by standard eyewear. You must obtain preauthorization from VSP to obtain this coverage.

Vision Care Plus

Here is how the Vision Care Plus plan option provides coverage:

Service	In-Network (Choice Network)	Out-of-Network ¹
Exam (1 every plan year)	After you pay a \$10 copay, then the plan pays 100%	You pay the full cost, and the plan will reimburse up to \$50
Prescription eyeglass lenses ² (1 pair every plan year)	After you pay a \$10 copay ³ , the plan pays 100% for single vision, bifocals or trifocal lenses For progressive or blended lenses, after you pay a \$30 copay, the plan pays 100% Scratch resistant coating covered in full Average savings of 20-25% on other lens enhancements	You pay the full cost, and the plan will reimburse: <ul style="list-style-type: none"> ■ Up to \$50 for single vision ■ Up to \$75 for lined bifocals and blended ■ Up to \$100 for lined trifocals and progressives Scratch resistant coating not covered
Eyeglass frame ² (Covered once every plan year)	After you pay a \$10 copay ³ , the plan pays up to \$200 (you receive 20% discount on remaining cost, if any)	You pay the full cost, and the plan will reimburse up to \$70
Prescription contact lenses ² (every plan year)	\$200 allowance available for contact lenses. The contact lens exam (fitting and evaluation) is covered in full after a copay of up to \$60. Special rebates available on select brands of contacts lenses on www.vsp.com	You pay the full cost, and the plan will reimburse up to \$105 if elected instead of glasses
Low vision care ⁴ <ul style="list-style-type: none"> ■ Supplementary testing ■ Supplemental care aids 	<ul style="list-style-type: none"> ■ You pay 25% of the approved cost, and the plan pays 75%, up to \$1,000 ■ Two Supplemental Eye Exams allowed every 2 years. VSP will pay up to \$125 for each eye exam 	<ul style="list-style-type: none"> ■ You pay the full cost, and the plan will reimburse up to \$125 for Supplemental Eye Exam ■ You pay 25% of the approved cost, and the plan pays 75%, up to \$1,000 ■ Reimbursement will only be made if the benefit criteria is met
Additional complete sets of eyeglasses	20% off unlimited additional pairs of prescription glasses and non-prescription sunglasses (when purchased from a VSP provider)	Not applicable
Laser VisionCare Program (PRK and LASIK)	You receive an average 15% discount on contracted laser center's fees or 5% on promotional prices, whichever gives you the lesser cost	Not applicable
Primary EyeCare Plan	Visit your VSP provider as often as needed for treatment of eye pain, pink eye, management of glaucoma and diabetic eye disease, or exams to monitor cataracts. You pay a \$10 copay for exam services only.	Not applicable

¹ Out-of-network benefits do not guarantee full payment. Services obtained through out-of-network providers are subject to the same timeframes and copayments as services obtained through VSP providers.

² You may choose coverage for either eyeglasses or contact lenses, but not both, during any plan year. If you choose contacts, you will be eligible for eyeglass lenses and frames the next plan year.

³ You pay one \$10 copay for lenses or frames, but not both.

⁴ Low vision is visual impairment not correctable by standard eyewear. You must obtain preauthorization from VSP to obtain this coverage.

A CLOSER LOOK: HOW THE VISION PLAN OPTION WORKS

To get the most out of the Northrop Grumman vision plan option, it is important to understand how the option works and which expenses are eligible for coverage.

In-Network or Out-of-Network in the Vision Plan Option: It Is Up to You

If you enroll in a Vision Plan option, 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 www.vsp.com for details.*

How to Use the Vision Plan Option

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 1-888-463-9954 or by going to the VSP website at www.vsp.com. This link is also accessible from the *Providers* page on *Benefits & You OnLine*.
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.

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, which is accessible from the *Providers* link at *Benefits & You OnLine* (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 1-888-463-9954.

- 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.

In addition for the Vision Care plan:

- Blended lenses are covered at 100% in-network; the Vision Care plan pay up to \$75 for blended lenses obtained out-of-network
 - Progressive lenses are covered at 100% in-network; the Vision Care plan pay up to \$100 for blended lenses obtained out-of-network.
- 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. If you choose contacts, you will be eligible for eyeglass lenses and frames the next 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 1-888-463-9954, 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 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 \pm .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.

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 Northrop Grumman 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, etc.) 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 Northrop Grumman 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 1-888-463-9954 or visit www.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.

FLEXIBLE SPENDING ACCOUNTS

OVERVIEW

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

With the flexible spending accounts (FSAs), you can:

- Set aside \$52 to \$2,550 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.
- Set aside \$52 to \$5,000 of pre-tax dollars annually in the dependent day care FSA for reimbursement of your eligible dependent day care expenses. If you earn more than \$115,000 in 2017, your contribution to the dependent day care FSA will be limited to \$4,000. (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. (See “Qualified Life Events” for details.)

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.

Your Contributions

If you choose to enroll in one or both of the flexible spending account (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

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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 -- \$5,000 for dependent day care FSA, \$2,550 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 \$2,550 for the remainder of the plan year (6 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 that 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 flexible spending account (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 a flexible spending account (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 1-800-829-3676
- At www.irs.gov.

The health care flexible spending account (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 31st, 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. 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 flexible spending account (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 if you have a valid prescription
 - Smoking-cessation programs (does not include expenses for drugs that do not require a prescription, such as nicotine gum or patches)
 - Sterilization reversal.
- 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 flexible spending account (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
- Domestic partner health care expenses

- 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 (June 30)
- Health club dues, YMCA dues, and related expenses
- Household help
- Liposuction
- Marriage or family counseling
- Maternity clothes, diaper service, and related expenses
- Custodial nursing home care
- Over-the-counter medicines and drugs for which you do not have a prescription
- 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 flexible spending account (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.

Limited Purpose Health Care FSA for HSA Participants

If you enroll in the Value plan option, you may be eligible to establish a Health Savings Account (HSA), which may be an employer and/or employee-funded account that can be used to reimburse eligible health care expenses. (See the Value plan section of the SPD for more information about HSAs.) However, IRS rules prohibit individuals with a General Purpose Health Care FSA from establishing and contributing to an HSA.

If you elect to establish an HSA through Fidelity Investments® and you also enroll in, or are automatically re-enrolled in, a Health Care FSA, the FSA will be a Limited Purpose Health Care FSA, which can be used for eligible dental and vision expenses only. Once you start contributing to a Limited Purpose FSA, you cannot change to a General Purpose FSA during the plan year.

Please note that if you enroll in the Value plan option and choose to establish an HSA other than through Fidelity (for example, at the bank where you do your personal banking) and you enroll in, or are automatically re-enrolled in a Health Care FSA, WageWorks, the FSA administrator, will not know about your HSA and your Health Care FSA will be a General Purpose Health Care FSA. That will make you ineligible to establish or contribute to your HSA and, if you make contributions to your HSA, you will suffer adverse tax consequences. If you choose to establish an HSA other than through Fidelity and you want your FSA to be a Limited Purpose Health Care FSA, you must, before the plan year begins, designate that your FSA be a Limited Purpose Health Care FSA either online through *NetBenefits* or by calling the NGBC.

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT

The dependent day care flexible spending account (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 him- or herself, the expenses you incur for his or her care must enable you to be gainfully employed, and your spouse must:

- Have a physical or mental condition that does not allow him or her 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 his or her normal functions does not necessarily mean that expenses you incur for his or her 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 flexible spending account (FSA). The publication is available:

- At your local IRS office
- From the IRS by calling 1-800-829-3676
- At www.irs.gov.

The following expenses are eligible for reimbursement under the dependent day care flexible spending account (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.

Ineligible Dependent Day Care Expenses

The following expenses are **not** eligible for reimbursement under the dependent day care flexible spending account (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

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- 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 or after your participation ends
- 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 \$5,000	The amount the lower-paid spouse earns, up to \$5,000
You and your spouse file a joint income tax return and your spouse also participates in a dependent day care flexible spending account	\$5,000 for your spouse's account and your account combined
You and your spouse file separate income tax returns	\$2,500 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 \$5,000 (or \$500 for each month that your spouse is a student or is disabled) if you have two or more eligible dependents

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 35% 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 \$1,050 ($35\% \times \$3,000 = \$1,050$). 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 \$2,100 ($35\% \times \$6,000 = \$2,100$).

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 flexible spending account, you cannot also claim the dependent care tax credit. This rule applies even if you have additional unreimbursed expenses.

Likewise, with two or more dependents, if you contribute the maximum amount (\$5,000) to the FSA, you may claim a partial tax credit for up to \$1,000 in expenses ($\$6,000 - \$5,000 = \$1,000$). Of course, smaller FSA contributions allow you to claim a higher partial tax credit.

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 WageWorks, 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 wageworks.com or call WageWorks at 1-877-WAGEWORKS 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 WageWorks 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 www.wageworks.com or by mail or fax
- 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 already were 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 EOB 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 August	\$100	\$100
Your submitted claim in August	\$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 August, 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 www.wageworks.com 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 August). 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 August	\$384
Your submitted claim in August	\$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 \$5,000. (If you are married, this limit applies to any reimbursements received by you and your spouse.) If you are reimbursed for more than \$5,000 in a calendar year, you will be responsible for paying taxes on the excess amount.

“Use It or Lose It Rule” and Other IRS Regulations

Before you enroll in a flexible spending account (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 Internal Revenue Service (IRS) places restrictions on the amount you can contribute.

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 \$500 of unused funds at the end of the plan year to the next plan year. The maximum rolled over amount that may be credited to your health care FSA at any time is \$500. 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 \$500 are forfeited. The rollover amount of \$500 does not impact the maximum election amount of \$2,550. 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 — see “COBRA” for details); 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.

Also, you cannot use amounts in one FSA to cover expenses of the other FSA.

How Your Other Benefits Are Affected

Your flexible spending account (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 (\$127,200 in 2017), 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 flexible spending accounts (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 participation ends are not eligible for reimbursement, and you forfeit any amounts left in your accounts. 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 “General Plan Administration: COBRA” for details.

HEALTH REIMBURSEMENT ACCOUNTS

OVERVIEW

A Health Reimbursement Account (HRA) is an employer-funded account used to reimburse eligible health care expenses. If you enroll in a healthcare FSA and have an HRA as described below, your HRA funds will be used before your healthcare FSA. Once you have exhausted your HRA, you may begin using your FSA to pay eligible expenses.

If you were enrolled in the Premium or Premium Plus plan option prior to July 1, 2016, Northrop Grumman credited funds to a Health Reimbursement Account (HRA). The amount depended on the plan in which you enrolled, the coverage level you selected, and if you enrolled midyear. If you have a balance in that HRA but dis-enroll from the Premium or Premium Plus plans, you will forever forfeit your HRA balance (subject to any rights you may have under COBRA). Please see the Premium and Premium Plus Plans section of the SPD for more information about this HRA. (Note: Participants in the Sunnyvale Represented Premium plan may still be eligible to receive credits to an HRA.)

You may also have an HRA associated with your past participation in the Anthem Consumer Driven Health Plan (CDHP). The rules described in the remainder of this section apply only to HRAs that were associated with the Anthem CDHP (and not to HRAs associated with the Premium or Premium Plus options).

If, on June 30, 2014, you were enrolled in the Anthem CDHP, had a HRA balance in excess of \$50 on that date, and enrolled in the Value plan option effective July 1, 2014, your unused HRA balance was transferred to CONEXIS for administration and set up as follows:

General Purpose Health Reimbursement Account (HRA): If you did not establish an Health Savings Account (HSA) through CONEXIS, your Anthem CDHP balance, if \$50 or more, became a General Purpose HRA administered by CONEXIS. This HRA balance can be used to pay medical and prescription drug expenses as well as dental and vision care expenses.

Limited Purpose Health Reimbursement Account (HRA): If you established an HSA through CONEXIS, your Anthem CDHP balance, if \$50 or more, became a Limited Purpose HRA administered by CONEXIS. This HRA balance 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.

Effective January 1, 2017, WageWorks began administering the General Purpose and Limited Purpose HRAs instead of CONEXIS.

As with a health care flexible spending account (FSA), you will receive a WageWorks Health Card, which you may use to pay for your eligible expenses. Alternatively, you may submit claims for reimbursement directly to WageWorks.

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 WageWorks 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 with WageWorks, are enrolled in the Anthem Value Plan and elect to contribute to an HSA through Fidelity during annual enrollment, Fidelity will notify WageWorks prior to the start of the new plan year so WageWorks can ensure your HRA is a Limited Purpose HRA. If it's a General Purpose HRA, WageWorks will change it 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 WageWorks 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 WageWorks during the annual enrollment window. Note: Once an HRA is a Limited Purpose HRA, it remains a Limited Purpose HRA unless you contact WageWorks and elect a General Purpose HRA for the new plan year. If you elect to establish and/or contribute to an HSA through Fidelity during the plan year, the HRA will revert back to a Limited Purpose HRA.

LIFE AND ACCIDENT INSURANCE

LIFE INSURANCE

Overview

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 pay the premiums. Unlike whole life insurance, term insurance policies do not build up a cash value.

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 or \$50,000, whichever is greater. 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.*

If you die, the plan pays benefits to the beneficiary or beneficiaries you choose. See the section entitled “Beneficiary Designation” for information about designating your beneficiary.

Note: *You can limit your basic life insurance coverage to \$50,000 to avoid paying imputed income tax. See “Imputed Income” for details.*

Optional Life Insurance

You may purchase Optional Life insurance for yourself, your spouse, your domestic partner, and your unmarried children described below:

- Your biological son or daughter, adopted son or daughter, stepson or stepdaughter, 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.
- Your disabled biological son or daughter, adopted son or daughter, stepson or stepdaughter, 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; or
 - on or after January 1, 2011 and while the person was under the age of 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.

Important Notes:

- You may **not** purchase Optional Life Insurance for your child if your child has Basic Life coverage under the Northrop Grumman Health Plan as an *active employee* of Northrop Grumman
- You may not purchase Optional Life Insurance for your child if your child is in the military of any country or subdivision of any country
- 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 does not qualify as a foster child for Optional Life Insurance.

For further details about domestic partner optional life insurance, call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

If you select optional life insurance, you pay the full cost with after-tax dollars, based on group rates negotiated by Northrop Grumman.

Your cost for optional life insurance for yourself is determined by the employee's age as of December 31 of the plan year and the coverage level selected. Your cost for optional life insurance for your spouse is determined by your spouse's age as of December 31 of the plan year and the coverage level selected. As your 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 at the start of the plan year. If you are on a leave of absence, and you want to increase your coverage, you must call the Northrop Grumman Benefits Center (NGBC) when you return to work.

For your dependent’s coverage to take effect, he or she 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 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.

If you were age 65 before July 1, 2016, your benefit was reduced by the plan’s age reduction factors. No further reductions occur after June 30, 2016.

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 maximum of \$1.25 million
- 2 x your annual base pay up to a maximum of \$1.25 million
- 3 x your annual base pay up to a maximum of \$1.25 million
- 4 x your annual base pay up to a maximum of \$1.25 million
- 5 x your annual base pay up to a maximum of \$1.25 million
- 6 x your annual base pay up to a maximum of \$1.25 million
- 7 x your annual base pay up to a maximum of \$1.25 million
- 8 x your annual base pay up to a maximum of \$1.25 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: $\$42,100 \times 3 = \$126,300$, 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.

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 optional life insurance coverage. 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.

Federal tax law requires that you pay imputed income taxes on the value of your employer-provided life insurance in excess of \$50,000. See "Imputed Income" for details.

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.

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 (e.g., 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 Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 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 for 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 or \$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.

The example below shows how imputed income is calculated.

Assume the following:

**NORTHROP GRUMMAN HEALTH PLAN
SUMMARY PLAN DESCRIPTION
JANUARY 2017**

- Age: 47
- Annual base pay: \$77,000
- Total basic coverage: \$77,000
- IRS value for each \$1,000 of coverage: \$0.15 per month (from the *IRS Rates for Calculating Imputed Income* column in the table below)
- The amount of life insurance coverage subject to taxation: \$27,000 (\$77,000 - \$50,000).

Age	Northrop Grumman Optional Life Insurance Rates (2017 Cost per Month per \$1,000 of Coverage)	IRS Rates for Calculating Imputed Income (Value per Month per \$1,000 of Coverage)
Under 25	\$0.039	\$0.050
25 – 29	\$0.047	\$0.060
30 – 34	\$0.061	\$0.080
35 – 39	\$0.068	\$0.090
40 – 44	\$0.076	\$0.100
45 – 49	\$0.115	\$0.150
50 – 54	\$0.176	\$0.230
55 – 59	\$0.337	\$0.430
60 – 64	\$0.506	\$0.660
65 – 69	\$1.004	\$1.270
70+	\$1.608	\$2.060

* Your contribution for optional life insurance for the duration of the plan year is based the age you attain during the plan year. . (For example, if you turn 45 in October of 2017, your contribution for the 2017 plan year is based on the age 45-49 contribution rate of \$0.115).

Follow these steps to determine the imputed income:

1. Take the total amount of life insurance subject to taxation \$77,000 - \$50,000 = \$27,000 and divide by \$1,000: 27.
2. Calculate the monthly IRS value for the amount of coverage subject to taxation:
 $\$0.15 \times 27 = \4.05 .
 Multiply this amount by 12 to determine the annual IRS value: $\$4.05 \times 12 = \48.60 .

In this example, \$48.60 is the additional taxable income you would have — not the tax itself.

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.

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 \$250,000. 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 “What Happens If You Become Disabled” 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 or elect portability on any optional coverage (see “Continuing Your Coverage Through Portability or Conversion” for details).*

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 in advance of death by the Plan.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Overview

Accidental death and dismemberment (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. AD&D insurance is administered by Life Insurance Company of North America.

Note: *The basic and optional AD&D insurance coverage described in this section is not available to you if you are eligible for other basic and optional AD&D coverage provided by Northrop Grumman.*

Basic AD&D Insurance

Northrop Grumman provides you with basic accidental death and dismemberment (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

You may purchase Optional AD&D insurance for yourself, your spouse, your domestic partner, and your unmarried children described below:

- Your biological son or daughter, adopted son or daughter, stepson or stepdaughter, 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.
- Your disabled biological son or daughter, adopted son or daughter, stepson or stepdaughter, 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; or
 - on or after January 1, 2011 and while the person was under the age of 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.

Important Note: 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.

For further details about domestic partner optional life insurance, call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

If you select optional AD&D insurance, you pay the full cost with after-tax dollars, based on rates negotiated by Northrop Grumman.

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 maximum of \$1 million
- 2 x your annual base pay up to a maximum of \$1 million
- 3 x your annual base pay up to a maximum of \$1 million
- 4 x your annual base pay up to a maximum of \$1 million
- 5 x your annual base pay up to a maximum of \$1 million
- 6 x your annual base pay up to a maximum of \$1 million
- 7 x your annual base pay up to a maximum of \$1 million
- 8 x your annual base pay up to a maximum of \$1 million
- 9 x your annual base pay up to a maximum of \$1 million

- 10 x your annual base pay up to a maximum of \$1 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 maximum of \$1 million
- 2 x your annual base pay up to a maximum of \$1 million
- 3 x your annual base pay up to a maximum of \$1 million
- 4 x your annual base pay up to a maximum of \$1 million
- 5 x your annual base pay up to a maximum of \$1 million
- 6 x your annual base pay up to a maximum of \$1 million
- 7 x your annual base pay up to a maximum of \$1 million
- 8 x your annual base pay up to a maximum of \$1 million
- 9 x your annual base pay up to a maximum of \$1 million
- 10 x your annual base pay up to a maximum of \$1 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:

Type of Loss*:	Percentage of AD&D Coverage Amount Paid		
	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%
Use of four limbs (quadriplegia)	100%	100%	200%
Use of both lower limbs or both upper limbs (paraplegia)	75%	75%	150%
Use of both limbs on the same side of the body (hemiplegia)	50%	50%	100%
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%	\$100,000

*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 arms or both legs
- For hemiplegia: total paralysis of the arm and leg on the same side of the body.

Paralysis means the total loss of use of an arm or leg. Severance means the complete and permanent separation and dismemberment of the part from the body.

Additional Benefits Under Optional AD&D Insurance

If you select optional AD&D insurance, the plan provides the following special benefits for you and your enrolled dependents:

Rehabilitation Benefit: 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 two years 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 minimum of \$4,500 and a maximum of \$18,000.

Rehabilitation means medical services, supplies, or treatment, or hospital confinement (or part of a hospital confinement) that satisfying all of the following conditions:

- Are essential for physical rehabilitation required due to the covered person's covered loss
- Meet generally accepted standards of medical practice
- Are performed under the care, supervision or order of a physician
- Prepare the covered person to return to his or any other occupation.

Common Accident Benefit: 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 die directly and independently of all other causes from a common accident and are survived by one or more dependent children.

Common accident means the same covered accident or separate covered accidents that occur within the same 24-hour period.

Seatbelt and Airbag Benefit: The plan will pay an additional benefit, subject to the conditions and exclusions described below, when you or an insured dependent die directly and independently of all other causes from a covered accident while wearing a seatbelt and operating or riding as a passenger in an automobile. 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.

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 positioned in a seat protected by a properly functioning and properly deployed supplemental restraint system (airbag).

Verification of proper use of the seatbelt at the time of the covered accident and that the supplemental restraint system properly inflated upon impact must be a part of an official police report of the covered accident or be certified, in writing, by the investigating officer(s) and submitted with the covered person's claim.

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

Supplemental restraint system means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Child Care Center Benefit: The plan will pay the benefit shown below for up to four years for the care of each surviving dependent child in a child care center if the death of you or your spouse/domestic partner results directly and independently of all other causes from a covered accident and all of the following conditions are met:

- 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 365 days 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.

This benefit will be payable to the surviving spouse/domestic partner if the spouse/domestic partner has custody of the child. If the surviving spouse/domestic partner does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each 12-month period that begins after the date of your or your spouse/domestic partner's death. A claim must be submitted at the end of each 12-month period. A 12-month period begins:

- When the dependent child enters a child care center for the first time, within 365 days from the date of the covered accident, after your or your spouse/domestic partner's death; or
- On the first of the month following your or your spouse/domestic partner's death, if the dependent child was enrolled in a child care center before your or your spouse/domestic partner's death.

Each succeeding 12 month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a child care center of less than 12 months.

A child care center is a facility that:

- Is licensed and run according to laws and regulations applicable to child care facilities; and
- Provides care and supervision for children in a group setting on a regular, daily basis.

A child care center does not include any of the following:

- A hospital
- The child's home
- Care provided during normal school hours while a child is attending grades one through 12.

Special Education Benefit: 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. Your or your spousedomestic partner's death must result, directly and independently of all other causes, from a covered accident for which an accidental death benefit is payable under the plan. 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.

A qualifying dependent child must meet all of the following conditions:

- Be enrolled as a full-time student in an accredited school of higher learning beyond the 12th grade level on the date of your or your spouse/domestic partner's covered accident; or be at the 12th grade level on the date of your or your spouse/domestic partner's covered accident and then enroll as a full-time student at an accredited school of higher learning within 365 days from the date of the covered accident and continue his education as a full-time student.
- Continue his education as a full-time student in such accredited school of higher learning.
- Incur expenses for tuition, fees, books, room and board, transportation and any other costs payable directly to, or approved and certified by, such school.

Payments will be made to each qualifying dependent child or to the child's legal guardian, if the child is a minor at the end of each year for up to four years. The insurance carrier must receive proof of the dependent child's enrollment and attendance

within 31 days of the end of each year. The first year for which a Special Education Benefit is payable will begin on the first of the month following the date you or your spouse/domestic partner died, if the surviving dependent child was enrolled on that date in an accredited school of higher learning beyond the 12th grade; otherwise on the date he enrolls in such school. Each succeeding year for which benefits are payable will begin on the date following the end of the preceding year.

Spouse/ Domestic Partner Training Benefit: 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 directly and independently of all other causes from a covered accident. Your spouse/domestic partner must have been insured under the plan on the date of your death to be eligible for this benefit. This benefit is subject to the conditions and exclusions described below.

This benefit will be payable if you die within one year of a covered accident and are survived by your spouse/domestic partner who:

- Enrolls, within three years after your death, in any accredited school for the purpose of retraining or refreshing skills needed for employment; and
- Incurs expenses payable directly to, or approved and certified by, such 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.

Coma Benefit: If you or an insured dependent is in a coma as a result of a covered accident, the plan will pay a Coma Benefit. After the covered person has been in a coma for one full month, the plan will begin to make monthly payments of 1% of the covered person's optional AD&D insurance coverage amount. The plan will make 11 monthly payments, provided the person remains in a coma during this period. If the person recovers, the payments will stop.

If the covered person dies while the monthly Coma Benefit payments are being made, or if the covered person remains in a coma after the 11 monthly payments have been made, he or she will be entitled to a lump sum payment equal to the full coverage amount.

Coma means a profound state of unconsciousness which resulted directly and independently from all other causes from a covered accident, and from which the covered person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a covered injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that covered accident.

Survivor Benefit: A Survivor Benefit will be paid, subject to the exclusions described below, if your death results directly and independently of all other causes from a covered

accident. Your spouse/domestic partner will receive a lump sum benefit equal to \$12,000.

If you do not have a spouse/domestic partner, no benefit will be paid.

Felonious Assault Benefit: The plan will pay the amount shown below, subject to the following conditions and exclusions, when you or an insured dependent suffer a covered loss resulting directly and independently of all other causes from a covered accident that occurs during a felonious assault or violent crime as described below. A police report detailing the felonious assault or violent crime must be provided before any benefits will be paid.

The benefit amount payable is 10% multiplied by the percentage of the covered person's optional AD&D coverage amount applicable to the covered loss, subject to a minimum of \$100 and a maximum of \$10,000.

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

- Actual or attempted robbery or holdup
- Actual or attempted kidnapping
- Any other type of intentional assault that is a crime classified as a felony by the governing statute or common law in the state where the felony occurred.

Benefits will not be paid for the treatment of any covered injury sustained or covered loss incurred during any:

- Violent crime or felonious assault committed by the covered person
- Felonious assault or violent crime committed upon the covered person by a fellow employee, family member, or member of the same household.
 - Family member means the covered person's parent, step-parent, spouse/ domestic partner or former spouse/ domestic partner, son, daughter, brother, sister, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, aunt, uncle, cousins, grandparent, grandchild and stepchild.
 - Fellow employee means a person employed by the same employer as the covered person or by an employer that is an affiliated or subsidiary corporation. It shall also include any person who was so employed, but whose employment was terminated not more than 45 days prior to the date on which the defined violent crime/felonious assault was committed.
 - Member of the same household means a person who maintains residence at the same address as the covered person.

Hospital Stay Benefit: The plan will pay the monthly benefit described below, subject to the following conditions and exclusions, if you or an insured dependent requires a hospital stay due to a covered loss resulting directly and independently of all other causes from a covered accident.

The hospital stay must meet all of the following:

- Be at the direction and under the care of a physician
- Begin within 90 days of the covered accident
- Begin while the covered person's insurance is in effect.

The benefit payable is 5% of the covered person's optional AD&D insurance coverage amount, subject to a minimum of \$250 and a maximum of \$1,000 per month. The maximum benefit period is 12 months per hospital stay per covered accident.

The benefit will be paid for each day of a continuous hospital stay that continues after the end of a benefit waiting period of seven days. Benefits will be paid retroactively to the first day of the hospital stay. If benefits are calculated on a monthly basis, pro rata payments will be made for confinements of less than one month.

Home Alteration and Vehicle Modification Benefit: The plan will pay 10% of your or your dependent's optional AD&D insurance coverage amount to a maximum of \$25,000, subject to the following conditions and exclusions, when you or an insured dependent suffer a covered loss other than a loss of life, resulting directly and independently of all other causes from a covered accident.

This benefit will be payable if all of the following conditions are met:

- Prior to the date of the covered accident causing such covered loss, the covered person did not require the use of any adaptive devices or adaptation of residence and/or vehicle
- As a direct result of such covered loss, the covered person now requires such adaptive devices or adaptation of residence and/or vehicle to maintain an independent lifestyle
- The covered person requires home alteration or vehicle modification within one year of the date of the covered accident.

Brain Damage Benefit: The plan will pay 100% of the covered person's optional AD&D coverage amount if you or an insured dependent suffers a covered injury that results directly and independently of all other causes from a covered accident and results in brain damage. The benefit will be payable if all of the following conditions are met:

- Brain damage begins within 60 days from the date of the covered accident
- The covered person is hospitalized for treatment of brain damage at least seven days within the first 120 days following the covered accident
- Brain damage continues for 12 consecutive months
- A physician determines that as a result of brain damage, the covered person is permanently totally disabled at the end of the 12-consecutive-month period.

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 optional AD&D coverage amount for the covered person whose covered accident is the basis of the claim.

Brain damage means physical damage to the brain that results directly and independently of all other causes from a covered accident and causes the covered person to be permanently totally disabled.

Permanently totally disabled means the covered person is totally disabled and is expected to remain totally disabled, as certified by a physician, for the rest of his life.

Totally disabled means:

- Inability of the covered person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
- Inability of the covered person who is not currently employed to perform all of the activities of daily living, including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

AD&D Exclusions: Losses Not Covered

Basic and optional AD&D insurance do **not** cover:

- Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane
- Commission or attempt to commit a felony or an assault
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof (except surgical or medical treatment required by an accident), except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage
- A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant, including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred.

Benefits Under Hazardous Conditions

Unlike some plans that exclude losses resulting from certain special hazards, the Northrop Grumman basic and optional AD&D insurance pays benefits if you suffer a loss under the following hazardous conditions:

- If you suffer a loss as a result of a declared or undeclared war or act of war occurring anywhere in the world, except in:
 - Countries where travel is permitted only under a license granted by the Office of Foreign Assets Control, unless such license is granted, or not required, or where such travel is undertaken at the request or under the direction of the United States Government
 - The United States and its territories and possessions
 - In any nation of which the covered employee is a citizen
- If you suffer a loss as a passenger, pilot, operator, or crew member while riding in or on, boarding or alighting from, or being struck or run down by any aircraft piloted by a licensed pilot
- If you suffer a loss which results directly independently of all other causes from unavoidable exposure to the elements following a covered accident
If a covered person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the covered person was riding in the course of a trip which would otherwise be covered under the plan, it will be presumed that the covered person's death resulted directly and independently of all other causes from a covered accident.

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.

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 Life Insurance Company of North America.

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 \$500,000 maximum
All eligible dependent spouses/domestic partners, provided Northrop Grumman agreed in advance to pay transportation expenses (including relocation)	\$50,000
All eligible dependent children, provided Northrop Grumman agreed in advance to pay transportation expenses (including relocation)	\$5,000

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)	50%
One hand or one foot	75%
Sight in one eye	60%
Speech or hearing in both ears	85%
Thumb and index finger of same hand	25%
Severance and reattachment of one hand or foot	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 arms or both legs
- For hemiplegia: total paralysis of the arm and leg on the same side of the body.

Paralysis means the total loss of use of an arm or leg. Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions

The exclusions shown for basic and optional AD&D insurance also apply to business travel accident insurance. Refer to that section for details.

Benefits Under Hazardous Conditions

For additional benefits under hazardous conditions, refer to the AD&D insurance section.

If you suffer a loss as a result of an aircraft skyjacking or an act of air piracy while riding as a passenger, pilot, operator, or crew member in or on, or boarding or alighting from, any aircraft. The plan defines skyjacking and air piracy as any illegal, nongovernmental, forceful commandeering of an aircraft.

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 \$20,000,000. If the total loss exceeds \$20,000,000, each covered person or his or her beneficiary receives a proportionate share of the \$20,000,000 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 accidental death and dismemberment (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:

- To the beneficiary or beneficiaries you have designated. You can designate your beneficiary online through the *NetBenefits* website at www.netbenefits.com/northropgrumman. If you do not have internet access, please call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. The NGBC will send you a paper designation to complete and return.
- 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
- To your surviving child(ren) if (1) and (2) above do not apply
- 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 Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 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 optional life insurance coverage.

Conversion and portability are characterized as follows:

- **Conversion** allows you to convert all or a portion of the terminating 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 optional life insurance (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.

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The following chart 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?	<ul style="list-style-type: none"> ■ Your basic life coverage ■ Your optional life coverage for yourself, your spouse/domestic partner and your dependent children ■ Your basic AD&D coverage (if you are under age 70) ■ Your optional AD&D coverage for yourself, your spouse/ domestic partner and your dependents (if you are under age 70). Dependents can only convert their insurance with the employee's conversion.
When can you convert?	<ul style="list-style-type: none"> ■ 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 the amount of your coverage reduces ■ 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?	<ul style="list-style-type: none"> ■ Yes, your spouse/domestic partner and child(ren) coverage can be converted. For accident insurance, dependents can only convert their insurance with the employee's conversion.
When can covered dependents convert?	<ul style="list-style-type: none"> ■ 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 the amount of spouse life coverage reduces ■ 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?	<ul style="list-style-type: none"> ■ 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 ■ For AD&D insurance, the maximum is \$250,000
Must I choose conversion within a certain time frame?	<ul style="list-style-type: none"> ■ 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 (62 days for AD&D) of the date coverage ends or reduces ■ When you convert, the insurance company will issue a new policy, which becomes effective: ■ Life insurance: The first day after the 31-day conversion period; exceptions are not permitted

**NORTHROP GRUMMAN HEALTH PLAN
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Conversion	
	<ul style="list-style-type: none"> ■ AD&D insurance: Within 62 days after coverage ends or within 31 days of receipt of a notice of conversion option. In no event can conversion be elected more than 105 days after coverage ends.
Is evidence of insurability (EOI) required?	<ul style="list-style-type: none"> ■ No, EOI is not required
What happens if I die within the first 31 days after coverage ends?	<ul style="list-style-type: none"> ■ 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 ■ AD&D insurance: If you die during the 31-day conversion period immediately after your coverage ended, your benefits are payable under the Group AD&D policy

The following chart shows when the portability features apply, and the conditions and limitations surrounding your choice to port your terminating optional life insurance coverage.

Portability	
What coverage can be ported?	<ul style="list-style-type: none"> ■ Your optional life coverage for yourself, your spouse/ domestic partner and your dependent child(ren)
When can you port your coverage?	<ul style="list-style-type: none"> ■ 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 can you NOT port your coverage?	<ul style="list-style-type: none"> ■ When you retire and you have access to the same coverage through a retiree option ■ When the Northrop Grumman group insurance policy terminates
How long will the portable coverage be in effect, and what reductions apply?	<ul style="list-style-type: none"> ■ Coverage reduces 50% on January 1 of the year that you reach age 70 ■ Coverage terminates on January 1 of the year the you reach age 80
Can a spouse/domestic partner and dependent child(ren) port their coverage?	<ul style="list-style-type: none"> ■ 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?	<ul style="list-style-type: none"> ■ 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?	<ul style="list-style-type: none"> ■ 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?	<ul style="list-style-type: none"> ■ The maximum amount of coverage that can be ported is the current amount of coverage, subject to state availability, up to \$1,000,000 for the employee ■ Up to \$250,000 for the spouse/domestic partner ■ Up to \$25,000 for dependent child(ren)

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Portability	
What is the minimum portable benefit?	<ul style="list-style-type: none"> ■ The minimum amount of coverage that can be ported is: ■ \$20,000 of group term life coverage for the employee ■ \$2,500 for the spouse/domestic partner ■ \$1,000 for dependent child(ren)
Can ported coverage be increased or decreased?	<ul style="list-style-type: none"> ■ Coverage cannot be increased ■ Coverage can be decreased; however, once coverage is decreased, it cannot be increased later
Is evidence of insurability (EOI) required?	<ul style="list-style-type: none"> ■ No, EOI is not required
Can you choose to convert your ported coverage?	<ul style="list-style-type: none"> ■ You may convert the ported amount; however, the ported coverage must terminate before a conversion policy will be issued.

Choosing Conversion or Portability

For life insurance, 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 AD&D insurance, you must choose conversion in writing within 62 days of the date coverage ends or within 31 days of receipt of a notice of conversion option. In no event can conversion be elected more than 105 days after coverage ends. Converted coverage becomes effective the day following the date coverage ended under the group policy.

For more information, contact the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

SHORT-TERM DISABILITY (STD)

Depending on where you work, you may have access to short-term disability (STD) benefits. 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. Northrop Grumman has engaged Unum Life Insurance Company of America (“Unum”) to serve as the claims administrator for the plan. Unum does not insure the STD benefits provided under the plan. STD benefits are self-insured by Northrop Grumman.

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.

For more information about the STD plan, access the Short-Term Disability summary plan description (SPD) at *Benefits & You OnLine* or call the NGBC for a printed copy.

LONG-TERM DISABILITY (LTD)

HOW THE LTD PLAN WORKS

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 Unum Life Insurance Company of America (Unum). Unum, 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.

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.*

*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.”*

Basic LTD Coverage

If you are eligible for company-paid basic LTD coverage, you are automatically enrolled in the basic LTD plan. Northrop Grumman provides this coverage at no cost to you.

The basic LTD plan pays 50% of your base pay, 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 pay, 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 pay*
- No optional LTD coverage.

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 you pay no taxes on the benefit, the real value of your benefit payments is actually greater than 60% of your monthly base pay.

Your cost for optional LTD coverage is based on your base pay and will increase or decrease as your base pay changes.

**Minus any other disability benefit income you might receive, up to a maximum of \$15,000 per month (see “How LTD Benefits Integrate With Other Sources of Income” for details).*

Selecting or Changing Optional LTD Coverage

You can select or change your optional LTD coverage at the following times:

- Within 45 days of when you first become eligible (usually your date of hire)
- During annual enrollment
- At any other time outside of annual enrollment (e.g., as a result of a qualified life event).

When you select LTD coverage at any time other than when you first become eligible, you may have to provide evidence of insurability (EOI). See “When Evidence of Insurability (EOI) Is Required” for details. To select or change optional LTD coverage at any time other than when you are first hired or during annual enrollment, call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

When Evidence of Insurability (EOI) Is Required

Evidence of insurability (EOI) is verification that you are in good health at the time you select optional LTD coverage. You may be required to provide EOI if:

- You enroll for optional LTD coverage at any time other than within 45 days of when you first become eligible (usually your date of hire)
- You reapply for coverage that you had previously cancelled

To provide EOI, contact the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 and request an LTD EOI form. Mail your completed form to the address provided. In addition, your doctor may be required to submit information regarding your health or give you a physical exam. You may be required to pay the cost of any physical exams performed to obtain coverage.

On the basis of the information you provide, Unum (the insurance company) determines your eligibility to enroll in the optional LTD plan.

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 a six-consecutive-month elimination, or waiting, period. 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 start the

six-month elimination period again. 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” 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 short-term disability (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 the HRSC.

How Disability Is Defined

During the first 24 months of your disability, Unum considers you disabled if:

- You are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury, and
- You have a 20% or more loss in your indexed monthly base pay due to the same sickness or injury.

Unum 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.

After 24 months of disability, the definition changes. You are considered disabled when Unum 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. “Gainful occupation” is a more restrictive definition of disability than “your regular occupation.” For example, if you are unable to perform the duties of your regular occupation, you may be able to find gainful occupation managing and facilitating the training of others. In this case, your disability benefits would end. Unum defines gainful occupation as an occupation that is providing — or can be expected to provide — you with an income at least equal to 60% of your indexed monthly base pay within 12 months of your return to work (see “Definition of Base Pay and Indexed Base Pay”).

Note: *The definition of disability does not change after 24 months for pilots. If you are a pilot for Northrop Grumman and would like to receive more information about LTD benefits, call the Northrop Grumman Benefits Service Center (NGBC) at 1-800-894-4194.*

Definition of Base Pay

Your cost for optional LTD coverage is based on your monthly base pay, as defined by your business unit. The amount of your LTD benefit is based on your monthly base pay on your last day of work. Contact the HRSC for details.

For the purpose of determining your LTD benefit payments, the plan uses your monthly base pay. 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, Unum may apply this amount toward an outstanding overpayment.

How and When to Claim Disability 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 Unum of a claim for LTD benefits as soon as possible to ensure that a claim decision can be made in a timely manner. Contact Unum within 90 days after the start of your disability.

To ensure that your claim is processed in a timely and confidential manner, call the Human Resources Service Center (HRSC) at 1-855-737-8364. The HRSC will put you in contact with Unum, who will start the claim process for you. You will be asked to sign an authorization form, allowing Unum to obtain the appropriate medical information from your doctor. If Unum 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 Unum 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 pay, 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. Unum 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, Unum 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. Unum 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
- End of year Vacation lump sum Payout (applies to Electronic Systems Sector Salaried Represented employees in entity 66 (Sunnyvale location) and entity 78 (Baltimore and Sykesville locations)).

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. Unum may obtain additional information from Northrop Grumman to determine whether a retirement plan is a Northrop Grumman retirement plan.
- Individual retirement accounts (IRA)
- Severance 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. Unum 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 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.

When you become disabled, the insurance company 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.

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 pay. For more information about indexed pay, see "Definition of Base Pay and Indexed Base Pay."

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.

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 six-consecutive-month period of disability before LTD benefit payments begin again.

For example, assume in January 2011 you experience an illness or injury, and the insurance company approves your LTD benefit payment. On August 1, 2011, you return to work after seven months of disability. At that point, you received one month of LTD benefit payments after completing the six-consecutive-month disability period.

- If this illness or injury disables you again **within** six months after you return to work (or by the end of January 2012), the insurance company considers this the same condition as the first. You do not have to complete a new six-consecutive-month disability waiting period, and LTD benefit payments 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, 2012), this is considered a separate disability. In this case, you have to complete a new six-consecutive-month period of disability before becoming eligible to apply 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 have to complete a new six-consecutive-month period of disability before becoming eligible to apply 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

The LTD plan does not pay benefits if your disability results from, is caused by, or is contributed to by any of the following:

- War, declared or undeclared, or any act of War, except when traveling to and from and working in countries outside the United States and Canada
- 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 After Two Years of Medical Leave

After you are on medical leave for two years, your employment with Northrop Grumman may terminate. However, if you are approved for a disability claim, 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.

A Note About Fraud

It is a crime if you knowingly — and with intent to injure, defraud, or deceive the LTD insurance company — provide any information or claim that contains false, incomplete, or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. The insurance company, Unum, will pursue all appropriate legal remedies in the event of insurance fraud.

GROUP LEGAL PLAN

The Group Legal Plan, through Hyatt Legal Plan, 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 (i.e., 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 Hyatt Legal Plans' website, www.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.

You may also call Hyatt Legal Plans' Client Service Center at 800-821-6400, Monday through Friday 8 am to 7 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.

TRAVEL PROTECTION

Emergencies can happen while traveling on vacation or company business, and Northrop Grumman provides you with access to travel assistance when you travel at least 100 miles from home. The service is administered by CIGNA Secure Travel[®], and you do not have to enroll to have coverage.

Through CIGNA Secure Travel, you receive special assistance for emergency medical, financial, legal and communication assistance when you travel.

This program provides emergency medical assistance including paying to arrange:

1. Transportation to a hospital or medical facility
2. Emergency medical evacuation
3. Repatriation of remains
4. Referrals to physicians, dentists and medical facilities
5. Prescription refill services*
6. New travel plans for a companion who lost existing arrangements due to delays caused by your emergency
7. Travel of a dependent child (under age 16) who is left unattended as a result of your illness or injury
8. Round-trip (economy class) transportation for a family member if you're expected to be hospitalized for more than 10 days
9. Up to \$10,000 cash advance for payment of emergency medical services

In time of emergency, Cigna Secure Travel can provide:

- Emergency cash – advance of up to \$1,500*
- Emergency changes to travel plans
- Emergency message center
- Assistance with lost or stolen items, including luggage, prescriptions and other personal belongings*
- Legal referrals to local attorneys, embassies and consultants
- Translation and interpretation assistance
- 24-hour multilingual assistance
- Advancement of bail*

**You are responsible for repaying these funds to Cigna Secure Travel as this program does not cover these expenses.*

The CIGNA Secure Travel customer service center is available 24 hours a day, 365 days a year. For more information about CIGNA Secure Travel, call 1.888.226.4567.

EMPLOYEE ASSISTANCE PROGRAM

The 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 includes 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 Beacon Health. For more information about the EAP and Work/Life Solutions, access the Employee Assistance Program link at *Benefits & You OnLine*.

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 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 for Northrop Grumman 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 Northrop Grumman 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.

If you have any questions about this information, call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 or contact the nearest regional office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits 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.

BENEFIT AND ADMINISTRATIVE CLAIMS

Types of 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.

How to File a Claim

Benefit Claims: 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. Be sure to keep a copy of everything for your records.

If you are enrolled in the Premium, Premium Plus, Sunnyvale Represented Premium or Value plan option, you must submit medical claims that you incur during the plan year to Anthem within **15 months** after the plan year ends. For example, assume you incur a claim in October 2017. Since the plan year ends on December 31, 2017, you have until March 30, 2019 to submit your claim for reimbursement. Prescription drug coverage in the Premium, Premium Plus and Value plans 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 twelve 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.

You must submit dental claims that you incur during the plan year within 12 months after the plan year ends. Vision claims must be submitted within 6 months after the plan year ends.

The medical, dental, and vision plan options do not pay claims that are submitted after these deadlines.

For details about how to file a claim for flexible spending account reimbursement, health reimbursement account (HRA) reimbursement, disability benefits, life insurance, and AD&D insurance, refer to those specific sections.

Administrative Claims: 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 a Benefit Claim or 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 a lawsuit based on that claim.

Authorized Representative

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

As of October 2017, 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.

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.

As of October 2017, 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.

Timeframes for Determinations

The timeframes for benefit determination for medical and disability benefits vary depending on the benefit and the type of claim. In this table, "Health" benefit claims include medical, prescription drug, mental health and substance abuse treatment, dental, vision, health reimbursement account (HRA), and health care flexible spending account (FSA) benefit claims.

Type of Claim	Initial Deadline for Claims Review	Time for You to Provide Additional Information	Extensions for Claims Review, if Necessary
Health: Urgent	72 hours	48 hours	None
Health: Urgent, concurrent care	24 hours*	48 hours	None
Health: Pre-Service	15 days	45 days	15 days
Health: Post-Service	30 days	45 days	15 days
Disability	45 days	45 days	Two 30-day Extensions
Life, AD&D and Business Travel Accident	90 days	45 days	90 days
Administrative	90 days	45 days	90 days

**Applies only when claim is submitted at least 24 hours before end of approved treatment.*

- **Health 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 being 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").

- **Health 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.
- **Health 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.
- **Health 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 #1: 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.

Example #2: In the case of disability benefits, the claims administrator must respond within 45 days, and may take up to two 30-day extensions, if circumstances warrant. You have 45 days to supply any additional information from the date you are notified that your claim is incomplete. If you take 35 days to supply the requested information, this 35-day period does not count toward the administrator’s time limits.

If Your Benefit or Administrative Claim Is Denied

If your Benefit or Administrative 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.

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 health (excluding dental, vision and FSA) claim, the date of service, name of the health care provider, and claim amount
- If a health (excluding dental, vision 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 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 health (excluding dental, vision, 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 explanation will also contain the following information:

- If the denial is based on an internal rule, guideline, or protocol, or standard, the denial will say so and 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
- If the denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims.

Appealing a Denied Benefit Claim (All Benefits Except Disability)

If your Benefit 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. Be sure to explain why you think your claim should be paid and provide all relevant details.
- If your claim is denied by the level 1 appeals review committee, and it is not an urgent claim or Administrative Claim, ask the claims administrator to submit your

claim to the appropriate level 2 appeals review committee 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 Denied Claim for Disability Benefits

Unum Life Insurance Company of America ("Unum") is the decision-maker for both 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. 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 Unum 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). Unum will notify you in writing if an additional 45-day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Unum may decide your appeal without that information.

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 Unum 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, Unum 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 the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, Unum will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain the following information:

- The specific reason(s) for the determination;
- A reference to the specific plan provision(s) on which the determination is based;

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- 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; and
- The statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

Appealing a Denied Administrative Claim

If your Administrative Claim is denied, you have the right to make an appeal by writing to the claims administrator. 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 Appeal 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.

Appealing a Rescission of Coverage

A Rescission of Coverage is a cancellation or discontinuance of health (excluding dental, vision, and health care flexible spending account) 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 his or her 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 Appeal 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

If you make a Benefit or Administrative 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” for details).

In the case of medical, prescription drug, mental health and substance abuse treatment, dental, vision, health reimbursement account (HRA) and health care flexible spending account (FSA) claims (“Health Claims”), and in the case of disability Benefit Claims, you have 180 days from the time that you receive a claim denial from the claims administrator to file an appeal. 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. In the case of all other benefits, you have 60 days from the time you receive a claim denial 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
Health: Urgent claims	180 days	72 hours	None
Health: 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
Health: 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 (60 days for dental claims)*	None
Life AD&D and Business Travel Accident	60 days	One level of appeal: 60 days	60 days
Disability	180 days	45 days	45 days
Administrative	65 days	One level of appeal: 60 days from the receipt of the appeal	60 days
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

* There is only one level of appeal for non-clinical prescription drug claims (e.g., claims that do not involve a determination of clinical appropriateness or medical necessity) to CVS/caremark under the Plan’s Premium, Premium Plus and Value plan options. Your claim denial letter from CVS/caremark will inform you whether there are one level or two levels of appeal. If there is only one level of appeal, CVS/caremark will have 60 days from the date of the receipt of your appeal to render its decision.

- **Urgent Health 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 Health 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 you level 1 appeal Your appeal must be considered within 15 days, with no extensions.
- **Post-Service Health Claims.** There are two levels of appeal, except that there is only 1 level of appeal for non-clinical prescription drug claims (e.g., claims that do not involve a determination of clinical appropriateness or medical necessity) to CVS/caremark under the Plan’s Premium, Premium Plus, Sunnyvale Represented Pemium and Value plan options. Your claim denial letter from CVS/caremark will inform you whether there are 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’s Premium, Premium Plus, Sunnyvale Represented Premium and 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 (60 days for dental claims), with no extensions.
- **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 for Disability Benefits.”
- **Administrative Claims.** There is only one level of appeal for Administrative Claims. You may file a claim appeal with the claims administrator within 65 days after you receive the claim denial. Your appeal must be considered within 60 days, with a 60-day extension permitted if necessary.
- **Rescissions of Coverage.** There is only one level of appeal for Rescissions of Coverage. You may file a claim appeal with the claims administrator within 180 days

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after you receive notice of the Rescission of Coverage. Your appeal must be considered within 60 days, with a 60-day extension permitted if necessary.

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Claims and Appeals Contact Information

Claims Administrator	Claims	Level 1 Appeals	Level 2 Appeals
Anthem Blue Cross ■ Premium Plan ■ Premium Plus Plan ■ Sunnyvale Represented Premium ■ Value Plan	Medical claims must be submitted to your local Blue Cross Blue Shield Plan. Please contact Member Services with questions. For pharmacy claims, see CVS/caremark below.	Anthem Blue Cross PO Box 54159 Los Angeles, CA 90054	Anthem Blue Cross PO Box 54159 Los Angeles, CA 90054
CVS/caremark (Prescription drugs for Premium, Sunnyvale Represented Premium, Premium Plus and Value Plan 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: 1-866-443-1172	CVS/caremark Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084 FAX: 1-866-443-1172
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
Unum Life Insurance Company of America (Long-Term Disability)	Unum Claims Services 655 North Central Avenue Suite 800 Glendale, CA 91203	Unum Appeals 655 North Central Avenue Suite 800 Glendale, CA 91203	No Level 2 appeals. LTD benefit claims have only one level of appeal
MetLife	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
Life Insurance Company of North America (AD&D and Business Travel Accident)	CIGNA P.O. Box 22328 Pittsburgh, PA 15222-0328	CIGNA Attention: Appeals P.O. Box 22328 Pittsburgh, PA 15222-0328	CIGNA Attention: Appeals P.O. Box 22328 Pittsburgh, PA 15222-0328
WageWorks	WageWorks Claims Administrator P.O. Box 14053 Lexington, KY 40512	WageWorks Claims Appeal Board P.O. Box 991 Mequon, WI 53092-0991	N/A
Benefit Plans Administrative Committee COBRA	Plan Administrator - Northrop Grumman Health Plan Northrop Grumman Corporation P.O. Box 77003 Cincinnati, OH 45277-1060	Benefit Plans Administrative Committee - Northrop Grumman Health Plan Northrop Grumman Corporation P.O. Box 77003 Cincinnati, OH 45277-1060	Benefit Plans Administrative Committee - Northrop Grumman Health Plan Northrop Grumman Corporation P.O. Box 77003 Cincinnati, OH 45277-1060

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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	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	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

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, health care flexible spending account (FSA), and disability 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.
- 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, the notice that you receive will provide, 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 and FSA) claim, the date of the service, name of the health care provider, and claim amount

- If a health (excluding dental, vision, 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 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” for details.)
- If a health (excluding dental, vision, 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, etc., 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, 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, level of care, effectiveness, or a determination that a treatment is experimental or investigational). 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.

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 filing 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 is 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 on the final level of appeal, 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. 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. A cause of action “accrues” when you know or should know that the claims 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 and have qualified for long-term disability benefits, under current Plan terms, your medical, dental and vision benefits could continue for up to two years, with contributions waived during that time. If Northrop Grumman amends the Plan so that contributions for medical benefits during a medical leave of absence are not waived in any case, even if long term disability benefits are approved, then Northrop Grumman has clearly denied your right to free medical benefits, 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.
- 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" 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, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after the date you enroll in your coverage.

In addition to creating rights for plan participants, ERISA imposes duties on the plan fiduciaries — the people responsible for operating the plan. At Northrop Grumman, 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.

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, as of October 2017, 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.

As of October 2017, 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.

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.

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), wellness program, and the health care flexible spending account (HCFSA) components of the Plan. The components of the Plan that are not subject to the HIPAA privacy rules are the life insurance, accidental death and dismemberment (AD&D) insurance, business travel accident insurance, short-term disability (STD), long-term disability (LTD), and the group legal plan components of the Plan.

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. The privacy rights under Title II of HIPAA are effective April 14, 2003. 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 Northrop Grumman to use and disclose protected health information for plan administration functions. 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 for plan administration purposes, and that Northrop Grumman may use or disclose your health information to administer benefits under the Plan. Northrop Grumman agrees, and has certified to the Plan, that it will not to 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 employees who will have access to your health information for plan administration functions:

- 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 Northrop Grumman, as allowed under the HIPAA rules:

- The Northrop Grumman Health Plan, or its Insurer or HMO, may disclose "summary health information" to Northrop Grumman 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 Northrop Grumman 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 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 1-800-894-1374. 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 (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
 - If you want to exercise this right, your request to the plan must be in writing, and you must include a statement to support the requested amendment.
- 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.

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.

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, 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 have an additional 45 days from the date of your election to pay your first COBRA premium. After that time, your premium payments are due as of the first of the month, with a 30-day grace period. 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 while an active employee (for example, Premium, Value, or HMO).
- 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, Medicare pays primary 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 Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

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 30 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, and vision), 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 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 with Northrop Grumman 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 1-800-894-4194 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.

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 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 and, if your payment is not received within 31 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.

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 www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep your local human resources representative or 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.

Note: 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 Military 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 the Premium, Premium Plus, Sunnyvale Represented Premium and Value medical plan options. 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 "Benefit and Administrative 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 One Enterprise Drive North Quincy, MA 02171
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

**NORTHROP GRUMMAN HEALTH PLAN
SUMMARY PLAN DESCRIPTION
JANUARY 2017**

Prescription Drug Plan in the Medical Plan Options	
Insured by:	Northrop Grumman self-insures the Prescription drug benefits in the Premium, Premium Plus, Sunnyvale Represented Premium and Value 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:	<p>For prescription drug benefits in the Premium, Premium Plus, Sunnyvale Represented Premium and Value medical plan options, claims are administered by:</p> <p>CVS/caremark (initial claim determinations) Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136</p> <p>CVS/caremark (appeals determinations) Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85072-2084</p> <p>For all other plan options, refer to the claims administrators and addresses provided in the chart under "Claims and Appeals Contact Information" in the "Benefit and Administrative Claims" section of this summary plan description (SPD), or refer to your medical ID card for claims administration details.</p>
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
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 Health DMO plan option, which is insured by: CIGNA Dental Health P.O. Box 189060 Plantation, FL 33318-9060 1-800-244-6224		
Claims administered by:	<table border="0"> <tr> <td>Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 1-415-972-8300</td> <td>CIGNA Dental Health P.O. Box 189060 Plantation, FL 33318-9060 1-800-244-6224</td> </tr> </table>	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 1-415-972-8300	CIGNA Dental Health P.O. Box 189060 Plantation, FL 33318-9060 1-800-244-6224
Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330 1-415-972-8300	CIGNA Dental Health P.O. Box 189060 Plantation, FL 33318-9060 1-800-244-6224		
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171		
Funded by ¹ :	Northrop Grumman and participant contributions		

**NORTHROP GRUMMAN HEALTH PLAN
SUMMARY PLAN DESCRIPTION
JANUARY 2017**

Vision Plan	
Insured by:	Vision Service Plan
Claims administered by:	Vision Service Plan P.O. Box 385018 Birmingham, AL 35238-5018 1-800-877-7195
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by ¹ :	Northrop Grumman and participant contributions

Basic and Optional Life 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 One Enterprise Drive North Quincy, MA 02171
Funded by ¹ :	For basic: Northrop Grumman; for optional: participant contributions

Basic and Optional Accidental Death and Dismemberment Insurance and Business Travel Accident Insurance	
Insured by:	LINA (Life Insurance Company of North America) 1601 Chestnut Street Philadelphia, PA 19192-2235 1-800-238-2125
Claims administered by:	LINA (Life Insurance Company of North America) P.O. Box 22328 Pittsburgh, PA 15222-0328 1-800-238-2125
Trustee ² :	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by ¹ :	For basic: Northrop Grumman; for optional: participant contributions

**NORTHROP GRUMMAN HEALTH PLAN
SUMMARY PLAN DESCRIPTION
JANUARY 2017**

Long-Term Disability Plan	
Insured by:	Unum Life Insurance Company of America 655 North Central Avenue Suite 800 Glendale, CA 91203
Claims administered by:	Unum Life Insurance Company of America 655 North Central Avenue Suite 800 Glendale, CA 91203
Trustee²:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Northrop Grumman and participant contributions

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:	WageWorks P.O. Box 14053 Lexington, KY 40512
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Participant contributions

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:	WageWorks P.O. Box 14053 Lexington, KY 40512
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Northrop Grumman and participant contributions

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.

GLOSSARY

Accidental death and dismemberment (AD&D) insurance — Insurance that pays benefits if, as a result of a covered accident, you die or lose a limb or your sight, speech, or hearing within 365 days of the accident. The amount the plan pays depends on the extent of your loss.

Acute care — Treatment for an immediate and severe episode of an illness, an injury related to an accident or other trauma or recovery from surgery. Typically, acute care is provided in a hospital. Unlike chronic care, acute care often is needed for only a short time.

After-tax contributions — Contributions for certain benefits that are deducted from your paycheck after federal, state, and local taxes are withheld.

Alternative care — Unconventional health care procedures, services or courses of treatment, such as Rolfing. Typically, the plan options do not cover alternative care.

Anabolic drugs — A group of synthetic hormones used to increase constructive metabolism that are derived from or closely related to androgen testosterone.

Annual maximum — The maximum number of treatments or services or amount of benefits that you or your enrolled dependents can receive each plan year. Annual maximums vary by plan.

Attention deficit hyperactivity disorder (ADHD) — A condition characterized by learning or behavior problems, difficulty sustaining attention, impulsive behavior (as in speaking out of turn), or excessive or uncontrollable activity.

Automatic payroll deductions — Costs that are deducted from your paycheck before your “net” amount is calculated.

Aversion therapy — Therapy intended to induce dislike for certain habits or antisocial behavior by using association with a noxious and/or graphic stimulus.

Base pay — Your pay for purposes of determining life insurance, AD&D insurance, and LTD coverage, as determined by your business unit.

Basic benefits — The benefits you receive automatically as an eligible Northrop Grumman employee. Northrop Grumman pays the full cost of these benefits.

Pre-tax contributions — Contributions for certain benefits that are deducted from your paycheck before federal, state, and local taxes are withheld.

Beneficiary — The person(s) whom you designate to receive your life and AD&D insurance benefits when you die.

Benefit levels — Levels of benefits that a plan option offers. These may range from comprehensive coverage (which includes preventive care) to minimum coverage for preventive or catastrophic care only. The benefit levels for plan options also can vary in the amount of deductibles and plan year maximums.

Benefit plan options — The various options available to you and your family within the Northrop Grumman Health Plan.

Benefits & You OnLine — The Northrop Grumman Internet/intranet benefit homepage (<http://benefits.northropgrumman.com>).

Benefits Services — The Northrop Grumman benefits department at several office locations.

Binding arbitration — A legal method used to efficiently resolve disputes outside the court system. When you enroll in an HMO or DMO, you agree to resolve all differences between you or your dependents and the claims administrator through binding arbitration.

Bitewing X-rays — A simultaneous X-ray of teeth in both the upper and the lower jaw.

Brand name prescription — A prescription drug that is protected by patent and is marketed under a specific name.

Bridges (dental) —

- Fixed - A set of one or more false teeth cemented in place in the mouth. Retainers secure the bridge to the teeth.
- Fixed-removable - A set of false teeth the dentist can remove but the patient cannot.
- Removable - A set of false teeth, usually held by clasps, that the patient can remove.

Business travel accident insurance — Insurance that pays benefits if, as a result of a covered accident, you or your eligible dependents die or lose a limb or your sight, speech, or hearing within 365 days of the accident that occurs while you and your accompanying eligible dependents are traveling on Northrop Grumman business. The amount the plan pays depends on the extent of your loss.

Carrier — A company that underwrites or administers a range of health benefit programs. May refer to an insurance company or a managed health plan.

Case management — A process in which a registered nurse and case management team is 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.

Certificate of Creditable Coverage — A document that provides proof of your previous medical coverage.

Coinsurance — Your percentage share of the cost of eligible expenses. For example, in the Premium plan option, the coinsurance arrangement is 80%/20% for in-network providers, in which case Northrop Grumman pays 80% of the Maximum Allowed Amount expenses and you pay 20%. You pay coinsurance after you meet the deductible.

Collective bargaining agreement — A contract between a union and an employer covering benefits, wages, and working conditions.

Congenital disorder — A condition that existed at or dates from birth.

Consolidated Omnibus Budget Reconciliation Act (COBRA) — A federal law that requires employers to offer continued health insurance coverage to employees and their dependents when their eligibility for group health insurance coverage ends, such as at termination of employment or divorce. COBRA applies to your medical, dental, vision, and health care flexible spending account benefits.

Continuous disability — For purposes of the long-term disability plan, a disability that lasts for at least six uninterrupted months. You can return to work for up to 30 days during this six-month period, and your disability is still considered continuous.

Contract employee — An individual — usually working at a Northrop Grumman site — who is not on the Northrop Grumman payroll, but instead works for a company that was retained by Northrop Grumman or its affiliates to provide a specific service.

Contributions — The amount you pay toward the cost of the benefits in which you enroll. Typically, contributions are deducted from your paychecks. Refer to your paycheck stub for information on contributions.

Conversion policy — An individual life or AD&D insurance policy which you can purchase to replace your Northrop Grumman basic and optional life insurance and/or basic and optional AD&D insurance after your employment ends. You do not have to provide evidence of insurability (EOI) for a conversion policy.

Coordination of benefits (COB) — A method of coordinating reimbursements for health care treatment and supplies when you or a family member is enrolled in more than one health care plan — for example, medical and auto insurance or the Northrop Grumman plan and your spouse's (or domestic partner's) employer's plan.

Copayment — A fee you pay to a provider at the time you receive care.

Coverage categories — The categories or tiers, such as employee only or employee and family that determine your cost of coverage.

Covered loss — The loss of life, limb(s), sight, speech, hearing or paralysis for which you are eligible to receive full or partial benefits under the AD&D Insurance plan.

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

Diagnosis — Identification of a condition by examination, testing and/or analysis.

Diagnostic and Statistical Manual of Mental Disorders (DSM III-R/IV) — A code book of mental disorder symptoms and illnesses.

Eligible dependents — Dependents eligible for benefit coverage under the plan, such as your spouse, qualified domestic partner, and certain children.

Eligible expenses — Charges for services or supplies for which the medical, dental, or vision plan options pay benefits.

Emergency — A sudden serious medical condition for which failure to receive immediate care could place your life in danger or could cause serious impairment of bodily functions.

Employee assistance program (EAP) — A confidential counseling and referral service, available to you and your family.

Employee Retirement Income Security Act of 1974 (ERISA) — A federal law that imposes reporting and disclosure requirements on group health and welfare, savings and pension plans.

Employer contribution — The amount Northrop Grumman contributes toward the premium cost of your benefits.

Estate — The assets and liabilities left by you when you die.

Evidence of insurability (EOI) — Proof that you and/or your dependents are in good health at the time you choose or increase your optional life or long-term disability insurance.

Experimental — A procedure, service or supply that, as determined by the claims administrator in its sole discretion, does not conform to accepted medical practice, is not approved by the appropriate governing body, such as the Food and Drug Administration, or has not completed scientific testing or whose effectiveness has not been established. Typically, experimental procedures, services or supplies are not covered under the medical or dental plan options.

Explanation of benefits (EOB) — A statement from a claims administrator or insurance company that describes services or treatments performed, dollar amounts paid by the plan, benefit limits, and denials. If you have coverage under more than one health care plan, you must submit a copy of your EOB along with your claim for reimbursement of expenses. In addition, it is important to keep a copy of your EOBs in your personal files for future reference.

Fiduciaries — The people or entities responsible for operating a plan. At Northrop Grumman, plan fiduciaries may include employees who make certain discretionary

decisions about the management or administration of the plans. Fiduciaries also may include outside investment advisors and trustees.

Flexible spending accounts (FSAs) — Two accounts, the health care FSA and the dependent day care FSA, which allow employees to pay certain health and dependent day care expenses with pre-tax dollars.

Generic drug — A copy of a brand name drug that no longer is protected by a patent. Generic drugs are therapeutically equivalent to the original and are less expensive.

Group — The employer (such as Northrop Grumman), union, trust, association, or organization through which you and your dependents are entitled to benefit coverage.

Group rates — The discounted insurance rates offered to an employer (such as Northrop Grumman), union, trust, association, or organization.

Health Insurance Portability and Accountability Act (HIPAA) — A federal law that places limits on health care plan preexisting condition exclusions, among other requirements, and defines privacy and security requirements for group health plans.

Health maintenance organization (HMO) — A medical plan that offers its members a wide range of medical services from a specific group of medical providers.

Health reimbursement account — In the Premium and Premium Plus plan options, Northrop Grumman credits a specified dollar amount into a Health Reimbursement Account (HRA) for you and your eligible dependents each year. The funds credited to your HRA are used to pay for the cost of any covered medical and prescription drug expenses. Any unused funds credited to your HRA roll over from plan year to plan year when you re-enroll in the Premium or Premium Plus plan options, and can be used to reduce your future out-of-pocket costs.

Home health care — 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.

Hospice care — Medical care provided to a terminally ill patient and emotional support for family members during the last months of a patient's life. Medical care emphasizes controlling the patient's pain and other symptoms rather than attempting to find a cure or prolong life. A licensed agency provides hospice care to the patient, either as an inpatient in a licensed hospice center or a private-duty nursing facility or at home as an outpatient.

Independent contractor — A non-employee who enters into a contract to furnish supplies or work at a certain price or rate.

Individual policy — Insurance for individuals and their dependents that is separate from a group insurance plan. Also see conversion policy.

Ineligible expenses — Expenses that are not covered by the plan.

In-network (or network) provider — A health care provider (such as a physician, dentist, hospital, or laboratory) that enters into a contract with the health plan to provide care at a specified, discounted rate. Typically, the plan options pay more when you receive treatment from a network provider. Also see in-network benefits and in-network care.

In-network benefits — The level of benefits you receive when you and/or your enrolled dependents are treated by network providers. Typically, the plan options pay more when you receive treatment from an in-network provider.

In-network care — Care provided or authorized by a network provider. Typically, the plan pays more when you receive treatment from an in-network provider.

Inpatient — A patient admitted to the hospital for an overnight stay.

Installment payments — Payments of equal amounts made over a period of time.

Investigational — See Experimental.

Job shopper — An individual — usually working at a Northrop Grumman site — who is not on the Northrop Grumman payroll but instead works for a company that was retained by Northrop Grumman or its affiliates to provide a specific service.

Leased employee — An individual who is not on the Northrop Grumman payroll but who provides services to Northrop Grumman or its affiliates as specified in an agreement between the individual and Northrop Grumman and who qualifies as a leased employee under Section 414(n) of the Internal Revenue Code.

Legal guardian — A person designated by the court to be legally responsible for a minor child(ren) in place of a parent.

Licensed child care facility — Any state-licensed facility, other than a family day care home, that provides non-medical supervision for children. The care must be in a group setting and for less than 24-hours a day.

Life insurance — Insurance that pays benefits in the event of a death.

Lump sum — Payment of your benefit in its entirety at one time.

Mail order prescriptions — Long-term or maintenance prescription medication that you can purchase through a medical plan option's prescription drug mail order program.

Maintenance medication — Drugs that are taken on a regular basis (for example, oral contraceptives, medications for a chronic condition such as high blood pressure or diabetes).

Maximum Allowed Amount — The amount determined by the claims administrator, that the Premium or Value 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. See the explanation in Premium, Premium Plus, Sunnyvale Represented Premium and Value Plan sections for details

Medicaid— A government program, administered, and operated individually by participating state and territorial governments, that provides medical benefits to eligible low-income individuals. Federal and state governments share the cost of the program.

Medically necessary — In general, services or supplies that meet the medical necessity criteria of the claims administrator. See "Medical Necessity" in the Premium, Premium Plus, Sunnyvale Represented Premium and Value plan sections of the SPD for a detailed definition.

Medicare — A federally administered, nationwide health insurance program that covers the cost of health care for individuals who are eligible for Social Security benefits. As a Northrop Grumman employee, you and Northrop Grumman pay a premium each pay period for your future Medicare benefits.

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.

Network (or in-network) provider — A health care provider (such as a physician, dentist, hospital, or laboratory) that enters into a contract with the health plan to provide care at a specified, discounted rate. Typically, the plan options pay more when you receive treatment from a network provider.

Network area (service area) — The geographic area, usually based on ZIP code, in which you must live to be eligible to participate in a plan.

Network specialist — A specialist who enters into a contract with the health plan to provide care at a specified, discounted rate. Typically, the plan options pay more when you receive treatment from a network specialist. Under some HMO and EPO plan options, to receive in-network benefits, you must receive a referral from your primary care provider (PCP) before visiting a network specialist.

Non-duplication of benefits — A method of combining reimbursements for health care treatment and supplies when you or a family member is enrolled in more than one health care plan, such as the Northrop Grumman plan and your spouse's (or domestic partner's) employer's plan. Under this method, payments from the Northrop Grumman plan plus payments from the other plan do not exceed the amount Northrop Grumman would have paid if there were no other coverage. Non-duplication of benefits applies to medical, mental health and substance abuse and prescription drugs.

Non-participating pharmacy — A pharmacy that has not entered into a contract with a plan option to dispense prescription drugs at a specified, discounted rate.

Non-represented employee — An employee who is not represented by a union or covered by a collective bargaining agreement.

Northrop Grumman Benefits Center (NGBC) — A telephone center staffed with trained benefits service representatives who can provide answers to your benefit questions or direct you to other resources. You can reach the NGBC at 1-800-894-4194. Benefits Center service representatives are available to assist you Monday through Friday (except most New York Stock Exchange holidays) from 8:30 a.m. and 8:30 p.m., Eastern time. If you are calling from outside the United States, dial the AT&T out-of-country access number, then 800-894-4194. TTY service is available at 1-888-343-0860.

Obstetrician/gynecologist (OB/GYN) — A physician who specializes in women's health, including pregnancy and child birthing.

Ophthalmoscopy — An exam of the retina of the eye. The doctor looks through a device with a special magnifying lens that provides a narrow view or a wide view of the retina.

Optional benefits — The benefits you can choose to purchase for yourself and your family (medical, dental, vision, optional life insurance, optional AD&D insurance, optional LTD, FSAs).

Oral surgery — Surgical treatment involving the teeth, mouth or jaw.

Orthodontic care — Treatment to correct the position of teeth.

Out-of-network benefits — The benefits you receive when you use a health care provider who is not part of the network (out-of-network provider). Typically, you pay more when you use an out-of-network provider.

Out-of-network care — Care you receive from a provider who is not part of the network (out-of-network provider). Typically, you pay more when you receive out-of-network care.

Out-of-network provider — A health care provider who has not entered into a contract with a plan to be a member of the plan's network. You pay more when you receive care from an out-of-network provider.

Out-of-pocket costs — The amount of your health care expenses that is not covered by the plan option and is paid by you. Out-of-pocket costs typically include copayments, deductibles, coinsurance and ineligible expenses.

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

Outpatient care — Health care you receive from a clinic, emergency room, or other health facility without being admitted as an overnight patient.

Participating pharmacy — A pharmacy that is a member of a plan's network of pharmacies and agrees to dispense prescription drugs to you according to the provisions of the plan.

Periapical disease — Disease of the tissues around the root of the tooth, including the gums and bones.

Periodontics — Treatment of the gums and supporting structures of the teeth.

Photorefractive keratectomy (PRK) — A type of corrective eye surgery.

Physician — A person who is legally qualified to practice medicine.

Plan administrator — The person or group of persons designated by the legal plan document as responsible for most day-to-day activities of the plan. These activities include determining eligibility for benefits, processing claims and appeals regarding claims, maintaining plan records, and distributing information about the plan to participants. The Plans Administrative Committee is the plan administrator.

Plan document — The legal document that contains all of the provisions, conditions, and terms of operation of a plan. The plan document may be made up of more than a single document.

Plan year — The 12-month period from January 1 to December 31.

Precertification — The advance review and approval of proposed hospital stays and specific health care services.

Predetermination of benefits — An application for approval of dental treatment and an estimate of eligible expenses — before treatment is received.

Preexisting condition — Any physical or mental condition that you or a dependent had within a specific period of time immediately before enrolling in a health plan. There may be limits to health care benefits for your dependents who have a preexisting condition, even if they did not receive treatment for the condition.

Premium — The cost of your plans. Premiums may change periodically. Your share of the premium is called your contribution.

Prenegotiated rates — Discounted rates that a health care provider agrees in advance to charge for services and care provided to plan participants.

Primary care provider (PCP) — Network family practitioners, general practitioners, internists, dentists, or pediatricians under the HMO and DMO options. PCPs arrange referrals and supervise other care, such as specialist services and hospitalization. All PCPs meet HMO or DMO qualification standards and are subject to periodic review.

Primary plan — If you are enrolled in more than one medical or dental plan, the plan that pays benefits first.

Prophylaxis — Professional teeth cleaning; may include scaling to remove stains and tartar from teeth.

Prosthodontics — Treatment to replace missing teeth or other dental structures.

Provider (medical) — A hospital, skilled nursing facility, ambulatory surgical facility, physician, practitioner, laboratory, or other individual or organization that is licensed to provide medical or surgical services, supplies and/or accommodations.

Qualified Medical Child Support Order (QMCSO) — An order or judgment from a state court or administrative agency that directs the plan administrator to cover a child for benefits under the plan. Applies to medical and dental benefits.

Recalled — When you are rehired after being terminated for lack of work or a reduction in workforce.

Referral — An arrangement, usually made by your primary care provider, under which you can be evaluated and treated by another provider, typically a specialist.

Rehabilitation — A provision under the long-term disability plan that facilitates your transition back to work if you become disabled.

Rehabilitation therapy — Therapeutic treatment to restore the use of a part of the body or bring it to a condition of health or useful and constructive activity.

Required contributions — The amount you must pay to continue benefits coverage for yourself and/or your dependents while you are on an unpaid leave of absence.

Secondary plan — If you are enrolled in more than one medical or dental plan, the plan that pays benefits after the primary plan. Also see primary plan.

Service area (network area) — The geographic area, usually based on ZIP code, in which you must live to be eligible to participate in a plan.

Skilled nursing facility — A specially qualified facility that has the staff and equipment necessary to provide skilled nursing care, or rehabilitation services and related health services. Care at the facility is provided by, or under the supervision of, licensed nursing personnel. Skilled rehabilitation services may include such services as physical therapy performed by or under the supervision of a professional therapist.

Social Security — A federal government program established in 1935 to provide old-age and survivors insurance, contributions to state unemployment insurance and old-age assistance.

Social Security wage base (SSWB) — The maximum amount of pay subject to Social Security (FICA) tax each year. Both you and Northrop Grumman pay FICA taxes on your pay up to the SSWB, which is updated each year by the Internal Revenue Service (IRS).

Specialist — A physician who, based on education and qualifications, concentrates on a particular specialty of medicine.

Subrogation — The Plan's or the insurance company's right to recoup benefits paid to you when another person or insurance company is legally responsible for your medical or dental expenses. For example, in the case of an automobile accident, a no-fault automobile insurance policy may pay your medical expenses.

Summary plan description (SPD) — A written statement required by ERISA that describes a plan in easy-to-read language. It includes a statement of eligibility, coverage, employee rights and claims and appeal procedures. This guide is the summary plan description for your Northrop Grumman Health Plan.

Term insurance — A type of life insurance that pays benefits in a lump sum only if you or enrolled dependents die while you are a Northrop Grumman employee and, in the case of optional life insurance, so long as you pay the premiums. Term insurance policies do not build up a cash value.

Whole life insurance — An insurance policy that builds up a cash value as premium payments accrue.

Workers' compensation — Medical and disability insurance benefits for an injury, illness, or disease that arises out of and in the course of your employment. Employers such as Northrop Grumman finance workers' compensation insurance, and it is a required benefit in most states.

Working spouse rule — A Northrop Grumman rule that requires your spouse (or domestic partner) to enroll in his or her employer's health care plan if the employer pays 50% or more of the cost of health care coverage. The rule applies even if your spouse's employer offers only one option, such as a health maintenance organization.

Work/Life Program — Part of the EAP, which includes Work/Life services, through 24/7 confidential counseling and referral services

**Northrop Grumman Health Plan
Premium Plan – Sunnyvale Represented**

(Eligible Sunnyvale Represented Employees)

January 2017

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Premium Plan – Sunnyvale Represented

This section of the Northrop Grumman Health Plan Summary Plan Description (SPD) describes features of the Sunnyvale Represented Premium plan option. This section is considered part of the SPD and must be read together with the “main” portion of the SPD, which contains the plan rules regarding eligibility, participation, costs, administration, and other important information regarding the plan that applies to the benefits described in this Sunnyvale Represented Premium plan benefit description section.

OVERVIEW OF THE SUNNYVALE REPRESENTED PREMIUM PLAN COVERAGE

The Sunnyvale Represented Premium plan is considered a consumer-driven health plan that puts you in charge of the money you spend for health care services. You have flexibility and control in choosing the health care services you and your family members receive — and in determining how the costs of those services are paid.

Medical and prescription drug coverage are combined in the Sunnyvale Represented Premium plan. However, Anthem administers the medical benefits under the plans and CVS/caremark administers the prescription drug benefit.

Here are the components of the Sunnyvale Represented Premium plan:

- **Health Reimbursement Account (HRA)**

Each plan year, Northrop Grumman credits a specified dollar amount in a Health Reimbursement Account (HRA) for you and your covered dependents. The funds credited in your HRA are used to pay for covered medical and prescription drug expenses, and help you meet all or part of your deductible. HRA funds are used first and automatically — you do not need to do anything for the HRA funds to be utilized. As long as there is enough money in your account, you pay nothing for covered services or prescription drugs. You can also use your HRA funds to pay for HRA Extras, also referred to as Qualified Health Expenses (QHE).

- **Deductible**

The deductible is the amount you pay for health care services before the plan begins to pay. The deductible can be met by a claim or claims for one family member or by any combination of claims from covered members of your family. HRA funds are used to help pay the deductible. If the deductible is greater than the HRA balance, the remaining deductible is your responsibility. Payments you make toward the deductible are included in your total out-of-pocket maximum. You do not have to meet the deductible before the plan begins paying for your preventive care or prescription drug expenses

- **Coinsurance**

Coinsurance is the percentage of the covered charges you pay for your medical and pharmacy services after you meet the deductible. When healthcare expenses exceed the annual deductible, the plan generally pays 80% (you pay 20%) of the in-network covered service and 50% if out-of-network, for the remainder of the plan

year. Because the deductible is waived for prescriptions, you will only be responsible for the coinsurance portion of the drug expense.

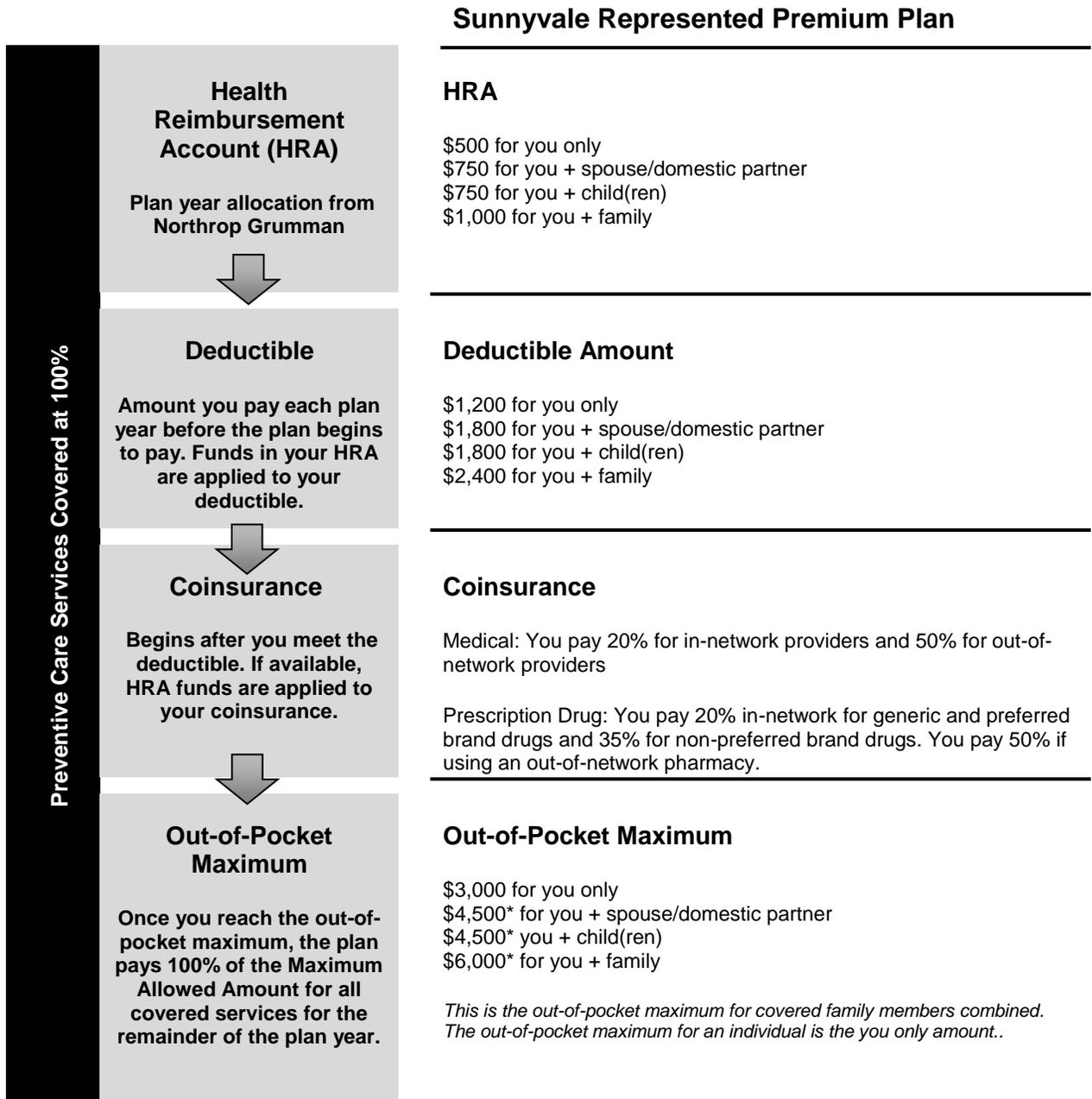
■ **Out-of-Pocket Maximum**

The out-of-pocket maximum is the most you pay in deductibles and coinsurance. After you reach your out-of-pocket maximum, the plan pays 100% of your eligible expenses for the remainder of the plan year. Any specific benefit maximums may also apply.

■ **Preventive Care Benefit**

Getting regular check-ups and exams can help you stay well. The Sunnyvale Represented Premium plan covers preventive care at 100%. The deductible and/or coinsurance do not apply to preventive care services, and the cost of the services is not deducted from the HRA.

The following graphic provides an overview of the Sunnyvale Represented Premium plan. For details, refer to the section called “How the Sunnyvale Represented Premium Plan Works.”



HOW THE SUNNYVALE REPRESENTED PREMIUM PLAN WORKS

Health Reimbursement Account (HRA)

Each year, Northrop Grumman credits a specified dollar amount to a Health Reimbursement Account (HRA) for you and your covered dependents. The amounts for each plan year are as follows:

Coverage Level	HRA Amount
You only	\$500
You + spouse/domestic partner	\$750
You + child(ren)	\$750
You + family	\$1,000

The HRA amounts may be prorated if you participate in the Premium plan for less than a full plan year, depending on when your participation begins. Any unused amounts credited in your HRA after the end of the plan year can be rolled over and used in the next plan year, as long as you continue to participate in the Premium plan.

The funds credited in your HRA (including any amounts that have been rolled over from a prior plan period) are used to pay for covered medical and prescription drug expenses, and help meet all or part of your deductible. HRA funds are used first and automatically — you do not need to do anything for the HRA funds to be utilized. As long as there is enough money credited in your account, you pay nothing for covered services or prescription drugs — no deductible or coinsurance. Covered services include routine medical services (such as physician office visits and lab tests) and pharmacy services.

You can also use your HRA funds to pay for HRA Extras (Qualified Health Expenses) — special services not typically covered by a traditional health plan, such as a smoking cessation program or a prescribed weight loss program. Refer to the list under “HRA Extras (Qualified Health Expenses)” for those expenses eligible to be paid under the Northrop Grumman Health Plan

In addition, you can use your HRA to cover other Premium plan costs, such as any covered services above the Maximum Allowed Amount. Any HRA amounts used to cover expenses above the Maximum Allowed Amount or for services beyond the benefit maximums or HRA Extras (Qualified Health Expenses) will not count toward meeting your deductible or out-of-pocket maximum. Maximum Allowed Amount is the maximum amount allowed by Anthem for a service. See “Maximum Allowed Amount Charges for Out-of-Network Providers” section for more information.

If you experience a qualified life event during the plan year that results in a decrease in coverage level (e.g., going from family to you-only coverage), your HRA allocation will not change until the beginning of the next plan year. If the qualified life event results in an increase in coverage level (e.g., from you only to family coverage), Northrop Grumman will credit an additional HRA allocation equal to the difference between the prorated amounts for the coverage level you are moving from to the coverage level you are moving to. If your participation in the Premium plan ends or any reason during the plan year, any unused balance credited in your HRA will be forfeited.

HRA Extras (Qualified Health Expenses)

In addition to using your HRA balance to pay for eligible medical expenses as defined by the Premium plan, you can use your HRA to cover the cost of certain qualified medical care expenses — called HRA Extras or Qualified Health Expenses (QHE). These services are not usually covered by traditional health plans. You decide how and when you spend your HRA dollars for HRA Extras (Qualified Health Expenses).

Below is a list of HRA Extras (Qualified Health Expenses) covered by your HRA:

- Acupuncture
- ADD/ADHD tools, software and equipment
- Autoette*
- Braille books and equipment
- Cancer treatment ancillary products*
- Chiropractor Cognitive Brain Therapies*
- Construction for installation of necessary medical equipment*
- Experimental treatments*
- Family planning counseling
- Fertility Enhancement
- Genetic testing*
- Guide dogs*
- Lodging while receiving medical treatment*
- Massage therapy provided by a physician*
- Orthotics/Arches*
- Personal Care Attendants when provided by a nurse or Certified Nurse Assistant*
- Reversal of sterilization procedures
- Smoking cessation programs
- Smoking deterrents*
- Special equipment in car for person with disability*
- Special equipment for hearing impaired*
- Training for the hearing impaired*
- Transgender Hormonal Therapy*
- Weight loss programs*

HRA Extras marked with an * require that your doctor complete your Qualified Health Expense claim form to verify that the expense meets the criteria defined under Section 213 of the Internal Revenue Code (see the note below). For the rest of the services, you file your own claim form without your doctor's verification. You can get a Qualified Health

Expense claim form by calling Anthem Member Services at 1-800-894-1374 or through the Anthem member website (accessible from the *Provider* icon at *Benefits & You OnLine*). From the Anthem site, go to My Benefits, and then Forms Library.

Note: *Qualified medical expenses are defined under section 213 and Publication 502 of the Internal Revenue Code as amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. The medical care expenses must be primarily to alleviate or prevent a physical or mental defect or illness. IRS Publication 502 provides additional guidance regarding qualified medical expenses. Northrop Grumman has identified some of these expenses as eligible HRA Extras (Qualified Health Expenses) that may be covered by your HRA.*

Deductible

You must meet the deductible for your coverage level before the plan begins paying your medical expenses. If you use all of your HRA, you are responsible for the remaining balance of your deductible. You pay the deductible as you incur additional medical expenses before the plan begins to pay for your medical services.

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 of the covered family members or claims from more than one family member can be combined to meet the deductible.

The deductible does not apply to prescription drug expenses or preventive care services.

In-network and out-of-network expenses count toward your deductible; however, if you use an out-of-network provider, any charges in excess of Maximum Allowed Amounts, which is the maximum amount of reimbursement payable for a specific service (see “Maximum Allowed Amount for Out-of-Network Providers” section), will not be counted toward meeting the amount.

Keep in mind that some medical costs you incur may not count toward your deductible such as:

- Any service that is not a covered service under the Premium plan
- Ineligible expenses such as cosmetic surgery or experimental procedures
- HRA Extras (Qualified Health Expenses) paid from your current year HRA
- Out-of-network provider expenses that are in excess of Maximum Allowed Amount charges
- 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
- Ineligible prescription drug charges including costs you incur for not complying with CVS/caremark’s prescription drug policies (See “Prescription Drug Coverage” for details).

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Any HRA balance rolled over from previous years can be used to cover your deductible and reduce your out-of-pocket costs.

The medical deductible amounts for each plan year are as follows:

Coverage Level	Deductible
You only	\$1,200
You + spouse/domestic partner	\$1,800
You + child(ren)	\$1,800
You + family	\$2,400

The deductible amounts may be prorated if you participate in the Sunnyvale Represented Premium plan for less than a full plan year, depending on when your participation begins.

Each plan year, you have a new deductible. Expenses credited to your deductible do not carry over from one plan year to the next.

Coinsurance

When medical expenses exceed the annual deductible, you pay a certain percentage of the cost of covered services through coinsurance. Because the deductible is waived for prescriptions, you will only be responsible for the coinsurance portion of the drug expense. Generally, the Sunnyvale Represented Premium plan pays 80% of the cost of most covered services if you use an in-network provider, and you pay 20%, up to an out-of-pocket maximum for the plan year. If you use an out-of-network provider, the Premium plan pays 50% of the cost of most covered services, up to Anthem's Maximum Allowed Amount or CVS/caremark's contracted 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). The out-of-pocket maximum is the most you pay in deductible and coinsurance expenses for covered services in a plan year. After you reach the out-of-pocket maximum, the Premium plan pays 100% of your eligible expenses for the remainder of the plan year, except for claim amounts that exceed the Maximum Allowed Amount or contracted amount. Claim amounts in excess of Maximum Allowed Amounts or contracted amounts do not count toward the out-of-pocket maximum.

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. Once you reach the out-of-pocket maximum under the

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Sunnyvale Represented Premium plan, the plan pays 100% of covered services for in-network providers and 100% of Maximum Allowed Amount charges for out-of-network providers.

The out-of-pocket maximums for each plan year are as follows:

Coverage Level	Out-of-Pocket Maximum
You only	\$3,000
You + spouse/domestic partner	\$4,500*
You + child(ren)	\$4,500*
You + family	\$6,000*

**This is the out-of-pocket maximum for all covered family members. The out-of-pocket maximum for an individual is the You only amount..*

Your out-of-pocket maximum is satisfied by the amounts paid toward the deductible, coinsurance or copayments, including eligible amounts paid with the HRA. Because you can use part of your HRA to pay for HRA Extras, your actual out-of-pocket maximum amount can vary from year-to-year. Please keep in mind that the more you use your HRA on covered services (instead of HRA Extras), the less you will have to pay out of your own pocket toward your out-of-pocket maximum.

Keep in mind that 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 Premium plan
- Ineligible expenses such as cosmetic surgery of experimental procedures
- Out-of-network expenses that are in excess of Maximum Allowed Amounts charges
- Charges that exceed the benefit maximums for services such as acupuncture and acupressure, chiropractic care and private duty nurses
- Any preauthorization penalties you incur (See “Preauthorization” for details)
- Ineligible prescription drug charges including costs you incur for not complying with CVS/caremark’s prescription drug policies (See “Prescription Drug Coverage” for details.)

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.

Example of How the Sunnyvale Represented Plan Works

Let's assume that this is your first year in the Premium plan option, and you have you + spouse coverage. Your deductible is \$1,800 and you receive an HRA allocation of \$750. Here are examples of how the plan will cover expenses.

	Plan/HRA pays	You pay
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You visit the doctor and incur \$100 in covered expenses.

The HRA is used to pay your \$100 doctor visit	\$100 (HRA) This amount is applied toward the deductible.	\$0
--	--	-----

Next, you purchase a prescription drug at an in-network pharmacy for \$100

No deductible applies to prescription drug expenses so you only are responsible for the 20% coinsurance or \$20. The HRA can be used to pay the \$20.	\$20 (HRA) \$80 (Plan)	\$0
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Next, your spouse has outpatient surgery, and the in-network covered expenses are \$8,000.

The remaining \$630 (\$750 - \$100 - \$20) HRA balance is used. This leaves \$7,370 in unpaid expenses from the outpatient surgery.	\$630 (HRA) This amount is applied toward the deductible.	Not applicable
Of the \$7,370, you pay \$1,070 to satisfy the remaining deductible (\$1,800 - \$100 - \$630).	Not applicable	\$1,070
Now that you have met the deductible, the plan will cover the remaining \$6,300 at 80%. The plan pays 80% of \$6,300 (or \$5,040) and you pay the remaining 20% or \$1,260	\$5,040	\$1,260
Total	\$5,800	\$2,330

In this example, your total out-of-pocket expense is the \$1,070 paid toward the deductible plus 20% of \$6,300 (\$1,260), for a total of \$2,330

In-Network or Out-of-Network

If you are enrolled in the Premium plan, you have a choice to make each time you need medical care — you may choose to see a provider in the Anthem BlueCard network (also known as the PPO network in some areas) or a provider outside the network. However, when you use 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 doctor will file your claims for you. Here is a comparison of some of the key differences between receiving care from in-network and out-of-network providers in the Premium plan.

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In-Network	Out-of-network
You must use a provider in the Anthem BlueCard or PPO network	You can go to any licensed provider outside the Anthem BlueCard or PPO network
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

Under the Sunnyvale Represented Premium plan, you do **not** need to choose and coordinate your care through a primary care provider (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.**
- Do not assume that just because a provider holds itself out as an Anthem network provider that the provider is in the network applicable to the Sunnyvale Represented Premium plan. To confirm the network status of the provider, log on to the Anthem member services website at www.anthem.com/ca and use the *Find a Doctor* tool or call Anthem at 1-800-894-1374.
- If you are unable to locate an in-network provider, please contact Anthem 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.

BlueCard Worldwide

When you travel outside of the U.S., you can get help finding doctors and hospitals in nearly 200 countries and territories around the world through Anthem’s BlueCard Worldwide Program. Call the BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide Service Center, you will need to pay the provider directly and submit an international claim form with original bills to the Service Center. Claim forms are available online at www.bluecardworldwide.com or by calling Anthem Member Services.
- 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.

Maximum Allowed Amount Charges for Out-of-Network Care

The Maximum Allowed Amount, as determined by the claims administrator (Anthem), is the maximum amount of reimbursement the claims administrator determines is payable for a specific service or supply that is covered under the Sunnyvale Represented Premium plan. The Premium plan provides coverage based on Maximum Allowed Amounts.

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 healthcare 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 Anthem Member Services 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 Anthem: hospital admissions and inpatient surgery, skilled nursing facility care, private duty nursing care, and home health care. 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:

1. 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
2. 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
 3. 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
 4. An amount negotiated by the claims administrator or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or
 5. 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.

For example, 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 over Maximum Allowed Amount ($\$400 - \100).

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

Your coinsurance is 50% of the Maximum Allowed Amount charge ($50\% \times \$100 = \50). Plus, you pay the difference between the billed amount and the Maximum Allowed Amount charge ($\$400 - \$100 = \$300$). In this example, you pay \$350 ($\$50 + \$300 = \350).

The amount you pay over the Maximum Allowed Amount charge is not credited to your plan year deductible or out-of-pocket maximum.

Anthem Member Services at 1-800-894-1374 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.

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 circumstance, 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 Anthem Member Services for authorized services information or to request authorization.

INTEGRATED HEALTH MANAGEMENT

The Sunnyvale Represented Premium plan offers a comprehensive suite of health and wellness programs that help employees and their covered family members better understand their health care benefits, navigate the health care system when they need it, understand treatment options and choices, reduce their costs and enhance the quality of life.

Each of the programs in Anthem's Integrated Health Management (IHM) is tailored to meet different health care needs, from those that want to stay well when they are healthy, to those that are at risk for an illness, to those who are at chronic or acute states of illness. IHM offers a wide range of assistance such as preauthorization, coaching, support, advice and medical guidance, as well as early identification of risk and outreach from registered nurses. IHM includes:

- Preauthorization
- MyHealth Coach
- Condition Care and Complex Care
- Case Management
- Neonatal Intensive Care Unit Management
- Organ Transplant Care
- FutureMoms
- 24/7 NurseLine
- Behavioral Health.

The following pages contain brief descriptions of IHM programs. For additional information or questions regarding any of these programs, please call Anthem at 1-800-894-1374.

Preauthorization

In the Sunnyvale Represented Premium plan, some procedures require preauthorization and may be subject to penalties or nonpayment if they are not preauthorized. 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 maternity, as described under “Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act”). Maternity 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.

If the services are not preauthorized, you may be responsible for paying a \$500 non-compliance penalty in addition to your normal coinsurance and deductible. (\$500 penalty does not apply to Hospice Care or Air Ambulance Services.)

While preauthorization is not required for outpatient procedures or medical imaging, such as CT scans or PET scans, you should be aware that these and other tests are not covered in all circumstances even if ordered by your physician. If a test is considered to be experimental, not medically necessary, or not effective, it will not be covered, and you will be responsible for the full cost. You should also be aware that the cost of these procedures varies by provider, and that Anthem offers a High Tech imaging service preauthorization process that can help you find cost-effective, quality service. Call Anthem for more information about this referral program.

Anthem manages the preauthorization process for the Premium plan option. In most cases, your provider will contact Anthem for preauthorization. Ultimately, however, preauthorization is your responsibility — not the doctor’s or hospital’s responsibility.

Anthem will review your treatment and work with your doctors to determine the appropriateness of your treatment and length of your stay in the hospital, if applicable.

Anthem will also work with you and your doctor to help you obtain the right follow-up care and services.

Anthem's medical management recommendations are neither health care nor medical services and are neither treatment advice nor treatment recommendations.

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

For more information about preauthorization call Anthem at 1-800-894-1374.

MyHealth Coach

MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern. Plan participants can turn to their MyHealth Coach to:

- Manage their health, from coaching on weight loss to education about the side effects of chemotherapy
- Learn how to set and achieve healthy lifestyle goals with a personalized health plan
- Talk about how their health plan works so they can get the most out of it
- Get help coordinating health care benefits before, during and after a hospital stay
- Find the right coaching program for their situation.

You and covered family members are eligible if you have a health condition that requires ongoing attention. Health conditions may include, but are not limited to, diabetes, asthma, depression, high blood pressure, heart disease, and pregnancy. Call a Health Coach to receive a confidential consultation and learn about the program.

Condition Care

Northrop Grumman Health Plan participants enrolled in the Premium plan have access to the Condition Care program through Anthem. This program is offered free of cost, and participation is completely voluntary — you and your covered family members participate only when and if you are interested in the services offered.

The Condition Care program:

- Uses a collaborative and holistic approach to help you better manage diabetes, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and asthma
- An Anthem nurse works with you to promote self-management of your condition
- Supports physician's plan of care
- Helps control health care costs
- Increases adherence to healthy lifestyle strategies & evidence based guidelines for care
- Enables overall health improvement
- Encourages preventive screenings and immunizations, such as flu vaccine
- Identifies depression and advises on access to appropriate behavioral health resources.

Anthem medical professionals routinely review medical and prescription drug claims in order to identify individuals who may benefit from the special health programs provided for Premium plan participants. Those eligible may be contacted by phone to review the health education services offered for their condition. These health programs are tailored to meet an individual's specific needs and personal objectives. The outreach activities for this program include phone calls and/or direct mail to affected participants. The Anthem representatives who contact eligible participants by phone will describe the health services available, answer any questions, and can also complete the enrollment process. The program is completely confidential and medical information is not shared with Northrop Grumman or with anyone else.

Employees who choose to participate will have access to education materials, telephone education sessions, and other support to help participants better understand and manage a health condition.

Complex Care

If you are not enrolled in another care program or you have more than one medical condition, you may be identified to participate in the Complex Care program. Complex Care provides enhanced management for acute and complex health situations based on your high risk medical condition.

With Complex Care:

- An Anthem nurse works with you to create an individualized care plan
- The program focuses on four areas: Utilization Management for when you are in hospital, medication/ treatment when you are at home, care coordination with your physicians and access to various health resources
- The nurse coordinates your needs by working closely with your physician.

These programs are voluntary, eligible participants can start or stop participating in these programs at any time. For more information, contact Anthem at 1-800-894-1374.

Case Management

Case management is an additional resource that helps coordinate and ensure the quality of health care. It is designed to help if you or an enrolled family member needs complex medical care for an extended period of time. The program consists of nurses and physicians representing all clinical specialties, who work with you and your physician to meet your long-term medical needs.

If you participate in the Premium plan, you — and your covered family members — have access to the case management program through Anthem. Case management is offered to you free of cost, and is mandatory when case management is necessary based on a medical condition. Although participation is voluntary in other situations, you are encouraged to take advantage of the program to ensure benefits coverage for situations involving complex medical treatment.

If you are referred to the case management program — depending on the severity of the diagnosis or expected length of hospital stay — a case management team will be assigned to you by Anthem. The team will include your case manager — a registered nurse who has at least three years of clinical experience related to your condition — and other experienced nurses and physicians representing the appropriate clinical specialties. They will work with you and your doctors to:

- Review your medical needs to ensure that your treatment plan incorporates the best practices available and that you have the resources you need to comply with your treatment plan
- Coordinate all your health care and ensure consistent quality care
- Help you navigate the health care system and make sure you obtain the highest level of coverage possible.

Your case management team also explores treatment alternatives that may be available to you. Sometimes, these alternatives include treatment that is typically considered ineligible for reimbursement. Anthem reviews these situations on a case-by-case basis and may approve payment.

The final decision on all medical care always remains with you, your family and your physician. If you or your physician does not agree with Anthem, you may continue your original course of treatment (or any other medical treatment you choose). However, in these cases, your medical plan option may limit payment of your expenses and, as a result, you may pay more.

For more information about case management, call Anthem at 1-800-894-1374.

Neonatal Intensive Care Unit (NICU) Management

This program provides support to high risk infants and their families. Nurses with neonatal and/or pediatric nursing experience promote the highest standards of care for

Neonatal Intensive Care Unit (NICU) infants and work with you and your family throughout the NICU stay to help you prepare for a smooth transition home.

The NICU program includes:

- Registered nurses experienced in neonatal care
- Assistance with getting the appropriate level of care in the hospital
- Discharge planning and follow-up
- Coordination of home health needs

If you have a complicated delivery and your baby is in NICU, the hospital will contact Anthem, and a NICU nurse will reach out to you. Additionally, if you are identified as having a high risk pregnancy through the FutureMom's program, you may be identified to be contacted by a NICU nurse

Organ Transplant Care

If you need an Organ transplant, Anthem'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 Sunnyvale Represented Premium plan offers two benefit levels for organ transplant services and follow-up care. Services provided by an in-network facility are covered at 80% coinsurance 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 Anthem, your transplant-related benefits will be paid at 100% with no deductible for a period of up to 12 months following the transplant. Transplant related

care rendered after 12 months will be reimbursed at 80% as appropriate, 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.

Travel Benefits when you use a Blue Distinction Center for Transplant

If the BDCT facility is over 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 hotel accommodations for you and one companion will be reimbursed at 100%, subject to coordination and approval by Anthem.

The following methods of transportation are acceptable for reimbursement:

- Bus, taxi, 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 will be paid at 100% with no deductible for up to 12 months following the transplant, subject to the following maximums:

- 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 Blue Cross including the legacy PPO, EPO and CDHP.

Changing plan options or suspending and re-enrolling in benefits will not restore the benefit.

FutureMoms

FutureMoms is a maternity program designed to help you have a healthy pregnancy and a healthy baby. When you register for this voluntary program, you will receive:

- Your own health coach. This is a registered nurse with expertise in prenatal/postnatal care who will follow your pregnancy and give you individualized attention and support.
- Toll-free access to a registered nurse line, 24/7, in case you have questions or concerns.
- Phone calls or mailers based on your pregnancy status, risk status, medical history and doctor's plan of care.
- Educational materials like a prenatal book that follows your pregnancy week by week. Also, materials to help you handle the unexpected.
- Lifestyle management, pharmacy, nutrition and behavioral health counseling.
- Postpartum support and guidance in areas like breastfeeding and depression.

24/7 NurseLine

The 24/7 NurseLine is staffed 24 hours a day seven days a week by registered nurses. Nurses provide you and your family members with health care education and decision support for routine health conditions.

- 24/7 nurses can help you choose the most appropriate use of health care resources, apply self-care, learn about specific medical conditions, treatment options, side effects associated with prescription drugs, and provide valuable lifestyle management and nutrition information.
- You can also call to access the audio library, an automated health library with information on over 300 medical topics.

To contact the NurseLine directly, call 1-866-800-8780.

Behavioral Health Resources

Anthem offers behavioral health resources which provide individualized support to employees and their covered dependents through 24/7 accessibility, proactive outreach and condition management. These programs include:

- Resource Center for 24/7 access to qualified staff including Master's level clinicians with experience in managing crises, providing guidance and finding treatment

programs, referrals, tools and resources. Referrals to Northrop Grumman's Employee Assistance Program as appropriate.

- Behavioral Health Care Management, for members with significant challenges related to combined mental health and physical health conditions
- Condition Care for Depression: provides support & resources for those who suffer from the most common depressive disorders
- Northrop Grumman designated clinical case managers work closely together for cases that involve both medical and behavioral health.

To contact the Behavioral Health Resource Center directly, call 1-866-621-0554.

HEALTH RESOURCES AND TOOLS

Whether you are going for a routine checkup, managing a medical condition, or getting ready for surgery, online tools and health resources can deliver the information and support you need around these topics and more.

Health Services and Cost Comparison Tool

Northrop Grumman has partnered with Castlight to bring you a health services and cost comparison cost tool which can help you make informed health care decisions. Use the tool to:

- Compare nearby doctors, medical facilities, and medical services based on the quality of care and the price you will pay
- See personalized cost estimates based your location and your medical plan
- Access patient reviews and ratings of doctors and facilities
- Search for your prescription medications and pharmacies near you.

Go to the “Tools and Resources” tab on *Benefits & You OnLine* to access the health services and cost comparison tool. You may also log on to the Anthem member website at www.anthem.com/ca (accessible through the *Providers* icon on *Benefits & You OnLine*) and select “Know Your Cost”. You will be redirected to Castlight’s website.

Find A Doctor

Anthem’s *Find A Doctor* will help you locate, and find information about, doctors and other health care services in your area. Whether you need a specialist, a pharmacy, a hospital, vision care, a chiropractor, or a nutritionist, you will find it in one place. In addition, this directory will help you:

- Find out which doctors are in the Anthem BlueCard or PPO network
- Get background information about physicians (including board certification and years in practice)
- Obtain valuable feedback from other patients about the quality of service they received
- Research customer service ratings, when available, that cover such things as ease of scheduling appointments, Internet readiness, and overall customer satisfaction.

To access *Find a Doctor*, log in to the Anthem member website at www.anthem.com/ca. By entering your user name and password, you will be able to access the secure site and search for providers and find other pertinent information. Under Useful Tools, click on Find a Doctor and choose what kind of doctor or health professional you want to find.

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.

- **LiveHealth Online:** Visit a doctor without leaving your home. LiveHealth Online is a convenient telehealth format that uses two-way video chat to connect you with U.S. board certified doctors over the Internet. LiveHealth Online offers on-line access to doctors 24 hours a day, 365 days a year and you don't have to make an appointment or wait at the doctor's office. Doctors can answer your questions, make a diagnosis, and prescribe basic medications, if you need them. Please remember that Northrop Grumman security procedures do not permit taking of video or photographs at company facilities so this on-line video service may not be used inside a company facility at this time, irrespective of whether you are using a personal device. LiveHealth Online may not be available in all states.
- **Urgent Care Centers.** Staffed with family, pediatric, ER 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 have an appointment.

To find urgent care in your area, log in to the Anthem member website at www.anthem.com/ca (accessible through the *Providers* icon on *Benefits & You OnLine*) and select Find Urgent Care. You may also link to LiveHealth Online after logging in to your Anthem account.

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

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you healthier. Anthem reviews your health claims to make sure your health care is on track and sees if they can save you money. Anthem checks what drugs you are taking and alerts your doctor if they spot a potential drug interaction. They also keep track of your routine tests and checkups, reminding you to make these appointments by mailing you a MyHealth Note. MyHealth Notes also summarize your recent claims.

Imaging and Sleep Management Programs

When you need imaging services like MRIs and CT scans or a sleep study, Anthem can help you get quality service at a lower cost.

- **Imaging services:** If your doctor refers you to an imaging provider, Anthem will review the referral. If there are more cost-effective quality choices, Anthem will let

you know. You can go with your doctor's referral or with one of the imaging providers suggested by Anthem.

- **Sleep studies:** If your doctor refers you for a sleep study or any sleep-related equipment or supplies, your doctor should call Anthem before you have any tests done or supplies sent to you. Depending on your health, you may be able to do the study in your home. Anthem will discuss the guidelines with your doctor and provide instructions on where to get materials and supplies to do your sleep study at home.

MEDICAL NECESSITY

The Premium 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 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.)
- Not educational, vocational, experimental, or investigational in nature as determined by Anthem
- 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.

Adult physicals, newborn baby care, and childhood immunizations received from a network provider are considered medically necessary. Maternity 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").

Northrop Grumman Health Plan SPD
Premium Plan – Sunnyvale Represented
January 2017

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 Expenses”
- Are provided to treat a diagnosed sickness or an injury (including a congenital defect or birth abnormality).

COVERED MEDICAL SERVICES

Services for which the Sunnyvale Represented Premium plan 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. Most services received from in-network providers will be covered at 80% of negotiated 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 under the Sunnyvale Represented Premium plan.

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 and the services are for the following:

- Chronic pain associated with the following conditions: arthritis, menstrual pain and irregularity, back pain, migraine, lumbago, pinched nerve, sciatica, post laminectomy, slipped disc, rheumatism, bell's palsy, spastic colon, bursitis, stroke, dysmenorrhea, tennis elbow, headaches, tendonitis, herpes zoster, and trigeminal neuralgia
- In lieu of traditional anesthesia
- Nausea related to chemotherapy or pregnancy.

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 Anthem 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.

Anesthesia

Coverage is provided for the administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, and provided the anesthesia is administered and charged for by a physician other than the operating surgeon or his assistant.

Anesthesia benefits will be reimbursed at 80% for in-network providers or 80% of the Maximum Allowed Amount for out-of-network providers.

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
- Protheses 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 at a frequency of three times per week for approximately 12 weeks.

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 paid through the HRA, 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, provided care commences within 12 months of the accident. 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 Premium plan when administered in an approved inpatient or outpatient setting. In order for coverage to be considered, an EOB from the dental plan must accompany any Anthem claims submissions.

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 which 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 cancelled.

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 (PKU) 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.

If the emergency room visit results in a hospital admission, you should notify Anthem within 72 hours of the admission.

Emergency room care as described above will be reimbursed at 80% for in-network and out-of-network providers.

Emergency room care for non-emergencies will be reimbursed at 50% for in-network and out-of-network providers. Care for non-emergencies is defined as care received in an emergency room for a service or condition that does **not** meet the prudent layperson's assessment of emergency (see description above).

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% for emergent care and for non-emergent care. Preventive care is reimbursed at 100% of charges.

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

Hearing

Coverage includes annual hearing exams, hearing aid repair, and up to two new hearing aids per participant per plan year. Contact Anthem for help locating a Durable Medical Equipment (DME) provider. Hearing aid batteries are not covered.

Home Health Care

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 4 hours. Preauthorization is required or you will be charged a \$500 penalty for failure to obtain preauthorization.

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. Charges incurred during periods of remission are not eligible under the provision of the plan.

Hospice care for you and your eligible dependents is covered for up to six months. Preauthorization is required for Hospice care services. A Personal Health Coach is 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% of contracted fees or 50% of Maximum Allowed Amount charges for out-of-network providers. 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 plan if treatments that foster natural conception are not successful. The plan covers:

- 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 EPO, PPO or CDHP plans. Changing plan options or suspending and re-enrolling in coverage will not restore the benefit.

Inpatient Medical Facility

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

- Inpatient room and board
- Inpatient ancillary services.

Preauthorization is required or you will be charged a \$500 penalty for failure to obtain preauthorization.

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
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy
- On-site 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 or you will be charged a \$500 penalty for failure to obtain preauthorization.

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

Maternity Care

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

If you become pregnant, you are invited to enroll in the Future Moms maternity program provided by Anthem. The program has important information to help you have a healthy pregnancy. Depending on your needs, a nurse will follow you throughout your pregnancy to provide support and help you carry out your doctor's instructions.

Also covered are services rendered in a birthing facility, provided that the physician in charge is acting within the scope of his 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 mother's benefit.

Expenses related to the newborn child are not covered unless the child is added as a dependent under the Plan within 30 days of the birth.

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 Premium plan.

Examples of medical supplies include:

- Diabetic supplies (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 Sunnyvale Represented Premium plan option includes mental health and substance abuse benefits as described in this section. The Premium plan will cover services from in-network providers at 80%; services from out-of-network providers will be covered at 50% of Maximum Allowed Amount charges.

Eligible Mental Health and Substance Abuse Expenses

The Sunnyvale Represented Premium plan pays 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:

- Charges for medically necessary licensed local ambulance service to or from the nearest hospital or approved qualified mental health and/or substance abuse treatment facility where the needed mental health treatment or evaluation can be provided, as authorized by Anthem
- Medically necessary outpatient charges at a hospital or approved qualified mental health and/or substance abuse treatment facility
- Family counseling including family therapy with family members to assist in the covered person's diagnosis and treatment
- The services of qualified mental health and/or substance abuse treatment providers, as determined by Anthem, who provide services within the lawful scope of the practice of:
 - Licensed psychiatrists
 - Licensed or registered psychologists
 - Licensed or registered psychotherapists
 - Licensed or registered psychiatric social workers.
- Semiprivate room and board charges, and medically necessary inpatient services and supplies at a hospital or qualified mental health and/or substance abuse treatment facility approved by Anthem. Preauthorization is required for these services or you will be charged a \$500 penalty for failure to obtain preauthorization.

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
- 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).

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- 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 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. 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 covered 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
- Psychological testing, 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, bioenergetic 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 (e.g., Autism Spectrum Disorder, mental retardation)
- Treatment or consultations provided by telephone.

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. 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.

Orthognathic Surgery

Orthognathic surgery is covered when medically necessary. Call Anthem 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 which 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 Premium plan is provided through CVS/caremark. See “Prescription Drug Coverage” for details.

Preventive Care

The Premium plan covers preventive services 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 Affordable Care and Patient Protection Act. The preventive benefits include routine office visits, lab services and X-rays, 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 Anthem 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%. Medications that are considered preventive care under the Patient Protection and Affordable Care Act are covered at 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 RN or LPN. 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 days per person per plan year. Preauthorization is required or you will be charged a \$500 penalty for failure to obtain preauthorization.

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 which 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 which 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 and 80% of the Maximum Allowed Amount for an out-of-network provider.

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 or you will be charged a \$500 penalty for failure to obtain preauthorization.

Covered services and supplies include semiprivate 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 Reassignment 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. The benefit payable for the assistant surgeon's services is 20% of the benefit payable for the primary surgeon.

Bilateral Surgical Procedures

Bilateral surgical procedures are defined as more than one procedure associated with a single surgical event. The benefit payable for bilateral procedures is 50% of the eligible benefit for the primary surgical procedure.

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. Co-surgeon services are covered at 50% of the eligible benefit of the surgeon's fee.

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 100% of the eligible surgical allowance for the highest paying procedure plus 50% of the eligible surgical allowance for the second highest paying procedure and 50% of the eligible surgical allowance for each additional procedure. For example, if the benefit normally pays 80%, the primary surgical procedure would be paid at 80%, and the remaining surgical procedures would be paid at 50% applying the 80% benefit.

Gender Reassignment Surgery

Gender reassignment surgery, excluding cosmetic surgery, may be covered, up to a lifetime maximum of \$75,000 per person. The lifetime maximum applies across all Anthem medical plans including any legacy EPO, PPO or CDHP plans. Benefits are subject to Anthem's Clinical Utilization Guidelines and preauthorization requirements. Call Anthem 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 Sunnyvale Represented Premium plan option covers the following expenses:

- Transplant procedures performed at a Blue Distinction Center for Transplant are covered at 100%
- Transplant procedures performed at an in-network provider are covered at 80%.
- Transplant procedures performed at an out-of-network facility are not covered.

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. Coverage is provided only with a diagnosis of morbid obesity, based on National Institutes of Health criteria, which can change periodically. For details, call Anthem Member Services at 1-800-894-1374.

Telemedicine

Services provided by LiveHealth Online (where you can have online video service with a doctor) are covered urgent care. 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. The \$10 copay will not be deducted from your HRA balance.

Temporomandibular Joint Dysfunction (TMJ)

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 Premium plan 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 (maximum combined limit for occupational and physical therapy visits is 60 per person per plan year*)
- **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 (maximum combined limit for occupational and physical therapy visits is 60 per person per plan year*)
- **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 Anthem at the number provided on your ID card for details on medical necessity requirements.

**Maximum applies to treatment and does not include the consultation. All visits for treatment apply to the annual maximum limit regardless if the expense is paid through the HRA, applied to the deductible, or paid by the plan.*

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 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 covered under the Premium plan. However, some of these expenses may be considered Qualified Health Expenses for which you may be able to use your Health Reimbursement Account (HRA) to cover. See “HRA Extras (Qualified Health Expenses)”.

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 transportation or lodging or mileage costs, except as defined for transplant coverage
- Charges for services or supplies that are not medically necessary, as determined by the claims administrator, 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/reconstructive surgery, except as described under “Covered 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 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.)

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- Expenses for vocational, work hardening, or training programs regardless of diagnosis or symptoms or for non-medically necessary education, except as specifically provided in the Premium plan
- 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. 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 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 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
 - Anthem, in its discretion, determines whether services or supplies are experimental.
- Charges for eye refractions, eyeglasses, and contact lenses
- 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 and donor search fees and surrogate mother charges, unless the surrogate mother is eligible under the Premium medical plan option at the time services are rendered
- Expenses for non-human organs, including services and supplies related to non-human organs

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- Charges for massage therapy not rendered by a physician
- The cost of care for the newborn child of an enrolled child, unless the newborn becomes 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
- 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 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
- Expenses for counseling services for the purpose of career or financial reasons
- Fees for private duty nursing while a patient 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 (RK), photo refractive keratectomy (PRK), astigmatic keratectomy (AK), 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 speech therapy to correct pre-speech deficiencies or to improve speech skills not fully developed, such as stuttering unless specified in the SPD
- 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 morbid obesity, as defined by the criteria of the National Institutes of Health
- Marriage counseling except through the employee assistance program (EAP).

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These examples are not intended to be all-inclusive. Charges for other procedures, services or supplies may be excluded if it is determined that they are not medically necessary, reasonable, or covered by the Sunnyvale Represented Premium plan.

Northrop Grumman reserves the right to exclude charges for any other condition, disease, ailment or illness not deemed to be medically necessary, reasonable, or otherwise covered. 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

The Sunnyvale Represented Premium plan option includes prescription drug coverage through CVS/caremark. 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 CVS/caremark's convenient Maintenance Choice® Program.

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/caremark Mail Service Pharmacy or Maintenance Choice® Program). See “How to Purchase Your Prescription Drugs” for details.
- The type of medication (generic, preferred brand, non-preferred brand, preventive or specialty). When available and appropriate, your prescription will automatically be filled with a generic drug. See “Mandatory Generics Program” for details.

The plan deductible does not apply to prescription drug expenses. Because the deductible is waived for prescriptions, you will only be responsible for the coinsurance portion of the drug expense. Prescription drug expenses are applied to your out-of-pocket maximum amount.

Prescription Drug Coverage Features		
	Retail Program (up to 30-day supply)	Maintenance Choice® Program (up to 90-day supply)¹
Refill limit	None	2 refills per prescription
CVS/caremark Pharmacies²		
Generic drugs	20% coinsurance	20% coinsurance, up to a maximum of \$200
Formulary drugs	20% coinsurance	20% coinsurance, up to a maximum of \$200
Nonformulary drugs	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
Specialty drugs	20% coinsurance up to a maximum of \$200 per prescription for a 30 day supply. After one retail fill, specialty drugs must be obtained through CVS/caremark Specialty Pharmacy.	
Non-CVS/caremark Pharmacies		
All prescription drugs	50% coinsurance	N/A

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

²To 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.

³Medications 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, and
- Prescribed in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies.

Preauthorization is required for compound drugs that cost more than \$300.

Visit the CVS/caremark website (www.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. 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 1-855-361-8565. The fact that your physician prescribes, orders, recommends, or approves a prescription or supply does not automatically mean it is an eligible expense under the plan. Always call CVS/caremark to confirm coverage.

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 U.S. Food and Drug Administration (FDA) approval for many ingredients included in compounds, they may not be covered or may require a prior authorization. Prior authorization is required for any compound prescription drug with costs exceeding \$300.00. Please contact CVS/caremark for additional information or with questions.

Want to Know How Much Your Prescription Drug Will Cost?

Use the prescription drug cost comparison tool at the CVS/caremark website, www.caremark.com, which is accessible from the *Providers* icon at *Benefits & You OnLine*, 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.

How to Purchase Your Prescription Drugs

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 Retail Pharmacy Program” for details.
- 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 either the CVS/caremark Maintenance Choice Program, which allows participants to fill a 90-day supply at a CVS/pharmacy location, or mail order through the CVS Mail Service Pharmacy. See “CVS/caremark Maintenance Choice” for details.

CVS/caremark Retail Pharmacy 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 1-855-361-8565 or go to the CVS/caremark website, www.caremark.com, which is accessible from the *Providers* icon at *Benefits & You OnLine*.

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 coinsurance at the pharmacy
5. If you participate in the health care flexible spending account (FSA) through WageWorks, you may pay your expense with your WageWorks Health Card or submit your receipts for reimbursement. (See “Flexible Spending Accounts” of the SPD for details).

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 the appropriate coinsurance and receive up to a 90-day supply of your medication. You will pay 20% coinsurance (or 35% for non-preferred brand medications) up to a maximum of \$200. You may 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. Take your prescription to a CVS/pharmacy location
2. Phone: Call CVS/caremark Customer Care at 1-855-361-8565
3. Mail: Fill out and return a mail service order form. You can download one from the CVS/caremark website, www.caremark.com, or request one from CVS/caremark Customer Care
4. Online: Visit www.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 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 retail pharmacy. Your HRA funds cannot be used for the expense, nor is the expense applied to your deductible or out-of-pocket maximum. If you have a health care flexible spending account (FSA), you may use your benefit card to purchase the drug.

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 U.S. Food

and Drug Administration (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 coinsurance), plus the difference in cost between the generic and the brand-name prescription drug. Any HRA funds you may have may be used to cover this charge. However, the charge will not apply toward your out-of-pocket maximum. If you have an FSA account, you may use your debit card 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.** HRA funds will not be applied to the cost and the amount paid 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 the lower-cost, equivalent front-line alternative, or you can speak to your doctor on your own. (Note: If you have a health care FSA, you may use your FSA funds to cover the cost of your prescription.)

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 or view the CVS/caremark Generic Step Therapy brochure posted to *Benefits & You OnLine*.

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 www.CVSCaremarkSpecialtyRx.com, including disease-specific information and interactive capabilities that allow patients to submit questions to pharmacists and nurses.

You pay 20% coinsurance up to a maximum of \$200 per prescription for a 30 day supply.

Call CVS/caremark at 1-855-361-8565 or access the CVS/caremark website (www.caremark.com), which is accessible from the *Providers* icon at *Benefits & You OnLine*, 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 1-855-361-8565.)

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:

- Your physician lists all of your diabetic supply requirements on one prescription,
- The order includes a diabetes medication, and
- Your order all of the supplies at the same time through the CVS/caremark Maintenance Choice Program.

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 1-855-361-8565.

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Value Plan

OVERVIEW

This section of the Northrop Grumman Health Plan Summary Plan Description (SPD) describes features of the Value plan option. This section is considered part of the SPD and must be read together with the “main” portion of the SPD, which contains the plan rules regarding eligibility, participation, costs, administration, and other important information regarding the plan that applies to the benefits described in this Value plan benefit description section.

Overview of Value Plan Coverage

With the Value plan, you pay the full cost of all covered medical services and prescription drug costs until you meet an annual plan year deductible. Once you meet the deductible for the plan year, the Value plan shares a percentage of the cost of care until you meet an out-of-pocket maximum. Medical and prescription drug coverage are combined in the Value plan. However, Anthem administers the medical benefit and CVS/caremark® administers the prescription drug benefit. The Value plan is an IRS-qualified “high deductible health plan” that may be paired with a Health Savings Account (HSA) to help you offset the cost of eligible medical expenses.

This chart shows the key features of the Value plan option. For more information, refer to the sections below.

	You Only		You + Spouse/Domestic Partner and You + Child(ren)		You + Family	
	In-network	Out-of-Network	In-network	Out-of-Network	In-network	Out-of-Network
% You Pay for Preventive Care	0% No deductible	0%* No deductible	0% No deductible	0% No deductible	0% No deductible	0% No deductible
Your Annual Deductible	\$1,700	\$3,300	\$2,700	\$4,800	\$3,300	\$6,400
Coinsurance – the % you pay after the deductible	20% of contracted rates**	50% of Maximum Allowed Amount	20% of contracted rates**	50% of Maximum Allowed Amount	20% of contracted rates**	50% of Maximum Allowed Amount

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Your Out-of-Pocket Maximum	\$6,000	\$12,000	\$9,000	\$18,000	\$12,000	\$24,000
	After you reach your annual out-of-pocket maximum, the plan pays 100%					

**Out-of-network preventive care is covered at 100% up to the Maximum Allowed Amount.*

***35% for Non-preferred brand prescription drugs*

HOW THE VALUE PLAN WORKS

Deductible

The deductible is the amount of money you pay before the Value plan begins to pay for your eligible medical and pharmacy expenses. This can be met by a claim or claims for one family member, or by any combination of claims from covered members of your family. The same deductible applies to both medical and prescription drug expenses — you don't have to meet separate deductibles for medical and pharmacy expenses.

Funds in an HSA can be used to cover your deductible.

The Value plan has 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.

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 is waived, 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.

The Deductible amounts for each plan year are as follows:

Coverage Level	In-Network	Out-of-Network
You only	\$1,700	\$3,200
You + spouse/domestic partner	\$2,700	\$4,800
You + child(ren)	\$2,700	\$4,800
You + family	\$3,300	\$6,400

Keep in mind that some medical costs you incur may not count toward your deductible such as:

- Any service that is not a covered service under the Value plan
- Ineligible expenses such as cosmetic surgery or experimental procedures

- Out-of-network provider expenses that are in excess of Maximum Allowed Amount charges. Maximum Allowed Amount is the maximum amount allowed by Anthem for a service. (See “Maximum Allowed Amount Charges for Out-of-Network Providers” for more information)
- 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
- Ineligible prescription drug charges including costs you incur for not complying with CVS/caremark’s prescription drug policies (See “Prescription Drug Coverage” for details.)

Each year, you have to meet a new deductible. Expenses credited to your deductible do not carry over from one plan year to the next.

Coinsurance

After you satisfy the deductible, you pay a certain percentage of the cost of covered services through coinsurance. Generally, the Value plan pays 80% of the cost of most covered services if you use an in-network provider, and you pay 20%, up to an out-of-pocket maximum for the plan year. If you use an out-of-network provider, the Value plan pays 50% of the cost of most covered services, up to the Maximum Allowed Amount, and you pay 50%, up to an out-of-pocket maximum (plus any amount in excess of the Maximum Allowed Amount). The out-of-pocket maximum is the most you pay in deductible and coinsurance expenses for covered services in a plan year. After you reach the out-of-pocket maximum, the Value plan pays 100% of your eligible expenses for the remainder of the plan year, except for claim amounts that exceed the Maximum Allowed Amount. Claim amounts in excess of Maximum Allowed Amounts do not count toward the out-of-pocket maximum.

For pharmacy expenses, generally, the Value plan pays 80% of the cost of Generic and Preferred Brand medications and 65% of the cost of Non-Preferred Brand medications, if you use an in-network pharmacy.

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.

In-Network Out-of-Pocket Maximum: 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 20% 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.

Out-of-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 after the out-of-pocket maximum has been met.

The out-of-pocket maximums for each plan year are as follows:

Coverage Level	In-network	Out-of-network
You only	\$6,000	\$12,000
You + spouse/domestic partner	\$9,000*	\$18,000
You + child(ren)	\$9,000*	\$18,000
You + family	\$12,000*	\$24,000

**This is the out-of-pocket maximum for all covered family members. The out-of-pocket maximum for an individual is the You only amount.*

Your out-of-pocket maximum is satisfied by the amounts paid toward the deductible, coinsurance or copayments, including amounts paid with an HSA.

Keep in mind that 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 Value plan
- Ineligible expenses such as cosmetic surgery or experimental procedures
- Out-of-network expenses that are in excess of Maximum Allowed Amounts charges
- Charges that exceed the benefit maximums for services such as acupuncture and acupressure, chiropractic care and private duty nursing
- Any preauthorization penalties you incur (See "Preauthorization" for details)
- Ineligible prescription drug charges including costs you incur for not complying with CVS/caremark's prescription drug policies (See "Prescription Drug Coverage" for details.)

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.

In-Network or Out-of-Network Providers

If you are enrolled in the Value plan, you have a choice to make each time you need medical care — you may choose to see a provider in the Anthem BlueCard network (also known as a PPO network in some areas) or a provider outside the network. However, when you use 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 doctor will file your claims for you.

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

In-Network	Out-of-network
You must use a provider in the Anthem BlueCard or PPO network	You can go to any licensed provider outside the Anthem BlueCard or 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

Under the Value plan, you do **not** need to choose and coordinate your care through a primary care provider (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.**
- Do not assume that just because a provider holds itself out as an Anthem network provider that the provider is in the network applicable to the Value plan. To confirm the network status of the provider, log on to the Anthem member services website at www.anthem.com/ca and use the *Find a Doctor* tool or call Anthem at 1-800-894-1374.
- If you are unable to locate an in-network provider, please contact Anthem 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.

BlueCard Worldwide

When you travel outside of the U.S., you can get help finding doctors and hospitals in nearly 200 countries and territories around the world through Anthem's BlueCard Worldwide Program. Call the BlueCard Worldwide 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 BlueCard Worldwide 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 BlueCard Worldwide Service Center, you will need to pay the provider directly and submit an international claim form with original bills to the Service Center. Claim forms are available online at www.bluecardworldwide.com or by calling Anthem Member Services.
- 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:
 1. For inpatient hospital care, the rate is based on date of admission
 2. For outpatient and professional services, the rate is based on the service date.

Maximum Allowed Amount for Out-of-Network Providers

The Maximum Allowed Amount, as determined by the claims administrator (Anthem), is the maximum amount of reimbursement the claims administrator determines is payable for a specific service or supply that is covered under the Value plan. The Value plan provides coverage based on Maximum Allowed Amounts.

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 this 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 healthcare 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 Anthem Member Services 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 Anthem: hospital admissions and inpatient surgery, skilled nursing facility care, private duty nursing care, and home health care. 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:

1. 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
2. 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
3. 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

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4. An amount negotiated by the claims administrator or a third party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management; or
5. 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.

For example, 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 over Maximum Allowed Amount ($\$400 - \100).

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

Your coinsurance is 50% of the Maximum Allowed Amount charge ($50\% \times \$100 = \50). Plus, you pay the difference between the billed amount and the Maximum Allowed Amount charge ($\$400 - \$100 = \$300$). In this example, you pay \$350 ($\$50 + \$300 = \350).

Amounts you pay over the Maximum Allowed Amount charge are not credited to your plan year deductible or out-of-pocket maximum.

Anthem Member Services at 1-800-894-1374 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.

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 circumstance, 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 Member Services for authorized services information or to request authorization.

Health Savings Account

A Health Savings Account (HSA) is an employee-owned tax-advantaged account used to reimburse eligible health care expenses. The HSA may be funded by your own pre-tax (or post-tax) contributions and contributions from Northrop Grumman, up to a certain annual limit. You own the HSA, and it's designed to help you save and budget for eligible expenses.

If you contribute money to an HSA, you can take advantage of the following:

- You don't pay federal taxes on your payroll deductions to your HSA. Contributions to HSAs may be subject to state income tax in some states.
- You don't pay taxes when you use funds for eligible health care expenses
- You can invest your account balance once you reach a minimum balance of \$1,000, and any earnings on invested funds are tax-free for federal tax purposes. (As with all investments, there may be investment fees depending on your investment decisions. Ask about these or other fees if you decide to invest your account balance.)

- The funds roll over year after year, and the account belongs to you and is portable should you leave the company.

Eligibility

To contribute to an HSA, you need to meet certain criteria (See Internal Revenue Service (IRS) Publication 969 for further details):

- You must be enrolled in an IRS-qualified “high deductible health plan” like the Value 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
- You cannot be claimed as a dependent on someone else’s tax return.

IRS Limits

There also 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 not exceed the IRS calendar year limits. For the 2017 calendar year, the limits are:

- \$3,400 for employee only coverage
- \$6,750 for family coverage (you + spouse/domestic partner, you + children, or you + family).

Participants age 55 and older (as of the end of the calendar year) may contribute an additional \$1,000 per calendar year. Employees are responsible for making sure they don’t exceed the annual IRS limit.

- 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.
- 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 the Value plan and otherwise HSA eligible. However, if you enroll in the Value plan midyear, you can generally contribute up to the annual contribution maximum if you enrolled by December 1. You must stay in the Value 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 end your employment with Northrop Grumman and do not enroll in another HSA eligible plan, the annual contribution maximum is prorated based on the number of months that you were enrolled and otherwise HSA eligible. If you fund your account for the entire year, then leave the plan, you will need to withdraw excess contribution dollars before the end of the tax filing date for the tax year if you have overfunded your account. Otherwise, you may be required to pay penalties. You will also have to include the excess amounts in your income. See IRS Publication 969 or consult 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®. However, you own the HSA and must establish your account on your own. If you set up an HSA with Fidelity, Northrop Grumman will be able to facilitate pre-tax payroll deductions to your HSA. You are free to set up an HSA at another institution, but if you do so, Northrop Grumman will be unable to allow you to make pre-tax payroll contributions to your HSA.

After enrolling in the Value Plan, you will be asked to set up your HSA with Fidelity on *Fidelity NetBenefits*® at www.netbenefits.com/northropgrumman.

Because the HSA is your account, you can stop or change your elections at any time through *NetBenefits*® at www.netbenefits.com/northropgrumman or by calling the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

Please be aware that neither Northrop Grumman nor Fidelity will monitor your contributions and if you exceed the limits. Please review your contribution amounts closely to ensure you have not exceeded the IRS limits.

Limited Purpose FSA for Value Plan Participants with an HSA

If you enroll in the Value plan and elect to establish an HSA through Fidelity, and you enroll in (or are automatically re-enrolled in) the Health Care Flexible Spending Account (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 HRA during the plan year.

Please note that if you enroll in the Value Plan and choose to establish an HSA other than through Fidelity (for example, at the bank where you do your personal banking) and you enroll in, or are automatically re-enrolled in, a Health Care FSA, Fidelity will not

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know about your HSA and your Health Care FSA will be a General Purpose Health Care FSA. That will make you ineligible to contribute to your HSA and, if you make contributions to your HSA, you will suffer adverse tax consequences. Before the plan year begins, you must call Fidelity to designate your FSA as a Limited Purpose FSA.

INTEGRATED HEALTH MANAGEMENT

The Value plan offers a comprehensive suite of health and wellness programs that help employees and their covered family members better understand their health care benefits, navigate the health care system when they need it, understand treatment options and choices, reduce their costs and enhance the quality of life.

Each of the programs in Anthem's Integrated Health Management (IHM) is tailored to meet different health care needs, from those that want to stay well when they are healthy, to those that are at risk for an illness, to those who are at chronic or acute states of illness. IHM offers a wide range of assistance such as preauthorization, coaching, support, advice and medical guidance, as well as early identification of risk and outreach from registered nurses. IHM includes:

- Preauthorization
- MyHealth Coach
- Condition Care and Complex Care
- Case Management
- Neonatal Intensive Care Unit Management
- Organ Transplant Care
- FutureMoms
- 24/7 NurseLine
- Behavioral Health

The following pages contain brief descriptions of IHM programs. For additional information or questions regarding any of these programs, please call Anthem at 1-800-894-1374.

Preauthorization

In the Value plan, some procedures require preauthorization and may be subject to penalties or nonpayment if they are not preauthorized. 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 maternity, as described under “Statement of Rights Under the Newborns’ and Mothers’ Health Protection Act”). Maternity 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 caesarean 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.

If the services are not preauthorized, you may be responsible for paying a \$500 non-compliance penalty in addition to your normal coinsurance and deductible. (\$500 penalty does not apply to Hospice Care or Air Ambulance Services.)

While preauthorization is not required for outpatient procedures or medical imaging, such as CT scans or PET scans, you should be aware that these and other tests are not covered in all circumstances even if ordered by your physician. If a test is considered to be experimental, not medically necessary, or not effective, it will not be covered, and you will be responsible for the full cost. You should also be aware that the cost of these procedures varies by provider, and that Anthem offers a High Tech imaging service preauthorization process that can help you find cost-effective, quality service. Call Anthem for more information about this referral program.

Anthem manages the preauthorization process for the Value plan. In most cases, your provider will contact Anthem for preauthorization. Ultimately, however, preauthorization is your responsibility — not the doctor’s or hospital’s responsibility.

Anthem will review your treatment and work with your doctors to determine the appropriateness of your treatment and length of your stay in the hospital, if applicable.

Anthem will also work with you and your doctor to help you obtain the right follow-up care and services.

Anthem's medical management recommendations are neither health care nor medical services and are neither treatment advice nor treatment recommendations.

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

For more information about preauthorization call Anthem at 1-800-894-1374.

MyHealth Coach

MyHealth Coach nurses serve as a central point of contact for individuals who have questions about a health care related topic, condition or concern. Plan participants can turn to their MyHealth Coach to:

- Manage their health, from coaching on weight loss to education about the side effects of chemotherapy
- Learn how to set and achieve healthy lifestyle goals with a personalized health plan
- Talk about how their health plan works so they can get the most out of it
- Get help coordinating health care benefits before, during and after a hospital stay
- Find the right coaching program for their situation.

You and covered family members are eligible if you have a health condition that requires ongoing attention. Health conditions may include, but are not limited to, diabetes, asthma, depression, high blood pressure, heart disease, and pregnancy. Call a Health Coach to receive a confidential consultation and learn about the program.

Condition Care

Northrop Grumman Health Plan participants enrolled in the Value plan have access to the Condition Care program through Anthem. This program is presented free of cost, and participation is completely voluntary — you and your covered family members participate only when and if you are interested in the services offered.

The Condition Care program:

- Uses a collaborative and holistic approach to help you better manage diabetes, heart failure, coronary artery disease (CAD), chronic obstructive pulmonary disease (COPD), and asthma
- An Anthem nurse works with you to promote self-management of your condition
- Supports physician's plan of care
- Helps control health care costs

- Increases adherence to healthy lifestyle strategies & evidence based guidelines for care
- Enables overall health improvement
- Encourages preventive screenings and immunizations, such as flu vaccine
- Identifies depression and advises on access to appropriate behavioral health resources.

Anthem medical professionals routinely review medical and prescription drug claims in order to identify individuals who may benefit from the special health programs provided for Value plan participants. Those eligible may be contacted by phone to review the health education services offered for their condition. These health programs are tailored to meet an individual's specific needs and personal objectives. The outreach activities for this program include phone calls and/or direct mail to affected participants. The Anthem representatives who contact eligible participants by phone will describe the health services available, answer any questions, and can also complete the enrollment process. The program is completely confidential and medical information is not shared with Northrop Grumman or with anyone else.

Employees who choose to participate will have access to education materials, telephone education sessions, and other support to help participants better understand and manage a health condition.

Complex Care

If you are not enrolled in another care program or you have more than one medical condition, you may be identified to participate in the Complex Care program. Complex Care provides enhanced management for acute and complex health situations based on your high risk medical condition. With Complex Care:

- A nurse works with you to create an individualized care plan utilizing stages of behavior change
- There are four principle areas of focus: Utilization Management for when you are in hospital, medication/ treatment when you are at home, care coordination with your physicians and access to various health resources
- A nurse coordinates your needs by working closely with your physician.

Eligible participants can start or stop participating in these programs at any time. For more information, contact Anthem at 1-800-894-1374.

Case Management

Case management is an additional resource that helps coordinate and ensure the quality of health care. It is designed to help if you or an enrolled family member needs complex medical care for an extended period of time. The program consists of nurses and physicians representing all clinical specialties, who work with you and your physician to meet your long-term medical needs.

If you participate in the Value plan, you — and your covered family members — have access to the case management program through Anthem. Case management is offered to you free of cost, and is mandatory only in situations where case management is necessary based on a medical condition. Although participation is voluntary in other situations, you are encouraged to take advantage of the program to ensure benefits coverage for situations involving complex medical treatment.

If you are referred to the case management program — depending on the severity of the diagnosis or expected length of hospital stay — a case management team will be assigned to you by Anthem. The team will include your case manager — a registered nurse who has at least three years of clinical experience related to your condition — and other experienced nurses and physicians representing the appropriate clinical specialties. They will work with you and your doctors to:

- Review your medical needs to ensure that your treatment plan incorporates the best practices available and that you have the resources you need to comply with your treatment plan
- Coordinate all your health care and ensure consistent quality care
- Help you navigate the health care system and make sure you obtain the highest level of coverage possible.

Your case management team also explores treatment alternatives that may be available to you. Sometimes, these alternatives include treatment that is typically considered ineligible for reimbursement. Anthem reviews these situations on a case-by-case basis and may approve payment.

The final decision on all medical care always remains with you, your family and your physician. If you or your physician does not agree with Anthem, you may continue your original course of treatment (or any other medical treatment you choose). However, in these cases, your medical plan option may limit payment of your expenses and, as a result, you may pay more.

For more information about case management, call Anthem at 1-800-894-1374.

Neonatal Intensive Care Unit (NICU) Management

This program provides support to high risk infants and their families. Nurses with neonatal and/or pediatric nursing experience promote the highest standards of care for

Neonatal Intensive Care Unit (NICU) infants and work with you and your family throughout the NICU stay to help you prepare for a smooth transition home.

The NICU program includes:

- Registered nurses experienced in neonatal care
- Assistance in level of care assignment
- Discharge planning and follow-up
- Coordination of home health needs.

If you have a complicated delivery and your baby is in NICU, the hospital will contact Anthem, and an Anthem NICU nurse will reach out to you. Additionally, if you are identified as having a high risk pregnancy through the FutureMom's program, you may be identified to be contacted by a NICU nurse.

Organ Transplant Care

If you need an Organ transplant, Anthem'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 Value plan offers two benefit levels for organ transplant services and follow-up care. Services provided by an in-network facility are covered at 80% coinsurance 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 Anthem, your transplant-related benefits will be paid at 100% after you have satisfied the deductible for a period of up to 12 months following the transplant.

Transplant related care rendered after 12 months will be reimbursed at 80% as appropriate, after the deductible is met.

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

Travel Benefits when you use a Blue Distinction Center for Transplant

If the BDCT facility is over 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 hotel accommodations for you and one companion will be reimbursed at 100% after the deductible is met, subject to coordination and approval by Anthem.

The following methods of transportation are acceptable for reimbursement:

- Bus, taxi, 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 will be paid at 100% after you have satisfied the deductible for up to 12 months following the transplant, subject to the following maximums:

- 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 Blue Cross including the legacy PPO, EPO and CDHP. Changing plan options or suspending and re-enrolling in benefits will not restore the benefit.

FutureMoms

FutureMoms is a maternity program designed to help you have a healthy pregnancy and a healthy baby. When you register for this voluntary program, you will receive:

- Your own health coach. This is a registered nurse with expertise in prenatal/postnatal care who will follow your pregnancy and give you individualized attention and support.
- Toll-free access to a registered nurse line, 24/7, in case you have questions or concerns
- Phone calls or mailers based on your pregnancy status, risk status, medical history and doctor's plan of care
- Educational materials like a prenatal book that follows your pregnancy week by week. Also, materials to help you handle the unexpected
- Lifestyle management, pharmacy, nutrition and behavioral health counseling
- Postpartum support and guidance in areas like breastfeeding and depression.

24/7 NurseLine

The 24/7 NurseLine is staffed 24 hours a day seven days a week by registered nurses. Nurses provide you and your family members with health care education and decision support for routine health conditions.

- 24/7 nurses staff the information line and can help members choose the most appropriate use of health care resources, apply self-care, learn about specific medical conditions, treatment options, side effects associated with prescription drugs, and provide valuable lifestyle management and nutrition information
- Callers can also access the audio library, an automated health library with information on over 300 medical topics.

To contact the NurseLine directly, call 1-866-800-8780.

Behavioral Health Resources

Anthem offers behavioral health resources which provide individualized support to employees and their covered dependents through 24/7 accessibility, proactive outreach and condition management. These programs include:

- Resource Center for 24/7 access to qualified staff including Master's level clinicians with experience in managing crises, providing guidance and finding treatment

programs, referrals, tools and resources. Referrals to Northrop Grumman's Employee Assistance Program as appropriate.

- Behavioral Health Care Management, for members with significant challenges related to combined mental health and physical health conditions
- Condition Care: Depression provides support & resources for those who suffer from the most common depressive disorders
- Northrop Grumman designated clinical case managers work closely together for cases that involve both medical and behavioral health.

To contact the Behavioral Health Resource Center directly, call 1-866-621-0554.

HEALTH RESOURCES AND TOOLS

Whether you are going for a routine checkup, managing a medical condition, or getting ready for surgery, online tools and health resources can deliver the information and support you need around these topics and more.

Health Services and Cost Comparison Tool

Northrop Grumman has partnered with Castlight to bring Anthem participants a health services and cost comparison cost tool which can help you make informed health care decisions. Use the tool to:

- Compare nearby doctors, medical facilities, and medical services based on the quality of care and the price you will pay
- See personalized cost estimates based your location and your medical plan
- Access patient reviews and ratings of doctors and facilities
- Search for your prescription medications and pharmacies near you.

Go to the “Tools and Resources” tab on *Benefits & You OnLine* (<http://benefits.northropgrumman.com>) to access the health services and cost comparison tool. You may also log on to the Anthem member website at www.anthem.com/ca and select “Know Your Cost”. You will be redirected to Castlight’s website.

Find A Doctor

Anthem’s *Find A Doctor* will help you locate and find information about doctors and other health care services in your area. Whether you need a specialist, a pharmacy, a hospital, vision care, a chiropractor, or a nutritionist, you will find it in one place. In addition, this directory will help you:

- Find out which doctors are in the Anthem BlueCard or PPO network
- Get background information about physicians (including board certification and years in practice)
- Obtain valuable feedback from other patients about the quality of service they received
- Research customer service ratings, when available, that cover such things as ease of scheduling appointments, Internet readiness, and overall customer satisfaction.

To access *Find a Doctor*, log in to the Anthem member website at www.anthem.com/ca (accessible from the *Provider* icon at *Benefits & You OnLine*). By entering your user name and password, you will be able to access the secure site and search for providers and find other pertinent information. Under Useful Tools, click on *Find a Doctor* and choose what kind of doctor or health professional you want to find.

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.

- **LiveHealth Online:** Visit a doctor without leaving your home. LiveHealth Online is a convenient telehealth format that uses two-way video chat to connect you with U.S. board certified doctors over the Internet. LiveHealth Online offers on-line access to doctors 24 hours a day, 365 days a year and you don't have to make an appointment or wait at the doctor's office. Doctors can answer your questions, make a diagnosis, and prescribe basic medications, if you need them. Please remember that Northrop Grumman security procedures do not permit taking of video or photographs at company facilities so this on-line video service may not be used inside a company facility at this time, irrespective of whether you are using a personal device. LiveHealth Online may not be available in all states.
- **Urgent Care Centers.** Staffed with family, pediatric, ER 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 have an appointment.

To find urgent care in your area, log in to the Anthem member website at www.anthem.com/ca (accessible through the *Providers* icon on *Benefits & You OnLine*) and select Find Urgent Care. You may also link to LiveHealth Online after logging in to your Anthem account.

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

MyHealth Advantage

MyHealth Advantage is a free service that helps keep you healthier. Anthem reviews your health claims to make sure your health care is on track and sees if they can save you money. Anthem checks what drugs you are taking and alerts your doctor if they spot a potential drug interaction. They also keep track of your routine tests and checkups,

reminding you to make these appointments by mailing you a MyHealth Note. MyHealth Notes also summarize your recent claims.

Imaging and Sleep Management Programs

When you need imaging services like MRIs and CT scans or a sleep study, Anthem can help you get quality service at a lower cost.

- **Imaging services:** If your doctor refers you to an imaging provider, Anthem will review the referral. If there are more cost-effective, quality choices, Anthem will let you know. You can go with your doctor's referral or with one of the imaging providers suggested by Anthem.
- **Sleep studies:** If your doctor refers you for a sleep study or any sleep-related equipment or supplies, you doctor should call Anthem before you have any tests done or supplies sent to you. Depending on your health, you may be able to do the study in your home. Anthem will discuss the guidelines with your doctor and provide instructions on where to get materials and supplies to do your sleep study at home.

MEDICAL NECESSITY

The Value 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.)
- Not educational, vocational, experimental, or investigational in nature as determined by Anthem
- 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.

Adult physicals, newborn baby care, and childhood immunizations received from a network provider are considered medically necessary. Maternity 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 Expenses”
- Are provided to treat a diagnosed sickness or an injury (including a congenital defect or birth abnormality).

COVERED MEDICAL SERVICES

Services for which the Value plan 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 act of war. Most services received from in-network providers will be covered at 80% of negotiated fees after the deductible is met. Most services received from out-of-network providers will be covered at 50% of Maximum Allowed Amount charges after the deductible is met. **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 under the Value plan. Except for preventive care, all services are subject to the deductible.

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 and the services are for the following:

- Chronic pain associated with the following conditions: arthritis, menstrual pain and irregularity, back pain, migraine, lumbago, pinched nerve, sciatica, post laminectomy, slipped disc, rheumatism, bell's palsy, spastic colon, bursitis, stroke, dysmenorrhea, tennis elbow, headaches, tendonitis, herpes zoster, and trigeminal neuralgia
- In lieu of traditional anesthesia
- Nausea related to chemotherapy or pregnancy.

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 Anthem 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.

Anesthesia

Coverage is provided for the administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, and provided the

anesthesia is administered and charged for by a physician other than the operating surgeon or his assistant.

Anesthesia benefits will be reimbursed at 80% for in-network providers or 80% of the Maximum Allowed Amount for out-of-network providers.

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
- Protheses 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 at a frequency of three times per week for approximately 12 weeks.

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, provided care commences within 12 months of the accident. 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 Value plan when administered in an approved inpatient or outpatient setting. In order for coverage to be considered, an EOB from the dental plan must accompany any Anthem claims submissions.

***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 which 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 cancelled.

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 (PKU) 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.

If the emergency room visit results in a hospital admission, you should notify Anthem within 72 hours of the admission.

Emergency room care as described above will be reimbursed at 80% for in-network and out-of-network providers.

Emergency room care for non-emergencies will be reimbursed at 50% for in-network and out-of-network providers. Care for non-emergencies is defined as care received in

an emergency room for a service or condition that does **not** meet the prudent layperson's assessment of emergency (see description above).

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% for emergent care and for non-emergent care. Preventive care is reimbursed at 100% of charges.

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

Hearing

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

Home Health Care

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 4 hours. Preauthorization is required or you will be charged a \$500 penalty for failure to obtain preauthorization.

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. Charges incurred during periods of remission are not eligible under the provision of the plan.

Hospice care for you and your eligible dependents is covered for up to six months. Preauthorization is required for Hospice care services. A Personal Health Coach is 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% of contracted fees or 50% of Maximum Allowed Amount charges for out-of-network

providers. 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.

Inpatient Medical Facility

The Value plan pays benefits toward the cost of the following types of inpatient hospital care services:

- Inpatient room and board
- Inpatient ancillary services.

Preauthorization is required or you will be charged a \$500 penalty for failure to obtain preauthorization.

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
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy
- On-site 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 or you will be charged a \$500 penalty for failure to obtain preauthorization.

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

Maternity Care

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

If you become pregnant, you are invited to enroll in the Future Moms maternity program provided by Anthem. The program has important information to help you have a healthy pregnancy. Depending on your needs, a nurse will follow you throughout your pregnancy to provide support and help you carry out your doctor's instructions.

Also covered are services rendered in a birthing facility, provided that the physician in charge is acting within the scope of his 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 mother'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.

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 Value plan.

Examples of medical supplies include:

- Diabetic supplies (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 Value plan includes mental health and substance abuse benefits as described in this section. The Value plan will cover services from in-network providers at 80%; services from out-of-network providers will be covered at 50% of Maximum Allowed Amount charges.

Eligible Mental Health and Substance Abuse Expenses

The Value plan 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:

- Charges for medically necessary licensed local ambulance service to or from the nearest hospital or approved qualified mental health and/or substance abuse treatment facility where the needed mental health treatment or evaluation can be provided, as authorized by Anthem
- Medically necessary outpatient charges at a hospital or approved qualified mental health and/or substance abuse treatment facility
- Family counseling including family therapy with family members to assist in the covered person's diagnosis and treatment
- The services of qualified mental health and/or substance abuse treatment providers, as determined by Anthem, who provide services within the lawful scope of the practice of:
 - Licensed psychiatrists
 - Licensed or registered psychologists
 - Licensed or registered psychotherapists
 - Licensed or registered psychiatric social workers.
- Semiprivate room and board charges, and medically necessary inpatient services and supplies at a hospital or qualified mental health and/or substance abuse treatment facility approved by Anthem. Preauthorization is required for these services or you will be charged a \$500 penalty for failure to obtain preauthorization.

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
- 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 as medically necessary
- Custodial care
- Educational rehabilitation or treatment of learning disabilities, regardless of the setting in which services are provided

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- 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. 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".
- Private duty nursing, except when medically necessary
- Psychological testing, 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, bioenergetic 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 (e.g., Autism Spectrum Disorder, mental retardation)
- Treatment or consultations provided by telephone.

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. 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.

Orthognathic Surgery

Orthognathic surgery is covered when medically necessary. Call Anthem 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 which 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 Value plan is provided through CVS/caremark. See "Prescription Drug Coverage" section for details.

Since medical and prescription drug coverage are combined in the Value plan, deductibles and out-of-pocket maximums are shared between medical and prescription drug coverage.

Preventive Care

The Value plan covers 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 Affordable Care and Patient Protection Act. The preventive benefits include routine office visits, lab services and X-rays, screening tests, immunizations, and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness, and death. Please contact Anthem 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%. In most cases, prescription drugs are not eligible as preventive services. Preventive services are not subject to the deductible.

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 RN or LPN. 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 days per person per plan year. Preauthorization is required or you will be charged a \$500 penalty for failure to obtain preauthorization.

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 which 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 which 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 and 80% of the Maximum Allowed Amount for an out-of-network provider.

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 or you will be charged a \$500 penalty for failure to obtain preauthorization.

Covered services and supplies include semiprivate 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
- Gender Reassignment surgery
- Multiple surgical procedures
- 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. The benefit payable for the assistant surgeon's services is 20% of the benefit payable for the primary surgeon.

Bilateral Surgical Procedures

Bilateral surgical procedures are defined as more than one procedure associated with a single surgical event. The benefit payable for bilateral procedures is 50% of the eligible benefit for the primary surgical procedure.

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. Co-surgeon services are covered at 50% of the eligible benefit of the surgeon's fee.

Gender Reassignment Surgery

Gender reassignment surgery, excluding cosmetic surgery, may be covered, up to a lifetime maximum of \$75,000 per person. The lifetime maximum applies across all Anthem medical plans including any legacy EPO, PPO or CDHP plans. Benefits are subject to Anthem's Clinical Utilization Guidelines and preauthorization requirements. Call Anthem for details.

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 100% of the eligible surgical allowance for the

highest paying procedure plus 50% of the eligible surgical allowance for the second highest paying procedure and 50% of the eligible surgical allowance for each additional procedure. For example, if the benefit normally pays 80%, the primary surgical procedure would be paid at 80%, and the remaining surgical procedures would be paid at 50% applying the 80% benefit.

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 Value plan covers the following expenses:

- Transplant procedures performed at a Blue Distinction Center for Transplants are covered at 100%.
- Transplant procedures performed at an in-network facility are covered at 80%
- Transplant procedures performed at an out-of-network facility are not covered.

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. Coverage is provided only with a diagnosis of morbid obesity, based on National Institutes of Health criteria, which can change periodically. For details, call Anthem Member Services at 1-800-894-1374.

Telemedicine

Services provided by LiveHealth Online (where you can have online video service with a doctor) are covered urgent care. If you have not met the plan deductible, you pay \$49 for each visit. Once the deductible is met, you pay a \$10 copayment for each service.

Temporomandibular Joint Dysfunction (TMJ)

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 Value plan 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 (maximum combined limit for occupational and physical therapy visits combined is 30 per person per plan year*)
- **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 (maximum combined limit for occupational and physical therapy visits combined is 30 per person per plan year*)
- **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 Anthem at the number provided on your ID card for details on medical necessity requirements.

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

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 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 through Anthem.

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 transportation or lodging or mileage costs, except as defined for transplant coverage
- Charges for services or supplies that are not medically necessary, as determined by the claims administrator, 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/reconstructive 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.)

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- Expenses for vocational, work hardening, or training programs regardless of diagnosis or symptoms or for non-medically necessary education, except as specifically provided in the Value plan
- 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. 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 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 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
- Anthem, in its discretion, determines whether services or supplies are experimental.
- Charges for eye refractions, eyeglasses, and contact lenses
- 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 and donor search fees and surrogate mother charges, unless the surrogate mother is eligible under the Value plan option at the time services are rendered
- Expenses for non-human organs, including services and supplies related to non-human organs

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- Charges for massage therapy not rendered by a physician
- The cost of care for the newborn child of an enrolled child, unless the newborn becomes 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
- 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 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
- Expenses for counseling services for the purpose of career or financial reasons
- Fees for private duty nursing while a patient 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 (RK), photo refractive keratectomy (PRK), astigmatic keratectomy (AK), 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
- 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 speech therapy to correct pre-speech deficiencies or to improve speech skills not fully developed, such as stuttering
- 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 morbid obesity, as defined by the criteria of the National Institutes of Health
- Marriage counseling except through the employee assistance program (EAP)
- Expenses related to infertility treatment

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These examples are not intended to be all-inclusive. Charges for other procedures, services or supplies may be excluded if it is determined that they are not medically necessary, reasonable, or covered by the Value plan.

Northrop Grumman reserves the right to exclude charges for any other condition, disease, ailment or illness not deemed to be medically necessary, reasonable, or otherwise covered. 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

Since medical and prescription drug coverage are combined in the Value plan, deductibles and out-of-pocket maximums are shared between medical and prescription drug coverage. However, prescription drug coverage in the Value plan is provided through CVS/caremark and not Anthem. You will receive a separate ID card from CVS/caremark.

Your pharmacy costs will be based on where you are within the Value plan and whether you use a pharmacy in the CVS/caremark pharmacy network:

- Until you meet the plan deductible, you will need to pay the cost of the covered drug. If using an in-network pharmacy*, your cost is the CVS/caremark contracted or negotiated rate.
- Once you meet the plan deductible, you will pay a percentage of the cost of the prescription drug, or coinsurance, until you reach the out-of-pocket maximum.
 - If using an in-network pharmacy*, you will pay 20% of the contracted cost for generic and formulary prescription drugs and 35% of the contracted cost for nonformulary prescription drugs
 - If using an out-of-network pharmacy, CVS/caremark will reimburse you 50% of the eligible expense.

You do not need to satisfy the deductible in order to be reimbursed for certain preventive prescription medications. When the deductible is waived, 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 (www.caremark.com) which is accessible through the *Providers* icon on *Benefits & You OnLine*.

**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.*

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, and
- Prescribed in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies.

Visit the CVS/caremark website (www.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 list. 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 1-855-361-8565. 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.

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 U.S. Food and Drug Administration (FDA) approval for many ingredients included in compounds, they may not be covered or may require a prior authorization. Prior authorization is required for any compound prescription drug with costs exceeding \$300.00. Please contact CVS/caremark for additional information or with questions

Want to Know How Much Your Prescription Drug Will Cost?

Use the prescription drug cost comparison tool at the CVS/caremark website, www.caremark.com, which is accessible from the *Provider* icon at *Benefits & You OnLine*, to determine your costs of specific prescription drugs — at a retail pharmacy and through the 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.

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 Retail Pharmacy Program” for details.
- 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. You will receive a 90-day supply of medication. See “CVS/caremark Maintenance Choice® Program” for details.

CVS/caremark Retail Pharmacy 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 continues to participate in the CVS/caremark network, and to find the pharmacy closest to you, call CVS/caremark directly at 1-855-361-8565 or go to the CVS/caremark website, www.caremark.com, which is accessible from the *Providers* icon at *Benefits & You OnLine*.

When you use a CVS/caremark participating pharmacy:

- Ask your doctor to write a prescription for up to a 30-day supply of your medication, plus refills, if appropriate
- Take your prescription to a CVS/caremark participating pharmacy
- 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.)
- Pay the appropriate deductible or coinsurance at the pharmacy
- If you participate in an HSA or General Purpose FSA or General Purpose HRA and have funds available, you may pay your expense with your Benefit Card or submit your receipts for reimbursement.

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 the appropriate deductible and/or coinsurance and receive up to a 90-day supply of your medication. If you have met the deductible, you will pay 20% coinsurance (or 35% for non-preferred brand medications) up to a maximum of \$200. (This maximum does not apply until you have met the deductible.) 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:

- Take your prescription to a CVS/pharmacy location
- Phone: Call CVS/caremark Customer Care at 1-855-361-8565
- Mail: Fill out and return a mail service order form. You can download one from the CVS/caremark website, www.caremark.com, or request one from CVS/caremark Customer Care
- Online: Visit www.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 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, 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 cost of the medication at your participating retail pharmacy. The amount you pay will not count toward your annual deductible or out-of-pocket maximum.

If you have an HSA, a General Purpose FSA, or General Purpose HRA, 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 U.S. Food and Drug Administration (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 an HSA, General Purpose FSA or General Purpose HRA, 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 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 an HSA, a General Purpose FSA or General Purpose HRA, you may use those funds to cover the cost of your prescription.

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 or view the 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:

5. Requirement for frequent dosing adjustments and intensive clinical monitoring
6. Need for intensive patient training and compliance assistance
7. Limited or exclusive product availability and distribution
8. 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:

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

Once you meet the plan deductible, you pay 20% coinsurance up to a maximum of \$200 per prescription for a 30 day supply. (This maximum does not apply until you have met the deductible.)

Call CVS/caremark at 1-855-361-8565 or access the CVS/caremark website, www.caremark.com, which is accessible from the *Provider* icon at *Benefits & You OnLine*, 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 1-855-361-8565.)

Special Information for Patients with Diabetes

The prescription drug benefit includes a special provision for diabetic kits. Your deductible must be met before the diabetic kit offer takes effect. **Once your deductible has been met** 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:

- Your physician lists all of your diabetic supply requirements on one prescription,
- The order includes a diabetes medication, and
- You order all of the supplies at the same time through the CVS/caremark Maintenance Choice Program.

The kit includes these supplies:

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

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

If you need a glucose monitor, you can order one at no charge by calling CVS/caremark at 1-855-361-8565.

***Northrop Grumman Health Plan
Group Legal Plan***

January 2017

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Group Legal Plan

OVERVIEW

The Group Legal Plan 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 automatically will roll over in the next 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 Hyatt Legal Plans' website, info.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.

You may also call Hyatt Legal Plans' Client Service Center at 800-821-6400, Monday through Friday 8:00 a.m. to 7:00 p.m., 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.

The level of benefit you receive depends on the option you choose — Basic or Advantage.

Here are some of the services fully covered by the plan:

Administrative Hearing Representation

Adoption and Legitimization

Civil Litigation Defense

Consumer Protection Matters

Criminal Matters

Debt Collection Defense

Document Review and Preparation

Restoration of Driving Privileges

Traffic Ticket Defense (No DUI)

Estate Matters

Juvenile Court Defense

Divorce, Dissolution and Annulment (Contested and Uncontested)

Enforcement of Modification of Support Order

Misdemeanor Defense

Real Estate Matters

Wills, Living Wills, and Powers of Attorney

ELIGIBILITY

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 same-sex or opposite-sex domestic partner
- Your unmarried children under age 19, or age 25 if a full-time student or performing missionary service.

Please keep in mind that 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.

HOW THE GROUP LEGAL PLAN WORKS

WEBSITE

To use the Group Legal Plan visit the Hyatt Legal Plans' website at info.legalplans.com. Once there, click on the "Members Log in" icon. You will be taken to a secure page that will require you to enter your Membership Number. After you enter your Membership Number you will be taken to a page that is specific for member services. On this page you can choose the following options:

- How Do I Use the Plan?
- Covered Services
- Attorney Locator
- Obtain Case Number
- Life Guide
- Self-Help Documents/Forms

CLIENT SERVICE CENTER

You may also use the Group Legal Plan, by calling Hyatt Legal Plans' Client Service Center at 1-800-821-6400. Client Service Representatives are available Monday through Friday from 8:00 a.m. to 7:00 p.m., Eastern time. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a Case Number which is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about the Legal Plan.

You then call the Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select your own attorney. Also, where there are no Participating Law Firms, you will be asked to select your own attorney. In both of these circumstances, Hyatt Legal Plans will reimburse you for these non-Plan attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents must have obtained a Case Number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the legal plan.

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. Please take time for yourself and your family to read the description of benefits carefully.

All benefits are available to you and your spouse (or domestic partner) and dependents, unless otherwise noted.

There are two Group Legal Plan options to choose from — the Basic Plan and the Advantage Plan.

BASIC PLAN – DEFINITION OF COVERED SERVICES

ADVICE AND CONSULTATION

Office Consultation

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the

Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

DOCUMENT PREPARATION

Demand Letters

This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Document Review

This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the

Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

PERSONAL INJURY

Personal Injury (25% Network Maximum)

Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

WILL AND ESTATE MATTERS

Probate (10% Network Discount)

Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Wills and Codicils

This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

ADVANTAGE PLAN - DEFINITION OF COVERED SERVICES

ADVICE AND CONSULTATION

Office Consultation

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The

Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

CONSUMER PROTECTION

Consumer Protection Matters

This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Personal Property Protection

This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters

Small Claims Assistance

This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

DEBT MATTERS

Debt Collection Defense

This service provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It does not include vacating a judgment; counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

Identity Theft Defense

This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

Tax Audits

This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

DEFENSE OF CIVIL LAWSUITS

Administrative Hearing Representation

This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense

This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense

This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

DOCUMENT PREPARATION

Affidavits

This service covers preparation of any affidavit in which the Participant is the person making the statement.

Deeds

This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters

This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Document Review

This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing homes agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property

Notes

This service covers the preparation of any promissory note for which the Participant is the payor or payee.

FAMILY LAW

Adoption and Legitimization (Contested And Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse (or domestic partner). Legitimization of a child for the Plan Member and spouse (or domestic partner), including reformation of a birth certificate, is also covered.

Divorce, Dissolution and Annulment (Contested and Uncontested)

This service is available to the Plan Member only, not to a spouse or dependents, for the first fifteen hours of service. This service includes preparing and filing all necessary pleadings, motions and affidavits, drafting settlement or separation agreements, and representation at the hearing or trial, whether the Plan Member is a plaintiff or a defendant. This service does not include disputes that arise after a decree is issued. It is the Plan Member's responsibility to pay fees beyond the first fifteen hours.

Enforcement of Modification Of Support Order

This service is available to the Plan Member and spouse, and covers representation after a judgment has been entered to enforce or modify a court's award of support or alimony, whether the Plan Member or spouse is a plaintiff or a defendant. This service does not cover transfer of a divorce decree from one state to another, the division of property, or collection activities after a judgment.

Name Change

This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement

This service covers the preparation of an agreement by a Plan Member and his or her fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Plan Member. The fiancé/partner must have separate counsel or must waive representation.

Protection from Domestic Violence

This service covers the Plan Member only, not the spouse (or domestic partner) or dependents, as the victim of domestic violence. It provides the Plan Member with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Uncontested Change or Establishment of Custody Order

This service is available to the Plan Member and spouse (or domestic partner), and covers preparation of petitions, consent forms and waivers, and representation at any court hearings provided all parties are in agreement to establish or modify a child custody order.

Uncontested Guardianship or Conservatorship

This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse (domestic partner) is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. If the proceeding becomes contested, the Plan Member or spouse (domestic partner) must

pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

IMMIGRATION

Immigration Services

This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

INSURANCE MATTERS

Insurance Claims

This service provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided the carrier is not affiliated with the Plan Member's Sponsor or Employer. Litigation of coverage issues is included. Litigation of damages is not included.

PERSONAL INJURY

Personal Injury (25% Network Maximum)

Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

REAL ESTATE MATTERS

Boundary or Title Disputes (Primary Residence)

This service covers negotiations and litigation arising from boundary or title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies.

Eviction and Tenant Problems (Primary Residence – Tenant Only)

This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan on the Participant's primary residence

Property Tax Assessment (Primary Residence)

This service covers the Participant for review and advice on a property tax assessment

on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing Of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or in obtaining a home equity loan on a Participant's primary residence. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, rental property or property held for business or investment.

Sale or Purchase of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Zoning Applications

This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

TRAFFIC AND CRIMINAL MATTERS

Felony Defense

This service covers representation for Participants in defense of any criminal felony charge. Representation includes court hearings, negotiation with the prosecutor and trial.

Juvenile Court Defense

This service covers the defense of a Plan Member and a Plan Member's dependent child in any juvenile court matter, provided there is no conflict of interest between the Plan Member and child. In that event this service provides an attorney for the Plan Member only, including services for Parental Responsibility.

Misdemeanor Defense

This service covers representation for Participants in defense of any criminal

misdemeanor charge except those relating to traffic or driving under influence charges. Representation includes court hearings negotiation with the prosecutor and trial. It does not include representation of a felony charge that is subsequently reduced to a misdemeanor.

Restoration of Driving Privileges

This service covers the Participant with representation in proceedings to restore the Participant's driving license.

Traffic Ticket Defense (No Dui)

This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

WILLS AND ESTATE MATTERS

Trusts

This service covers the preparation of revocable and irrevocable living trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

This service covers the preparation of a living will for the Participant.

Powers Of Attorney

This service covers the preparation of any power of attorney when the Participant is granting the power.

Probate (10% Network Discount)

Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Wills And Codicils

This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

MAJOR TRIAL

Major Trial – In Network

All covered matters that require a trial are covered through completion with no hour limits or dollar caps when service is provide by a plan attorney.

Major Trail – Out Of Network

This service covers up to \$10, 000 for a covered matter when using a non-network attorney.

EXCLUSIONS

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the employer, MetLife® and affiliates, and plan attorneys
- Matters in which there is a conflict of interest between the employee and spouse (domestic partner) or dependents in which case services are excluded for the spouse (domestic partner) and dependents
- Appeals and class actions
- Farm and business matters, including rental issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

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.

You may port your Hyatt Legal Plan coverage within 30 days of your coverage end date. Call Hyatt Legal Plans' Client Service Center at 1-800-821-6400. Client Service Representatives are available Monday through Friday from 8:00 a.m. to 7:00 p.m., Eastern time.

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 Hyatt Legal Plans, Inc. Hyatt Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to Hyatt 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. Hyatt 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 Hyatt Legal Plans at **1-800-821-6400**. 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, Hyatt 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.

DENIAL OF BENEFITS AND APPEAL PROCEDURES

Denials of Eligibility

Hyatt verifies eligibility using information provided by *the Northrop Grumman Benefit Center*. When you call for services, you will be advised if you are ineligible and Hyatt Legal Plans will contact the Northrop Grumman Benefit Center for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

**Northrop Grumman Health Plan SPD
Group Legal Plan
January 2017**

Benefit Plan Administrative Committee - Northrop Grumman Health Plan
Northrop Grumman Corporation
P.O. Box 77003
Cincinnati, OH 45277-1060

Denials of Coverage

If you are denied coverage by Hyatt Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

Hyatt Legal Plans, Inc.
Director of Administration
Eaton Center 1111 Superior Avenue
Cleveland, Ohio 44114-2507

(For Florida plans contact Hyatt Legal Plans of Florida, Inc. at the above address.)

The Director will issue Hyatt Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under Section 502(a) of ERISA.