

NORTHROP GRUMMAN

A thin, curved line that starts under the 'N' and ends under the 'M', following the contour of the company name.

Summary Plan Description

Northrop Grumman Retiree Medical Plan

January 2017

A Guide to Your Northrop Grumman Retiree Medical Plan

This guide provides information about the Northrop Grumman Retiree Medical Plan. If you have questions not answered in this guide, contact the Northrop Grumman Benefits Center (NGBC)* at 1-800-894-4194. Benefits Center 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 the U.S., dial the AT&T out-of-country access code, then dial 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 Retiree Medical Plan or this guide and cannot modify the Plan or this guide. Accordingly, the terms of the Northrop Grumman Retiree Medical 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 Retiree Medical Plan (also referred to as the "Retiree Medical Plan" or "Plan"), as in effect on January 1, 2017. The benefits described in this SPD are offered to certain retired or terminated employees of Northrop Grumman Corporation. Northrop Grumman reserves the right to amend, modify or terminate any and all parts of this Plan at any time and for any reason.

Most medical benefits provided under the Plan are provided on a "self-insured" basis. Other medical benefits and all of the life insurance 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 retiree contributions are deposited in the trust and are used to pay benefits.

The self-insured medical benefits provided under the Plan are described in detail in separate benefit descriptions. The insured medical and life insurance benefits provided under the Plan are described in detail in the coverage certificate or subscriber contract through which those benefits are provided. Those separate benefit descriptions and subscriber contracts are considered part of, and must be read together with, this "main" portion of the SPD, which contains the plan rules regarding eligibility, participation, costs, administration, and other important information applicable to the benefits described in those separate documents and subscriber contracts.

Northrop Grumman (also referred to as the "Company" in this guide) refers to Northrop Grumman Corporation and Northrop Grumman's affiliates that participate in the Plan.

*If your retiree medical benefits are administered by Benefits Outsourcing Solutions, also referred to as the Northrop Grumman Benefits Service Center (NGBSC), please call the NGBSC at 1-800-410-6605.

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INTRODUCTION

PLAN HIGHLIGHTS

Plan Effective Date

The original effective date of the Northrop Grumman Retiree Medical Plan was January 1, 2006. This SPD describes the terms of the Plan as in effect on January 1, 2017.

Northrop Grumman Retiree Medical Plan For Retirees under Age 65

The Northrop Grumman Retiree Medical Plan provides medical and prescription drug coverage for eligible retirees and their dependents who are under age 65. The specific plan options you are eligible to elect depend on where you live and your Medicare status.

To receive retiree medical benefits for you and your family, you must actively enroll yourself and your dependents in a medical plan option under the Northrop Grumman Retiree Medical Plan. You are not automatically covered under the Northrop Grumman Retiree Medical Plan, even if you satisfy the eligibility requirements. Depending on your company heritage and hire date, you and Northrop Grumman will either share the cost for coverage, or you will be required to pay the full cost.

Northrop Grumman Retiree Medical Plan for Retirees Age 65 and Older

If you are age 65 or older, your primary health insurance will be Medicare and you have the option to purchase additional coverage that supplements Medicare. The Northrop Grumman Retiree Medical Plan does not offer Medicare supplemental insurance as group coverage to most retirees* and their eligible dependents age 65 or older.^{1,2}

¹ Your last day of medical and prescription drug coverage under the Plan will end on the day before your "Medicare Eligibility Date." Your Medicare Eligibility Date is the first day of the month in which you reach age 65. So, for example, if your 65th birthday is on June 15th, you can enroll in Medicare effective June 1st and so your last day of medical and prescription drug coverage under the Plan would be May 31st. Medicare considers you to turn age 65 on the day *before* your 65th birthday, so if your birthday is on the first day of a month, Medicare will consider you to turn age 65 on the last day of the preceding month, which impacts your Medicare Eligibility Date. For example, if your 65th birthday is on June 1st, Medicare will consider you to reach age 65 on May 31st and you can enroll in Medicare effective May 1st; your last day of medical and prescription drug coverage under the Plan would be April 30th.

² Some retirees with certain heritage classifications may be eligible for Medicare supplemental coverage under the Northrop Grumman Retiree Medical Plan.

Northrop Grumman has partnered with OneExchange, a private insurance exchange, to help its retirees understand and enroll in individual Medicare supplemental insurance plans. Please call OneExchange at 1-855-832-0976 for more information about their services.

If you are eligible for subsidized retiree medical coverage and have reached your Medicare Eligibility Date, you will receive subsidized coverage in the form of a Retiree Health Reimbursement Arrangement (RHRA). Northrop Grumman will provide each eligible individual retiree with a fixed annual “credit” amount that can be used to help pay for an individual Medicare supplemental plan of his or her choice. This RHRA can be used for an individual supplemental plan, prescription drug, dental, vision or Medicare Part B premiums. To receive your RHRA credit, you must enroll in Medicare Parts A & B and enroll in individual Medicare supplemental coverage through OneExchange or enroll in individual Medicare supplemental and/or prescription drug coverage through Kaiser and notify OneExchange of your enrollment.

If you are not eligible for subsidized retiree medical coverage, you will not be eligible for an RHRA and will be responsible for the full cost of medical and prescription drug coverage.

Life Insurance

Certain heritage retirees who terminated employment before December 2, 2006, are eligible for life insurance benefits under the Plan. See the “Life Insurance” section later in this SPD for the life insurance eligibility rules.

ELIGIBILITY AND COST OF COVERAGE

Retiree Eligibility

The Northrop Grumman Retiree Medical Plan provides benefits for eligible retirees of Northrop Grumman Corporation. The plan also provides benefits to eligible retirees of certain companies (“heritage companies”) acquired by Northrop Grumman. The heritage company eligibility rules described below are generally designed to be consistent with the retiree medical eligibility provisions of the plans in effect at the heritage company at the time it was acquired by Northrop Grumman. However, the medical eligibility provisions set forth below are final and control in the event that there is any discrepancy with the eligibility provisions of a heritage company plan. The Benefit Plans Administrative Committee, in its sole discretion, may (but is not required to) refer to and interpret the terms of any heritage company plan in order to resolve any question regarding eligibility under the Northrop Grumman Retiree Medical Plan.

You will be eligible to participate in the Northrop Grumman Retiree Medical Plan if you satisfy one of the following requirements :

- You terminate from active service with Northrop Grumman at age 55* or older with a minimum of 10 years of service**
- You terminate from active service with Northrop Grumman at age 65* or older with a minimum of 5 years of service**
- You terminate from active service with Northrop Grumman and meet the eligibility provisions of a heritage company group (described below) at the time of termination.

*If you terminate from active employment on or after your Medicare Eligibility Date (see the *Northrop Grumman Retiree Medical Plan for Retirees Age 65 and Older* section for a description of the Medicare Eligibility Date) and you do not meet the eligibility provisions of a heritage company group that entitles you to medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan or a Company credit to a Retiree Health Reimbursement Arrangement (RHRA), you will not be eligible to participate in the Northrop Grumman Retiree Medical Plan (unless you are eligible for Life Insurance, as described later). This is true even if you meet the age and service requirements set forth above. However, if you meet the age and service requirements set forth above and you have a spouse/domestic partner who has not reached his/her Medicare Eligibility Date or a dependent child under age 26, they will be eligible for coverage under the Northrop Grumman Retiree Medical Plan. See the *Dependent Eligibility* section for details.

**See the *Years of Service* section for rules regarding calculating years of service.

Effective as of March 31, 2011, Huntington Ingalls Industries, Inc. (referred to as “HII”) was spun off from Northrop Grumman Corporation (referred to as the “HII Spin-off”). In connection with the HII Spin-off, HII and Northrop Grumman entered into an Employee Matters Agreement describing the treatment of employee benefits (referred to as the “Employee Matters Agreement”). Pursuant to the Employee Matters Agreement, the portion of the Plan covering eligible former employees of Northrop Grumman Corporation who were identified as “HII Retirees” under the Employee Matters Agreement was spun-off to the Huntington Ingalls

Industries, Inc. Retiree Medical Plan (referred to as the “HII Retiree Medical Plan”) and the HII Retiree Medical Plan and HII assumed liability for providing benefits to the HII Retirees and to individuals identified in the Employee Matters Agreement as “HII Employees” who subsequently terminate employment and qualify for coverage under the HII Retiree Medical Plan.

Cost of Coverage

If you enroll in medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan, in general, you are responsible for paying the full cost of coverage unless you are a member of an eligible heritage company group (described below) for which Northrop Grumman contributes toward the cost of coverage. When you reach your Medicare Eligibility Date, you are not eligible for medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan unless noted below. If you are a member of a heritage company group eligible for subsidized coverage, you may be eligible for the Company-paid Retiree Health Reimbursement Arrangement as described in a separate benefit description. Specific information regarding your cost for coverage and the amount (if any) contributed by Northrop Grumman is provided to you at the time of your retirement and on a periodic basis thereafter. As noted previously, Northrop Grumman reserves the right to amend, modify, or terminate the plan at any time and for any reason. This right includes, but is not limited to, the right to change or eliminate Northrop Grumman’s contribution toward the cost of retiree medical coverage.

Heritage Company Groups

Aerojet Heritage

- You were hired prior to January 1, 1997, by an Aerojet heritage company that was acquired by Northrop Grumman prior to January 1, 2005, or you have Aerojet pension service prior to 1997 that is being counted toward your pension credit, and
- You terminate employment at age 55 or older with 120 months of cumulative pension service.

Defense (Advanced) Systems

- You were employed by Defense Systems heritage prior to February 2, 1987, and in a Defense Systems entity on or before June 30, 2003
- You accumulate 75 points at termination, and
- You are age 55 or older at the time of termination.

Former Westinghouse

- You were hired prior to July 1, 2003, and in the former Westinghouse heritage on or before June 30, 2003
- You terminate employment at age 58 or older with a minimum of 30 years of service, or
- You terminate employment at age 60 or older with a minimum of 10 years of service.

Note: Former Westinghouse retirees can “age into” a subsidized benefit, which means that if an individual retires at age 55 or older with sufficient years of service, but has not attained the

*specified age, he or she may enroll in the plans and pay the full cost of coverage or defer benefits upon retirement. Once the retiree has attained the appropriate age, he or she is eligible for the subsidized benefit. For example, if an individual terminates employment at age 55 with 30 years of service, he or she will be eligible for the subsidized benefit at age 58. **Please note:** To be eligible for the “age into” benefit, you (the employee) must be at least age 55 at the time of termination.*

Frozen or closed groups of former Westinghouse employees that were transferred to the IT sector on June 30, 2002, also retain eligibility for former Westinghouse heritage retiree benefits.

Grumman

- You were hired prior to January 1, 1993, and you were in a Grumman heritage entity on or before June 30, 2003, and at termination, you meet one of the following requirements:

Your age plus years of service total 75 or more

You are age 50 or older with a minimum of 20 years of service

You are age 60 or older with at least one year of service.

St. Augustine employees hired before January 1, 1993: Years of service prior to January 1, 1998, are not included for purposes of meeting eligibility requirements or calculating the subsidy amount or duration.

Note: *You are eligible to receive a subsidy for the same number of months that you were employed by Northrop Grumman. (The subsidy period begins on your termination date, not the date you enroll in coverage, if later.) After that, you will be required to pay the full cost for coverage. There is no subsidy available for spouses.*

Interconnect Technologies

- Certain Interconnect Technologies heritage employees are eligible for select retiree medical plan options under the Northrop Grumman Retiree Medical Plan. This frozen group includes certain retirees classified by Northrop Grumman as terminated from Interconnect Technologies and eligible for and enrolled in an Interconnect retiree medical plan at the time Northrop Grumman acquired Interconnect. It also includes certain employees who had 10 years of service with Interconnect Technologies prior to 1993 and who were employed by Northrop Grumman when the Interconnect Technologies facility closed August 31, 2007.

Litton

- Certain Litton heritage retirees are eligible for select medical plan options under the Northrop Grumman Retiree Medical Plan. This frozen group includes certain retirees classified by Northrop Grumman as retired from Litton Discontinued Operations and Litton Corporate who were eligible and enrolled in retiree medical benefits at the time Northrop Grumman acquired Litton Industries, Inc. in April 2001. It also includes certain retirees classified by Northrop Grumman as part of the Poly Scientific group who were eligible and enrolled in retiree medical benefits at the time Northrop Grumman sold Poly Scientific in September 2003.

Logicon

- You were hired prior to July 1, 2003, and in the Logicon heritage on or before June 30, 2003, and
- You terminate employment at age 55 with a minimum of five years of service, or
- You terminate employment at age 65, regardless of your years of service.

Lucas Aerospace

- Certain Lucas Aerospace Power Equipment Retired Hourly Over 65 and Retired Salary retirees are eligible for select medical plan options under the Northrop Grumman Retiree Medical Plan. This frozen group includes certain retirees classified by Northrop Grumman as retired from TRW's Lucas Aerospace Power Equipment division who were eligible and enrolled in retiree medical benefits at the time Northrop Grumman acquired TRW, Inc. in 2002

Navigation Systems

- You were employed by Navigation Systems prior to July 1, 2003, and in the Navigation System heritage on or before June 30, 2003, and
- You are at least age 55 with five years of service when you terminate employment.

Navigation Systems Grandfathered Group

- You terminated employment prior to July 1, 1991, under the plan rules in effect at the time.

Newport News Salaried

- You were hired prior to January 1, 2004, and in the Newport News heritage on or before December 31, 2003 and
- You terminate employment at age 55 or older with 10 or more years of service after age 45.
- Effective July 1, 2007, any now retired Newport News Salaried employee who went on long-term disability on or after January 1, 2004 and had ten years of service with the company (regardless of age), is eligible for retiree medical coverage effective July 1, 2007 if they were not previously eligible. Effective July 1, 2007 there will be no minimum age requirement to be eligible for retiree medical coverage if you terminate employment due to disability.

Norden Represented

- You were hired prior to January 1, 2004, in the collective bargaining unit covered by the collective bargaining agreement between Norden and IUE Local 81244 and in a Norden heritage entity on or before December 31, 2003, and
- You are between ages 55 and 65 with 10 years or more of service, or
- You are age 65 or older, regardless of your years of service.

Norden Non-Represented

- You were hired prior to July 1, 2003, and you were in a Norden heritage entity on or before June 30, 2003, and
- You are between ages 55 and 65 with 10 years of service, or
- You are age 65 or older, regardless of your years of service.

If you are laid off and your age plus years of service equals at least 65 and you are at least age 50 but less than 55 at the time of termination, you may join the plan upon reaching age 55.

Northrop

- You were hired prior to July 1, 2003, and you were in a Northrop heritage entity on or before June 30, 2003, and
- You terminate employment at age 55 or older with a minimum of 10 years of service, or
- You terminate employment at age 65 or older with a minimum of 5 years of service.

Rolling Meadows

- You were hired prior to July 1, 2003, and you were in a Rolling Meadows heritage entity on or before June 30, 2003, and
- You terminate employment between age 55 and age 64 with a minimum of 20 years of service, or
- You terminate employment between age 60 and age 64 with a minimum of five years of service.

TRW Heritage (including Mission Systems and Space Technology)

- You were hired prior to January 1, 2005, and
- You were in a TRW heritage entity on or before December 31, 2004, and
- You terminate employment at age 55 or older with a minimum of 10 years of service, or
- You terminate employment at age 65 or older with a minimum of five years of service.

Sterling

- Frozen group of active employees who are eligible upon retirement or termination of employment.

Multi-Heritage Subsidy Eligibility

If you are eligible for more than one heritage company subsidy (as described above), you may choose the heritage subsidy that best suits your situation upon employment termination. Your heritage subsidy decision is irrevocable. You may not change to another heritage subsidy in the future.

Heritage eligibility and subsidy are determined by the sector with which you were affiliated on June 30, 2003. For example, if you were working at a Grumman entity on July 1, 2003, and later transferred to an IT entity, your heritage, for purposes of the Northrop Grumman Retiree Medical Plan, would be Grumman. If you were employed at different sectors or entities with different retiree Heritages prior to July 1, 2003, you will be considered multi-heritage when you terminate employment and you will be able to choose the heritage subsidy that best suits your situation upon retirement. Transfers on or after July 1, 2003 will not be counted for determination of Heritage eligibility.

Years of Service

For the Northrop Grumman Retiree Medical Plan, your years of service are used to determine eligibility for retiree medical benefits and a heritage subsidy only. It does not mean you have earned a non-forfeitable right to any particular benefit.

For purposes of the heritage company group eligibility provisions, your years of service will be determined in accordance with the Northrop Grumman pension plan in which you are a participant at the time of retirement.

The remainder of this *Years of Service* section describes how years of service are calculated for all other purposes under the Plan. You earn years of service based on employment with the Company. If you need help determining if your business unit is part of the Company, call the NGBC.

You earn a year of service for each calendar year in which you complete 1,000 or more hours for which you are paid (or are entitled to be paid) by the Company (including paid sick leave, vacation time, jury duty and, in some cases, certain qualified leaves of absence, such as military leaves, and medical leaves up to two years from the beginning of the leave).

For example, let's assume:

- Date of hire: September 1, 2001
- Hours of service as of December 31, 2001: 600
- Hours of service in 2002: 2,100

In this example, the participant does not have 1,000 or more hours of service in 2001, so he or she does not earn a year of service for that year. In 2002, the participant has 2,100 hours of service, so he or she does earn one year of service for 2002.

Breaks in Service

A break in service is a period during which you complete fewer than 501 hours of service in a calendar year.

If you are not 100% vested under the Northrop Grumman pension plan in which you are a participant (or not eligible for a Northrop Grumman pension plan), and you experience five consecutive break-in-service years, any years of service you have accumulated prior to the five

year break in service period will not count for purposes of eligibility and, if applicable, heritage subsidy under the Northrop Grumman Retiree Medical Plan.

If, however, you experience a break in service after you are 100% vested under the Northrop Grumman pension plan in which you are a participant, the years of service you have accumulated before the break in service will still count for purposes of eligibility and/or heritage subsidy, if applicable, under the Northrop Grumman Retiree Medical Plan.

Rehire Rules

If you are eligible for a heritage company subsidy under the Northrop Grumman Retiree Medical Plan (as described above) and your active employment terminates and you are later rehired, your eligibility for your heritage subsidy under the Northrop Grumman Retiree Medical Plan upon your return will be determined by your years of service under the Northrop Grumman pension plan in which you are a participant.

If you are rehired, you will retain eligibility for your heritage company subsidy under the Northrop Grumman Retiree Medical Plan if you were 100% vested in your pension benefit of your heritage company when you terminated employment initially. If you were not vested in your pension benefit when you terminated employment, the break-in-service rules apply when you are rehired. See “*Breaks in Service*” above for details. You will still need to meet the age and service requirements described above to be eligible for retiree medical coverage.

If You Transfer

Except as provided above in the heritage company rules, if you transfer to another part of the Company and you are eligible for a heritage company subsidy, you will retain your eligibility for subsidy. If your transfers allow you to be eligible for more than one heritage company subsidy (as described above), you may choose the heritage subsidy that best suits your situation upon employment termination. Your heritage subsidy decision is irrevocable. You may not change to another heritage subsidy in the future.

Discontinued Operations

If you terminate employment at age 55 or older with at least ten years of service, or at age 65 or older with at least five years of service, from an entity classified by Northrop Grumman as a discontinued operation for purposes of the Retiree Medical Plan, you will be eligible to participate in the Retiree Medical Plan by paying the full cost of coverage. However, if you terminate from active employment on or after your Medicare Eligibility Date (see the *Northrop Grumman Retiree Medical Plan for Retirees Age 65 and Older* section for a description of the Medicare Eligibility Date) and you do not meet the eligibility provisions of a heritage company group that entitles you to medical and prescription drug coverage under the Plan or a Company credit to the RHRA, you will not be eligible to participate in the Plan (unless you are eligible for Life Insurance, as described later). This is true even if you meet the age and service requirements set forth above. If you meet the age and service requirements set forth above and you have a spouse/domestic partner who has not reached his/her Medicare Eligibility Date or a

dependent child under age 26, they will be eligible for coverage under the Plan. See the *Dependent Eligibility* section for details.

You are not eligible for the benefits under the Northrop Grumman Retiree Medical Plan if any of the following apply:

- You are covered as a dependent of an active Northrop Grumman employee. (You may join the plan upon termination of coverage in the active plan.)
- You are a retiree who dropped coverage prior to January 1, 2005
- You terminated employment prior to January 1, 2005, and did not elect retiree medical at the time of termination
- You did not meet the age and service requirements when you terminated
- You are rehired by Northrop Grumman as an active employee. You may reenroll in the Northrop Grumman Retiree Medical Plan in the same heritage under which you originally enrolled if you terminate employment in the future.
- You were identified as an “HII Employee” in the Employer Matters Agreement, unless you meet the age and service requirements of this Plan, disregarding any years of service with Northrop Grumman Corporation prior to March 31, 2011 and any years of service with Huntington Ingalls Industries, Inc.³ (In other words, if you were identified as an HII Employee and return to work at Northrop Grumman Corporation, you will, upon your return to Northrop Grumman, start with zero years of service for purposes of determining eligibility under this Plan.).

Dependent Eligibility

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

Unless otherwise noted, dependents may be covered only if the retiree is also covered. If the retiree drops coverage, then coverage for the spouse and/or dependents is also terminated.

By enrolling any person in the Retiree Medical 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

³ Note: Special rules apply for people identified as HII Employees in the Employee Matters Agreement but who returned to work with Northrop Grumman Corporation on or before May 15, 2011.

- 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 Retiree Medical 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 timely provide required proof of eligibility constitutes fraud or an intentional misrepresentation of material fact and is prohibited by the Retiree Medical Plan
- If a person does not meet the eligibility requirements at the time of enrollment, Northrop Grumman will cancel that person's coverage as of the date of enrollment
- If a person ceases to meet the eligibility requirements at a time after enrollment, Northrop Grumman will cancel that person's coverage as of the date that person ceased to meet the eligibility requirements
- If you refuse or fail to provide timely 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 timely notify Northrop Grumman immediately if a person ceases to meet the eligibility requirements, or if you refuse or fail to 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 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
 - The spouse of an eligible retiree at the time of the employee's termination or retirement. The spouse does not need to have been covered under the active medical plan in order to be eligible for participation in the Retiree Medical Plan.
 - 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 your coverage must be provided. 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.

- A spouse acquired after the employee’s termination or retirement may be added at full, unsubsidized cost. (Exception: A new pre-Medicare spouse may be added at subsidized rates for individuals who qualify for the Former Westinghouse heritage.)

■ **Your Domestic Partner**

- The same sex or opposite sex domestic partner of an eligible retiree at the time of the employee’s termination or retirement and who is not the eligible retiree’s legal spouse. The domestic partner does not need to have been covered under the active medical plan in order to be eligible for participation in the Retiree Medical Plan. If you certify that your domestic partner was your domestic partner (as defined below) at the time of your retirement or termination of employment, he or she may be added at the heritage spouse rate; otherwise, he or she will be added at full cost. 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
- 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. If you believe that your Domestic Partner qualifies for tax-free benefits, please contact the NGBC. You will be required to fill out an affidavit as to the tax-qualified status of your Domestic Partner. In addition, the value of the benefit may be considered additional taxable income. 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.

* **PLEASE NOTE:** Unless you are eligible for post-65 medical and prescription drug coverage under the Plan based on your heritage, medical and prescription drug coverage under the Plan for your spouse or domestic partner will terminate on their Medicare Eligibility Date (see the *Northrop Grumman Retiree Medical Plan for Retirees Age 65 and Older* section for a description of the Medicare Eligibility Date). If your spouse or domestic partner is not eligible for Medicare (e.g., not enough quarters of work), then your spouse or domestic partner may remain in medical and prescription drug coverage under the Plan until your Medicare Eligibility Date.

Other Eligible Dependents

The following people are eligible for health coverage as your dependents if they meet the requirements stated. For information on when their coverage ends, see the chart titled “When Coverage Ends.”

■ 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 adopted 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 while at least age 19 but under 25 and while a full-time student, and
 - 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 before January 1, 2011,
 - The child became disabled before the age of 19, and
 - 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 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, 2011,
 - Your brother or sister became disabled before age 19,
 - You claim your brother or sister sibling as a dependent on your federal tax return, and
 - You are 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 before January 1, 2011,
 - Your brother or sister became disabled while at least age 19 but under 25 and while a full-time student,
 - 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 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, 2011,
 - Your brother or sister became disabled while under 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 age 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, 2011,
 - Your grandchild became disabled before age 19,
 - 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 before January 1, 2011

- Your grandchild became disabled while at least age 19 but under 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:
 - The grandchild became disabled on or after January 1, 2011,
 - The grandchild became disabled while under 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 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

For any retiree covered under the Retiree Medical Plan, ineligible dependents include, but are not limited to:

- The spouse or dependent children who are covered under the Northrop Grumman Health Plan. These dependents may be moved to the Retiree Medical Plan upon termination of coverage under the Northrop Grumman Health Plan.
- The divorced or legally separated spouse of a retiree, even if the retiree is required to provide coverage (COBRA coverage may be available on a temporary basis)
- The former domestic partner of a retiree, once the partnership has been dissolved (COBRA-like coverage may be available on a temporary basis)
- Dependent children of a retiree that exceed the maximum age (COBRA coverage may be available on a temporary basis)
- Dependent children who are employed by Northrop Grumman and eligible for a Northrop Grumman medical plan option as an active employee.

Split Coverage

You and your eligible family members must be covered under the same medical plan option in the Northrop Grumman Retiree Medical Plan. However, if you are eligible for Medicare and your eligible dependent(s) are not, or if your eligible dependent is eligible for Medicare and you are not, you do not need to be covered under the same medical plan option — you can choose different plan options even if they are administered by different carriers. (Note that unless you qualify for post-65 medical and prescription drug coverage under the Plan based on your heritage, your medical and prescription drug coverage under the Plan will terminate on the day before your Medicare Eligibility Date.) For example, if you are eligible for Medicare based on disability and you choose coverage under the Anthem Medigap-type plan option, your covered family members not eligible for Medicare can choose any pre-Medicare plan option available to them under the Northrop Grumman Retiree Medical Plan.

Note: In the Northrop Grumman Retiree Medical Plan, dependents generally may not enroll in coverage unless the retiree is also enrolled. If you reach your Medicare Eligibility Date and are no longer eligible for medical and prescription drug coverage under the Northrop Grumman

Retiree Medical Plan, your spouse/domestic partner may continue their medical and prescription drug coverage until his/her Medicare Eligibility Date.

Layoff Provision

Employees who are laid off on or after January 1, 2005, and meet the following requirements, are eligible for coverage under the Northrop Grumman Retiree Medical Plan:

- Employees who were laid off at age 53 or older with a minimum of 10 years of service. Benefits may not start earlier than age 55, but the participant may defer coverage.
- Employees who were laid off before age 53 and the sum of whose age and years of service is 75 or more. Benefits may not start earlier than age 55, but the participant may defer coverage.

Employees may be eligible for subsidized coverage on the same basis as retirees from the same heritage group, if eligible.

Disability Provision

Employees who meet the following requirements are eligible for benefits under the Northrop Grumman Retiree Medical Plan:

- Have a disability that began on or after July 1, 2003, and for which the long-term disability (LTD) carrier approved the payment of LTD benefits. (The applicable disability beginning date for the heritage TRW group is January 1, 2005; for the heritage Newport News group, the beginning date is January 1, 2004.)
- Have a minimum of 10 years of service regardless of age.

Employees may be eligible for subsidized coverage on the same basis as retirees from the same heritage group, if eligible.

Retirees are eligible to continue participation in the Retiree Medical Plan as long as their disability is approved by the LTD carrier (subject to the rule that medical and prescription drug coverage will end on the day before the retiree's Medicare Eligibility Date). If the individual is no longer considered to be disabled, coverage under the Retiree Medical Plan will end. If the retiree ceases to be eligible for LTD benefits due to a maximum age limit for LTD benefits, he or she may continue coverage as a retiree under the terms applicable to his or her heritage group.

If You and Your Spouse Both Are Retired from Northrop Grumman

If you and your spouse both are retired from Northrop Grumman and both of you qualify for coverage under the Retiree Medical Plan, you have two options for your medical coverage:

- Your spouse may be covered as your dependent under the Northrop Grumman Retiree Medical Plan, or vice versa, or
- You can be covered under your Retiree Medical Plan option and your spouse can be covered under his or her own Retiree Medical Plan option.

Questions about Eligibility

If you have questions about eligibility for coverage under the Northrop Grumman Retiree Medical Plan, please call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

Address Changes

Your address is used in the administration of the Plan for purposes of determining 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 NGBC immediately to report the change.

MEDICAL

HOW THE NORTHROP GRUMMAN RETIREE MEDICAL PLAN WORKS

If You Are Under Age 65

Retirees and their eligible dependents under age 65 are eligible for medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan. The retiree medical plan options vary by geographic location and Medicare eligibility. The sections below describe medical and prescription drug coverage available through the Northrop Grumman Retiree Medical Plan. If you have questions about these plan options, please call the Northrop Grumman Benefits Center at 1-800-894-4194.

If You Are Age 65 or Older

Retirees and their eligible dependents who reach their Medicare Eligibility Date are not eligible for medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan⁴. Your Medicare Eligibility Date is the first day of the month in which you reach age 65. So, for example, if your 65th birthday is on June 15th, you can enroll in Medicare effective June 1st and so your last day of medical and prescription drug coverage under the Plan would be May 31st. Medicare considers you to turn age 65 on the day *before* your 65th birthday, so if your birthday is on the first day of a month, Medicare will consider you to turn age 65 on the last day of the preceding month, which impacts your Medicare Eligibility Date. For example, if your 65th birthday is on June 1st, Medicare will consider you to reach age 65 on May 31st and you can enroll in Medicare effective May 1st; medical and prescription drug coverage under the Plan would end on April 30th.

Instead of providing you with continued medical and prescription drug coverage under the Plan, Northrop Grumman has partnered with OneExchange, a private insurance exchange, to help its retirees understand and enroll in individual Medicare supplemental insurance. For more information about their services, please call OneExchange at 1-855-832-0976.

If you are eligible for subsidized coverage under the Northrop Grumman Retiree Medical Plan based on your heritage company status, you may be eligible for the Company-paid Retiree Health Reimbursement Account Arrangement (RHRA). In some cases, your spouse may also be eligible for a Company-paid credit to your RHRA. The RHRA reimburses you for some or all of the cost of your and/or your spouse or domestic partner's individual Medicare supplemental and prescription drug premiums, as well as dental, vision and Medicare Part B premiums. For more information about the RHRA, please refer to the "Retiree Health Reimbursement Arrangement" benefit description or call OneExchange at 1-855-832-0976.

⁴ Certain retirees based on their heritage company status may continue to be eligible for medical and prescription coverage under the Northrop Grumman Retiree Medical Plan. Please refer to the "Eligibility and Cost of Coverage" section.

Cost for Coverage in the Northrop Grumman Retiree Medical Plan

Each plan option has a cost associated with it. The cost for each benefit is based on the following:

- The option you choose. Generally, the higher the level of benefits you choose, the higher the cost.
- Whether you or your spouse is Medicare-eligible
- Your coverage category:
 - You only
 - You + spouse (or domestic partner).
 - You + child(ren)
 - You + family (retiree, child(ren), and spouse/domestic partner)

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

As noted above, unless you qualify for a Northrop Grumman contribution toward the cost of coverage due to your classification as a member of a heritage group with a subsidized benefit, you will be required to pay 100% of the cost for Retiree Medical Plan coverage.

When Coverage Ends

Medical and prescription drug coverage in the Northrop Grumman Retiree Medical Plan ends on the date indicated for you and/or your covered dependents on the occurrence of any of the following events:

Event	Termination Date
Retiree or spouse/domestic partner reaches Medicare Eligibility Date*	■ Coverage for the retiree or spouse/domestic partner ends the day before their Medicare Eligibility Date. Coverage for other eligible dependents may continue.
Death of the retiree	■ Coverage for surviving dependents ends at the end of the month of the retiree's death (Coverage for dependents may continue as described in the "Survivor Options" section or the "COBRA" section)
Dependent Child Reaches Age 26	■ Coverage for the dependent terminates as of the end of the month in which the dependent turns 26 (coverage may be continued as described in the "COBRA section)
Dependent Child covered pursuant to a QMSCO is no longer required to be covered by the QMSCO	■ Coverage for the dependent terminates on the date on which coverage is no longer required by the QMSCO (the

Event	Termination Date
	child may be eligible for coverage under another eligibility provision)
Your dependent child covered beyond the limiting age as a result of a disability marries or ceases to be considered disabled by the Plan	<ul style="list-style-type: none"> ■ On the date of the marriage or the date the dependent ceases to be considered by the Plan to be disabled (coverage may be continued as described in the “COBRA” section)
Retiree requests cancellation of coverage under the plan	<ul style="list-style-type: none"> ■ Coverage for the retiree and all covered dependents ends on the first of the month following the request
Retiree fails to pay the required premium	<ul style="list-style-type: none"> ■ Coverage for the retiree and all covered dependents ends if you fail to make a timely payment. Payments are due on the first day of each month, and, if your payment is not received within 30 days after the first day of the month (the “grace period”), coverage will be suspended 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 30, your coverage will be suspended retroactive to April 30. If this occurs, you will be responsible for any claims incurred after the date on which your coverage ends. You will have the opportunity to re-enroll in the Northrop Grumman Retiree Medical Plan during the next Retiree Annual Enrollment period or if you experience a qualified life event. Re-enrollment will not result in the payment of claims incurred between the end of the period for which payment was made and the date re-enrollment is effective.
Retiree returns to active employment at Northrop Grumman	<ul style="list-style-type: none"> ■ Coverage for the retiree and all covered dependents ends under the Northrop Grumman Retiree Medical Plan as of the day the retiree becomes an active employee at Northrop Grumman
Retiree fails to submit required documentation requested as a result of a dependent audit	<ul style="list-style-type: none"> ■ Coverage for the dependent will end on the date specified in the audit notice. ■ Coverage for the dependent may be reinstated at the next Retiree Annual Enrollment or the date the required documentation is provided to the Northrop Grumman Benefits Center
Your spouse/domestic partner loses eligibility due to a divorce or the end of a domestic partnership	<ul style="list-style-type: none"> ■ On the effective date of the divorce or end of the domestic partnership

**Does not apply to retirees in certain heritage company classifications.*

Note: *Certain states may require continuation of coverage for dependent children beyond the dates specified above. The special continuation of coverage rules apply only if you are covered under a coverage option that provides benefits through an insurance contract. Please contact the Northrop Grumman Benefits Center (NGBC) for additional information.*

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.*

Note: *In the event that your coverage ends in the middle of the month, you will not receive a refund for the amount you have paid for the partial coverage (except if you return to active benefit-eligible service with Northrop Grumman).*

ENROLLING IN YOUR RETIREE MEDICAL PLAN OPTION

When You Can Enroll in the Northrop Grumman Retiree Medical Plan

You may select or change your medical plan option:

- When you terminate employment
- During the Retiree Annual Enrollment
- First of the month following a request to change options through the Northrop Grumman Benefits Center (NGBC). However, you may not drop coverage during the Plan year and then elect coverage later that same Plan year without a qualified life event
- If you experience a qualified life event.

Note: *The Premium plan option and certain HMOs have restrictions on when you can enroll. Please contact the Northrop Grumman Benefits Center (NGBC) for additional information. Participants in Medicare Advantage HMOs may make mid-year changes in accordance with Centers for Medicare & Medicaid Services (CMS) regulations.*

Eligibility Date

The eligibility date is the earliest date that a retiree (or surviving dependent) is eligible to participate in the Retiree Medical Plan. Depending on the reason for separation from active service, the eligibility date will vary as described in the following chart. In most cases, the individual has the option to defer coverage to a later date. If coverage is deferred, the individual can participate in the plan on the first of the month following his or her election.

Type of Termination	Eligibility Date
Retirement, Quit, Discharge	■ The first of the month coincident with or next following the employee's date of termination provided the employee meets the qualifications on the date of separation from active service.
Total and permanent disability (see requirements in the "Disability Provision" section)	■ The first of the month following two years of disability.
Employee no longer covered as a dependent in the active plan	■ The first of the month following the date he or she is no longer covered as a dependent in the active plan.
Layoff at age 53 or older with 10 years of service	■ No earlier than the first of the month following the employee's 55th birthday. (Coverage may be deferred past age 55.)

Type of Termination	Eligibility Date
Layoff prior to age 53 with 75 points	<ul style="list-style-type: none"> ■ No earlier than the first of the month following the employee's 55th birthday. (Coverage may be deferred past age 55.)
Death of a retiree (survived by a dependent)	<ul style="list-style-type: none"> ■ Coverage for the covered dependent(s) continues uninterrupted as long as payments continue to be made as described in the "Survivor Options" section of the "COBRA" section.
Death of an active employee who was eligible for retirement at the time of death (survived by a dependent)	<ul style="list-style-type: none"> ■ Coverage for covered dependent(s) generally continues for the end of the month plus one year after the death of the employee through the Northrop Grumman Health Plan. Then, the covered dependent(s) becomes eligible for coverage under the Retiree Medical Plan the first of the month following the end of any available extension of coverage under the active plan.
Deferred coverage at employment termination	<ul style="list-style-type: none"> ■ The first of the month following an election to participate.
Suspended Coverage After January 1, 2005	<ul style="list-style-type: none"> ■ During any Annual Enrollment with coverage effective January 1. ■ The first of the month coincident or next following a qualified life event.

If You Defer or Suspend Medical Coverage

When you initially become eligible for coverage under the Northrop Grumman Retiree Medical Plan, you may defer coverage until a later date. For example, if you have coverage under your spouse's plan, you can defer your coverage under the Northrop Grumman Retiree Medical Plan and enroll at a later date if you lose coverage under your spouse's plan.

After you enroll in the Northrop Grumman Retiree Medical Plan, you may suspend coverage and reenroll. If you suspend coverage, you will have the opportunity to re-enroll:

- During the annual enrollment period
- If you experience a qualified life event.

When you enroll for coverage, you do not need to provide proof of coverage for the time period that you were not covered under the Northrop Grumman Retiree Medical Plan.

If you defer or suspend coverage and you die before you enroll or reenroll, your spouse and/or dependents will not be eligible to enroll in coverage.

The above rules also apply to surviving spouses and dependents.

The deferral and suspension rules described in this section do not apply to retirees who terminated employment prior to January 1, 2005. Retirees who did not enroll or who waived retiree medical coverage prior to January 1, 2005, are not allowed to reenroll in the plan.

When You Can Enroll Your Dependents

You can add *existing* eligible dependents to your retiree medical plan when you first enroll in the plan or during the annual enrollment period. You can enroll your existing dependents during the plan year only when you experience a qualified life event such as marriage or loss of other coverage, that allows enrollment in the plan. The change must be reported within 31 days of the event or you will have to wait until the next annual enrollment period to add your dependents.

In addition, if you have a *new* dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependent, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Coverage for new dependents as a result of birth, adoption, or placement for adoption will be effective on the date of the event.

Under the Northrop Grumman Retiree Medical Plan, if you do not enroll your eligible dependents within 31 days, you will not be able to enroll them until the next annual enrollment period or until you experience a qualified life event.

To enroll your dependent, you must complete all required enrollment steps. If your dependent is age 45 or older or eligible for Medicare, as a condition of eligibility and enrollment, you must provide his or her Social Security Number.

Initial Enrollment

If you want to participate in the Retiree Medical Plan, you must make an election by calling the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. You will receive the materials necessary to make your election, including an explanation of the medical plan options available to you, your cost for each option, and enrollment instructions.

Generally, your benefit elections remain in effect for the remainder of the plan year. However, you may change your medical plan option as permitted under the election change rules described in these sections. If you timely enroll a child born to you or your spouse, coverage will become effective on his or her date of birth, even if the child is in a hospital. (You must complete all steps required to enroll the child within 31 days after the date of birth. Simply calling the NGBC or adding the child to your account will not complete the child's enrollment)

Enrolling During Annual Enrollment

Each year you have an opportunity to reassess your medical plan choices and make changes during the annual enrollment period. Your benefit elections are effective for the following plan year — from January 1 through the following December 31. Before the annual enrollment begins, Northrop Grumman sends you a packet with information about your medical plan options and their costs and instructions on how you can enroll.

Generally, if you do not make changes, your current coverage (if available) will carry over to the following plan year, at the new year's rates. In the event that your current coverage is not available and you fail to elect an available option, your coverage will default to the Premium plan option. If you are Medicare-eligible and in a heritage group that permits you to remain covered under the Plan's medical coverage options (rather than having coverage terminate or change to the RHRA), your coverage will default to, the Anthem Medigap-type option with prescription drug coverage.

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 must select new health care benefits based on your new home ZIP code. (For example, if you are in an HMO, and you move to an area where that HMO is not offered, you must select an option in your home ZIP code.) Call the Northrop Grumman Benefits Center (NGBC) and provide a benefits service representative with your new address, to ensure coverage will be in effect at the time of your move. You will be advised whether your current medical option is still available and offered the opportunity to make a new election.

Qualified Life Events

A qualified life event is a change in your personal situation that results in the gain or loss of eligibility for a Northrop Grumman Retiree Medical Plan option, your spouse's employer's plan, or your dependent's employer's plan. Qualified life events include the following:

- Change in marital status, including marriage, divorce, annulment, and death of spouse
- Change in number of dependents, including birth, adoption, placement for adoption, and death of dependent
- Change in employment status (termination or commencement of employment) for your spouse or your dependent
- Change in work schedule, including a reduction or increase in hours of employment for 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 for you, or change in residence or worksite for your spouse or your dependent, that results in a loss of coverage

- 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).

The benefit change you make must be on account of and consistent with the qualified life event. You have 31 days from the date of the qualified life event to make your benefit changes through *Fidelity NetBenefits*® at www.netbenefits.com/northropgrumman or by calling the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. If you do not make your changes within 31 days, you must wait until the next annual enrollment period, unless a dependent is no longer eligible. In that case, coverage for the dependent will be discontinued retroactive to the date eligibility was lost, regardless of when the loss of eligibility was reported. For events reported after 31 days, no premiums will be refunded.

Mid-Year Change in Medical Option

You may make mid-year changes to a medical option, and the change will be effective the first of the month following the request to make a change. No retroactive changes are permitted. If you are covered in the Premium plan option, you may cancel your coverage during the plan year, but you may not re-enroll in a different plan option such as an HMO until the following plan year. You may not add dependents to coverage outside of annual enrollment, unless you experience a qualified life event. To make a mid-year change, call the NGBC at 1-800-894-4194.

OVERVIEW OF MEDICAL OPTIONS

The medical plan options available to you and your family depend on your Medicare status and where you live.

	Not Medicare-eligible	Medicare-eligible
Available nationwide	<ul style="list-style-type: none"> ■ Premium plan ■ Value plan 	<ul style="list-style-type: none"> ■ Premium plan ■ Medigap-type plan with or without prescription drug coverage
Available in certain geographic locations based on ZIP code	<ul style="list-style-type: none"> ■ Regional HMOs 	<ul style="list-style-type: none"> ■ Medicare HMOs

The options differ by level of coverage, your contribution for coverage, and the way you receive medical care. If you or a covered dependent is eligible for Medicare that individual must enroll in Medicare Parts A and B immediately upon eligibility or your termination of active employment. If you do not enroll immediately, you will be responsible for a larger portion of the Medicare-eligible participant's medical expenses and some carriers, such as Anthem, may not be able to pay claims for benefits.

Note: If you are under 65 and Medicare eligible due to a disability or End-Stage Renal Disease (ESRD), call the Northrop Grumman Benefits Center to review your plan options.

You can also choose no medical coverage when you become eligible for the Northrop Grumman Retiree Medical Plan and then enroll at a later date. When you enroll for the first time, you will not need to provide proof of coverage for the time you were not covered under the plan. This rule only applies to individuals who terminate employment on or after January 1, 2005. See *"If You Defer or Suspend Medical Coverage"* for more details.

Enrolling in a Medicare Prescription Drug Plan

Northrop Grumman requires enrollment in Medicare Parts A and B when you become eligible for Medicare. However, you do not need to enroll in the Medicare prescription drug program (Medicare Part D or Medicare Rx) to receive prescription drug coverage under the Northrop Grumman Retiree Medical Plan. If you do enroll in a separate Medicare D plan, your prescription coverage under the Northrop Grumman Retiree Medical Plan will be terminated.

The prescription drug coverage under the Northrop Grumman Retiree Medical Plan is considered "creditable coverage" for purposes of Medicare Rx (Medicare Part D), and as long as you are continuously enrolled in creditable prescription drug coverage, you will not pay a penalty if you later decide to drop coverage under the Northrop Grumman Retiree Medical Plan and enroll in a Medicare prescription drug plan.

Note: *If you are enrolled in a Medicare Advantage HMO, the prescription coverage under the HMO is considered to be Medicare Part D coverage. Under the Medicare rules, if you enroll in a separate Medicare prescription drug program, you will be disenrolled from your Medicare Advantage HMO.*

Your Contribution for Coverage

If you enroll in a medical plan option, you contribute to the cost for coverage with after-tax dollars. Your contributions will be deducted from your pension checks, if you so elect, or you will be directly billed by the Northrop Grumman Benefits Center for your share of the cost for coverage.

The amount of your contribution depends on your Northrop Grumman heritage, your Medicare status, the plan you choose, and whom you choose to cover (your “coverage category”). For cost information, please call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

Premium Plan Option

The Premium plan option is offered nationwide. It is considered to be a consumer-driven health plans that puts you in charge of how your health care dollars are spent. Here is an overview of how the Premium plan option works:

- Preventive Care is 100% covered if you use an in-network provider. 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 and prescription drugs before the plan begins to pay
- Each benefit plan year, Northrop Grumman credits a specified dollar amount to a Health Reimbursement Account (HRA)* for you and your enrolled dependents. The HRA may be used by any or all covered dependents.
- HRA funds pay for covered services such as doctor visits and prescription drugs and help satisfy all or part of the deductible. The HRA is used first and automatically. You do not need to do anything for your HRA funds to be utilized. As long as there are enough funds in your account, you pay nothing for covered services or prescription drugs — no deductible, coinsurance, or copays.
- If your deductible is greater than your HRA balance, the remaining deductible is your responsibility
- 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. (HRA funds, if available, are used to cover your coinsurance.)
- After you reach the annual out-of-pocket maximum, the plan pays 100% of your eligible expenses for the remainder of the plan year
- Unused funds credited to your HRA roll over to the next plan year, and can be used to reduce your future out-of-pocket medical costs

- If you are Medicare-eligible, the Premium plan works a bit differently. The Premium plan generally covers your prescription drug costs and any other medically necessary expenses not covered by Medicare.

Prescription drugs are covered the same way as any other medical expenses. There is no cost while you have funds available in your HRA. Once the HRA is exhausted, prescription drug costs are subject to the deductible. There is no separate deductible or out-of-pocket maximum (once you reach your annual maximum, prescriptions are covered at 100% in-network).

For additional information about the Premium plan, refer to the “Premium Plan” portion of the SPD.

** The HRA is prorated on a quarterly basis, and adjusted depending on actual date of enrollment.*

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.

For information about Health Savings Accounts, consult IRS Publication 969.

For additional information about the Value plan medical plan option, refer to the Value plan section of the “Medical Plan Options” portion of the SPD.

Health Maintenance Organization (HMO) Medical Plan Options

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

HMOs provide care through a network of PCPs and specialists. In most HMO plan options, you must choose a network PCP to provide or coordinate all of your care (including specialist referrals). A PCP may be a family practitioner, general practitioner, internist, or pediatrician. All

network PCPs meet the HMO's qualification standards and are subject to periodic review. Care that is not coordinated by your PCP is not covered by the HMO.

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

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.

Domestic partner coverage may not be offered by all HMOs in all states.

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 plan member materials and on your medical plan ID card.

Medigap-type Plan Option (Medicare-Eligible)*

If you are Medicare-eligible, regardless of your age, one of your medical plan choices is the Medigap-type plan option, which helps you pay some of the medical costs that Medicare Parts A and B do not cover, such as the coinsurance for physicians' services and hospitalization.

***Note:** The Medigap-type plan option covers Medicare-approved amounts. If your provider does not accept Medicare assignment, you may have to pay an extra fee charged by the provider.*

IMPORTANT: It is your (or your dependent's) responsibility to enroll in Medicare Parts A and B on a timely basis so that your (and/or their) Part A and Part B coverage is effective as of the earliest date that it could be effective under Medicare's eligibility rules, which is generally the first day of the month during which you turn age 65 (for this purpose, you are considered to turn age 65 on the day before your 65th birthday). For example, if you will turn age 65 on September 22, you must start the Medicare enrollment process early enough so that your Medicare Part A and B coverage is effective September 1. You may need to begin the enrollment process up to three months before the month in which you turn age 65 or otherwise become eligible in order for your coverage to be effective on the first day of that month. You may also be eligible for Medicare if you become disabled before turning age 65 or you have End-Stage Renal Disease or ALS. **The Northrop Grumman Medigap-type option pays claims as if you are enrolled in Medicare Parts A and B regardless of actual enrollment status.** You should contact Medicare at 1-800-633-4227 (TTY users: 1-877-486-2048) or visit www.medicare.gov for details regarding Medicare eligibility and enrollment.

You may elect the Medigap-type option with or without prescription drug coverage. The prescription drug benefit is administered by CVS/caremark®. Note: You do not need to enroll in Medicare Rx (Medicare Part D) to be eligible to enroll in the prescription drug benefit. However, if you enroll in Medicare Rx (Medicare Part D), you will not be able to also enroll in the prescription drug coverage offered with the Medigap-type option.

For a summary of the Medigap-type benefits provided by Northrop Grumman, refer to the “Medigap-type Medical Plan Option” SPD or call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. For information on Medicare and Medigap plans in general, go to www.medicare.gov.

**This option is available to participants under age 65 and eligible for Medicare due to disability or ESRD. It is also available to certain retirees age 65 and older based on their heritage company classification. Generally, medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan ends when the participant becomes Medicare eligible due to reaching age 65.*

Medicare Advantage HMO Plan Option (Medicare-Eligible)*

The Medicare Advantage HMO plan option is offered to Medicare-eligible retirees (regardless of age) in some geographic locations based on ZIP code. This plan option offers prescription drug coverage and may offer additional benefits to Medicare Parts A and B, such as vision coverage. Generally, if you enroll in this option, you must select a PCP, who will be responsible for providing your general care and referring you to specialists, as needed. All care must be provided by the HMO network providers, except in an emergency.

If you choose a Medicare Advantage HMO in which you are not currently enrolled, you must assign your Medicare coverage to the plan by submitting a carrier-specific Medicare Advantage enrollment form to the HMO carrier for processing. While you are waiting for your Medicare enrollment form to be approved, you will have temporary “default” coverage under the plan. As soon as your Medicare enrollment form is approved, you will be enrolled in your Medicare Advantage HMO effective the first day of the following month. You must be enrolled in Medicare Parts A and B in order to participate in a Medicare Advantage HMO.

Note: *Under Medicare rules, if you are enrolled in a Medicare Advantage HMO, and choose to enroll in a separate Medicare prescription drug program (also known as the Medicare Part D or Medicare Rx plan), you will be disenrolled from your Medicare Advantage HMO.*

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

If you require medical care before your Medicare enrollment form is approved, please call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 as soon as possible.

**This option is available to participants under age 65 and eligible for Medicare due to disability or ESRD. It is also available to certain retirees age 65 and older based on their heritage company classification. Generally, medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan ends when the participant becomes Medicare eligible due to reaching age 65.*

Medicare Supplement HMOs*

If you are eligible for Medicare, one of the medical plan options available to you may be a Medicare Supplement HMO. Medicare Supplement HMOs are offered in limited locations under the Northrop Grumman Retiree Medical Plan. Availability is based on your home ZIP code.

Coverage for this plan option is provided through Medicare-approved health care facilities, and includes Medicare-approved prescription drug coverage through the HMO.

All Medicare-approved services and supplies are covered under this plan option, as well as some additional services and supplies not approved by Medicare. For services and supplies covered under this plan option that are not covered by Medicare, you are responsible for a per-visit copayment; then the plan generally pays 100% of eligible expenses.

You must select a PCP to coordinate your care and refer you to specialists when necessary. Additionally, certain covered services require preauthorization from the plan. When you use a PCP to coordinate your care, and you get preauthorization when required, you do not have to pay Medicare deductibles and coinsurance charges. However, if you receive care from out-of-network providers, or you do not get the required preauthorization, you will be subject to Medicare deductibles and coinsurance.

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 Medicare Supplement HMO plan options and how they coordinate with Medicare, please contact the HMO directly.

**This option is available to participants under age 65 and eligible for Medicare due to disability or ESRD. It is also available to certain retirees age 65 and older based on their heritage company classification. Generally, medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan ends when the participant becomes Medicare eligible due to reaching age 65.*

TRICARE Supplement Plan

The TRICARE Supplement Plan is available through Selman & Company, an insurance broker. The TRICARE Supplement Plan is not considered part of the Northrop Grumman Retiree Medical Plan.

Northrop Grumman offers limited administrative and recordkeeping services support to our retirees who are eligible for TRICARE and want to enroll in a TRICARE supplement. Northrop Grumman will collect the premiums for this coverage and will forward payments to Selman & Company on behalf of retirees who choose to purchase the TRICARE Supplement. If you choose to purchase the TRICARE Supplement through Selman & Company, you pay the full cost of coverage. Northrop Grumman is not permitted to pay any part of the cost of coverage. 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 offered by Selman & Company.

A 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.

A 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 offered by Selman & Company, 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.

If You or Your Dependent Becomes Eligible for Medicare

As described previously, if you or your dependent become eligible for Medicare due to reaching age 65, your or your dependent's medical and prescription drug coverage under the Northrop Grumman Retiree Medical Plan will end as of your Medicare Eligibility Date unless you are in a heritage company classification that allows for continued coverage. You may contact OneExchange, a private insurance exchange, at 1-855-832-0976 to review what Medicare supplemental plans may be available to you.

The following information applies if you or your dependent becomes eligible for Medicare due to disability or ESRD or you are in a heritage company classification that allows for continued medical and prescription drug coverage after age 65.

If you or your dependent becomes eligible for Medicare, regardless of your age, your coverage will be affected as described below. As noted previously, the Medicare-eligible individual must enroll in Medicare Parts A and B on a timely basis so that Medicare Part A and B coverage is effective as of the earliest date that it could be effective under Medicare rules.

- **Premium plan:** If you are enrolled in the Premium plan, you may remain with the same plan. No election will be required. The Premium plan will begin coordinating benefit payments with Medicare.
- **Value plan:** If you are enrolled in the Value plan, you will be enrolled automatically in the Medigap-type option with prescription drug coverage, unless you make a different election.

- **HMO Options:** You may remain with the HMO if you reside in the service area covered by the Medicare HMO. If the HMO is not available and you do not make an election to move to another option, then you will be enrolled in the Anthem Medigap-type option with prescription drug coverage. The Medicare eligible participant must assign his or her Medicare benefits to the HMO or coverage will default to the Anthem Medigap-type option with prescription drug coverage.

BENEFIT MAXIMUMS

The Plan does not impose lifetime or annual dollar limits on benefits that the Plan Administrator has determined to be essential health benefits. A lifetime dollar limit is the total amount the Northrop Grumman self-insured medical plan options (Premium plan, Value plan, and Medigap-type options) pay 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, as well as annual limits (other than dollar limits) on certain services.

For information about maximums in the 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.

RETIREMENT HEALTH CARE SECURITY FUND

The Retirement Health Care Security Fund (RHCSF) is closed. Plan participants elected to receive a full refund of their account balance including interest or used their account balance to purchase protection for caps on Company contributions for retiree medical coverage. If the participant elected to receive or was provided a refund, he or she will be subject to the caps on the employer contribution for pre-Medicare coverage. If the participant elected to purchase protection, he or she will not be subject to caps on the employer contributions for pre-Medicare coverage.

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, the Plan is granted a lien on the proceeds of any such recovery and you are required to reimburse the plan for those expenses. When you accept benefit payments made on your behalf from a Northrop Grumman Retiree Medical Plan option, you agree to:

- Reimburse the plan for the full amount of benefit payments made on your behalf in connection with the injury or illness for which you make a recovery
- 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 term for the plan's right of recovery is 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 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. No "collateral source" rule, "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the plan's subrogation and reimbursement rights.

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.

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.

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

Remember, the benefits you receive from a Northrop Grumman Retiree 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 Retiree Medical Plan option and his or her employer's plan). When this happens, the Northrop Grumman Retiree 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 Retiree Medical Plan options consider the benefit payments you receive from another group plan. When the Northrop Grumman Retiree Medical Plan is the secondary payer, the Northrop Grumman Retiree 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 Retiree Medical Plan option.

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

Exception: Premium plan option. If you are eligible for Medicare, the Premium plan will apply a coordination of benefits provision to coordinate payments with Medicare. Under the coordination of benefits provision, the Premium plan considers the benefit payments you receive from Medicare. When the Northrop Grumman Retiree Medical Plan is the secondary payer, the Premium plan pays up to the maximum benefit that otherwise would be payable under the HRA plan. This means that the Premium plan payment will be equal to the total allowed charge minus the benefit paid by Medicare, subject to plan deductible and other plan design provisions.

This provision ensures that payments from Medicare, plus any payments from the Northrop Grumman Premium plan option, do not exceed the total allowed charge.

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 Retiree 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.

If you and/or your dependents have coverage under the Northrop Grumman Retiree Medical Plan and another medical plan, the order in which benefits are paid generally depends on whether the coverage is in an active plan or a retiree plan, and whether you are Medicare-eligible, as shown in the chart on the next page. If you are covered under another plan, you should contact the plan administrator for the coordination of benefit rules under the plan.

These are some general guidelines:

	Northrop Grumman's Retiree Medical Plan option pays...	Your spouse's active medical plan option pays...	Medicare pays...
If you are...			
Not Medicare eligible	Second	First	Not applicable
Medicare-eligible	Third	First	Second
If your spouse is...			
Not Medicare eligible	Second	First	Not applicable
Medicare-eligible	Third	First	Second
If your child is...			
Not Medicare eligible	Second	First	Not applicable
Medicare-eligible	Third	First	Second
	Northrop Grumman's Retiree Medical Plan option pays...	Your spouse's retiree medical plan option pays...	Medicare pays...
If you are...			
Not Medicare eligible	First	Second	Not applicable
Medicare-eligible	Second	Third	First
If your spouse is...			
Not Medicare eligible	Second	First	Not applicable
Medicare-eligible	Third	Second	First
If your child is...			

Not Medicare eligible	First, if your birthday falls earlier in the year than your spouse's birthday; second, if your birthday falls later in the year than your spouse's birthday	First, if your birthday falls later in the year than your spouse's birthday; second, if your birthday falls earlier in the year than your spouse's birthday	Not applicable
Medicare-eligible	Second, if your birthday falls earlier in the year than your spouse's birthday; third, if your birthday falls later in the year than your spouse's birthday	Second, if your birthday falls later in the year than your spouse's birthday; third, if your birthday falls earlier in the year than your spouse's birthday	First

If you are divorced, legally separated, or not married to your child's parent and your child is enrolled in both a Northrop Grumman Retiree 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 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.

The COB questionnaire requests information about any other insurance under which you, your spouse or your children 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 Retirees

While you were an active employee, if you or one of your dependents had coverage with Northrop Grumman and Medicare, the Northrop Grumman Health Plan paid primary to Medicare. That means the Northrop Grumman Health Plan paid benefits first, and then Medicare paid benefits second.

However, once you terminate employment, Medicare pays primary to any retiree medical plan under which you are covered. This means that Medicare pays its benefits first and Northrop Grumman's Retiree Medical Plan pays benefits second. The Northrop Grumman plans are designed to pay only that portion of a medical expense that would not be covered by either Medicare Part A or B, regardless of whether you (or a dependent) have actually enrolled in Medicare. Therefore, it is important to enroll in Medicare Parts A and B at the earliest opportunity. Some carriers, such as Anthem, are unable to settle claims for benefits unless you are enrolled in Medicare Parts A and B. As noted previously, you do not need to enroll in Medicare Part D prescription drug coverage in order to receive prescription drug coverage under the Northrop Grumman Retiree Medical Plan.

If you and/or your dependent do not enroll in Medicare Part B (Supplementary Medical Insurance) as soon as you become eligible or, if you enroll, you discontinue coverage and then subsequently reenroll, you may pay higher Medicare premiums. The higher premiums do not apply to you or your spouse for periods when you are an active employee enrolled in one of the Northrop Grumman health plan options. However, you and/or your dependent must enroll in Medicare Part B as soon as your active employment ends to avoid paying higher Medicare premiums. Remember, even if you do not enroll in Medicare Part B when you are first eligible, your Northrop Grumman Retiree Medical Plan option claims administrator will process your claims as if you had enrolled and will provide coverage based on your estimated Medicare payments. As a result, if you are not enrolled in Medicare Part B, you could be responsible for paying significant medical expenses that are not covered by the Plan or Medicare. Refer to the "*Medigap-Type Option*" section above or contact Medicare at 1-800-633-4227 (TTY users: 1-877-486-2048) for information about enrolling in Medicare.

End-Stage Renal Disease

If you (or a covered dependent) became eligible for Medicare coverage because of end-stage renal disease and you are not already entitled to Medicare due to age or disability at the time you become eligible for Medicare due to end-stage renal disease, your Northrop Grumman Retiree Medical Plan option pays primary for the first 30 months you are enrolled in (or eligible to enroll in) Medicare. Thereafter, Northrop Grumman pays secondary to Medicare. If you (or a covered dependent) become eligible for Medicare coverage due to end-stage renal disease at a time when you are already entitled to Medicare due to age or disability, Medicare will remain the primary payer.

For details on all aspects of your Medicare benefits,
go to the Medicare Web site at www.Medicare.gov or call 1-800-MEDICARE (1-
800-633-4227).

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 or Value plan option — rather than an HMO option — may be the best choice for you.

If you enroll in the Premium or Value plan option, your dependents can visit a physician in the PPO network 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.

In general, if you participate in an HMO, your dependent must use HMO 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.

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

Under federal law, the Northrop Grumman Retiree Medical 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 Northrop Grumman Retiree Medical 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 Northrop Grumman Retiree Medical 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.

LIFE INSURANCE

Company-sponsored retiree life insurance will not be offered for retirements with an effective date of January 1, 2007 or later. If you terminate employment on or after December 2, 2006, your retirement date will be on or after January 1, 2007 (all retirements must commence on the first of the month coincident with or following your date of termination from Northrop Grumman). Retiring employees will be given the option of converting their employee basic life insurance to an individual policy, and/or choosing conversion or portability for their optional life insurance, within 31 days of their employment termination date. Any retiree life insurance benefit that is in place prior to January 1, 2007 will continue as long as the required premiums are paid, but is subject to Northrop Grumman's right to amend or terminate coverage.

Certain heritage groups have grandfathered or negotiated retiree life insurance coverage that will be available to eligible employees who retire on or after January 1, 2007. The eligibility requirements, coverage amounts, and terms for heritage groups are described below.

ELIGIBILITY AND COVERAGE AMOUNTS

Certain heritage retirees who terminated employment before December 2, 2006, are eligible for life insurance coverage as shown below. Life insurance will not be offered to retirees on or after January 1, 2007, except as noted in this section.

Aerojet:

Group	Coverage Amount
<ul style="list-style-type: none"><li data-bbox="203 1186 760 1276">■ Employees who were employed by Aerojet and insured on December 1, 1975, and remain employed until retirement.<li data-bbox="203 1291 760 1413">■ Some bargaining unit retirees who retired prior to July 1, 1991, and whose bargaining agreement provided for retiree life insurance coverage.	<ul style="list-style-type: none"><li data-bbox="789 1186 1347 1339">■ Employees insured on December 1, 1975, who remain employed until retirement, will receive 25% of the amount in force on December 1, 1975, or \$3,000, whichever is greater.

Coverage will continue for current grandfathered retirees and active grandfathered employees who retire on or after January 1, 2007, and who meet the eligibility requirements.

Former Westinghouse Heritage Basic Life:

Group	Coverage Amount
<ul style="list-style-type: none"> ■ <i>Grandfathered:</i> employees and retirees who were continuously covered since December 31, 1991, and retire with 10 or more years of service 	<ul style="list-style-type: none"> ■ Coverage amount is \$50,000, offered at no cost to the retiree <p>Coverage amount remains in full until the retiree reaches age 62. At age 62, the amount will reduce 5% every month until 1/3 of the original benefit is reached (\$16,667).</p> <p>If on June 30, 2016 the coverage amount is greater than \$16,667, future reductions will occur annually on the later of the employee's birthdate or retirement date in a lump sum to \$25,000 and then \$16,667.</p> <p>Coverage will continue for current retirees.</p>
<ul style="list-style-type: none"> ■ <i>Non-Grandfathered:</i> employees and retirees who were not continuously covered since December 31, 1991, and retire with 10 or more years of service prior to December 1, 2005. Eligible individuals must be receiving retiree benefits under the Northrop Grumman Retiree Medical Plan prior to January 1, 2006. 	<ul style="list-style-type: none"> ■ \$7,500 <p>Coverage amount remains in full until death.</p> <p>Employees who retire on or after December 1, 2005, are not eligible for coverage.</p>

Former Westinghouse Heritage Additional Grandfathered Life:

Group	Coverage Amount
<ul style="list-style-type: none"> ■ Employees and retirees who were covered under the ES Grandfathered Additional Life plan on December 31, 1991, have been continuously covered, and, at the time of retirement, have at least 10 years of service. 	<ul style="list-style-type: none"> ■ Amount in effect on December 31, 1991 (amount varies per person) <p><i>Retiree pays for coverage until age 62, then the benefit becomes fully subsidized. At age 62, the amount reduces by 5% each month until the value equals 1/3 of the original amount.</i></p> <p><i>If on June 30, 2016 the coverage amount is greater than 1/3 of the original amount, future reductions will occur annually on the later of the employee's birthdate or retirement date in a lump sum to 1/2 of the original amount and then 1/3 of the original amount.</i></p>

Coverage will continue for current grandfathered retirees and those active grandfathered employees who retire on or after January 1, 2007, and meet the eligibility requirements.

Grumman:

Group	Coverage Amount
<ul style="list-style-type: none"> ■ Those who terminated between December 1, 1980, and December 31, 1991, and were eligible to retire (excluding terminations due to total and permanent disability). <p><i>You did not have to elect retiree medical to be eligible.</i></p>	<ul style="list-style-type: none"> ■ \$2,000, at no cost to the retiree

Closed group of retirees. In-force coverage will continue. No new retirees are eligible.

Newport News Salaried:

Group	Coverage Amount
<ul style="list-style-type: none"> ■ Grandfathered salaried group eligible to retire prior to January 1, 1995 (but didn't necessarily retire). 	<p>Retirement eligibility: age 55 with at least 10 years of service</p> <ul style="list-style-type: none"> ■ If eligible to retire between May 1, 1976, and January 1, 1995 – 25% of Active Basic Life (1.5 times salary) ■ If eligible to retire between May 1, 1976, and January 1, 1995, but did not retire until after January 1, 2004 – 25% of Active Basic Life (one times salary)
<ul style="list-style-type: none"> ■ Salaried group eligible to retire on and after January 1, 1995, who retired prior to January 1, 2007. Eligible individuals must be receiving retiree benefits under the Northrop Grumman Retiree Medical Plan prior to January 1, 2007, to be eligible for retiree life insurance. 	<p>\$10,000</p>

Coverage will continue for current grandfathered retirees and those current grandfathered active employees who retire on or after January 1, 2007, and meet the requirements.

Retirees who were covered under the Newport News Retiree Life plan on December 31, 2006, may continue coverage. Employees who retire on or after January 1, 2007, are not eligible for retiree life.

Northrop:

Group	Coverage Amount
<ul style="list-style-type: none"> ■ Individuals who retired after July 1, 1993 and prior to January 1, 2007, and as active employees had Northrop life insurance coverage. Eligible individuals must be receiving retiree benefits under the Northrop Grumman Retiree Medical Plan prior to January 1, 2007, to be eligible for retiree life insurance. 	<ul style="list-style-type: none"> ■ \$5,000 (if retiree had only basic life insurance coverage as an active employee) ■ May elect an additional \$5,000, \$10,000 or \$15,000 for a maximum benefit of \$20,000 (if retiree had basic and optional life insurance coverage as an active employee) <p><i>Must elect coverage at the time of retirement, except disabled participants who, at the end of two years of disability and once approved for LTD, continue life insurance coverage until age 65, retirement or no longer disabled.</i></p>

Retirees who were covered under the Northrop Retiree Life plan on December 31, 2006, may continue coverage as long as they pay the required premium. Employees who retire on or after January 1, 2007, are not eligible for retiree life insurance coverage.

TRW Heritage (including Mission Systems and Space Technology):

Group	Coverage Amount
<ul style="list-style-type: none"> ■ Retirees between January 1, 1998, and December 1, 2006 	<ul style="list-style-type: none"> ■ \$7,500
<ul style="list-style-type: none"> ■ Retirees between October 1, 1989, and December 31, 1997 	<ul style="list-style-type: none"> ■ MS, ST: \$7,500 ■ Old BSC: \$5,000
<ul style="list-style-type: none"> ■ Retirees prior to October 1, 1989 	(varies by location)

Retirees who were covered under the TRW Retiree Life plan on December 31, 2006, may continue coverage. Employees who retire on or after January 1, 2007, are not eligible for retiree life insurance coverage

With the exception of the grandfathered groups listed above, employees who retire on or after January 1, 2007, will not be eligible for life insurance coverage. In addition, you are not eligible for life insurance benefits under the Northrop Grumman Retiree Medical Plan if any of the following apply:

- You were identified as an “HII Retiree” in the Employer Matters Agreement
- You were identified as an “HII Employee” in the Employer Matters Agreement, unless you meet the age and service requirements of this Plan, disregarding any years of service with Northrop Grumman Corporation prior to March 31, 2011 and any years of service

with Huntington Ingalls Industries, Inc. (In other words, if you were identified as an HII Employee and return to work at Northrop Grumman Corporation, upon your return to Northrop Grumman, you will start with zero years of service for purposes of determining eligibility under this Plan.*)

Those individuals who were retired as of December 31, 2006, and who had retiree life insurance at that time, will be able to keep that coverage, subject to Northrop Grumman's right to amend or terminate coverage in the future.

If you retired prior to January 1, 2007, and you were eligible for contributory life insurance, but deferred participation in the Northrop Grumman Retiree Medical Plan without electing life insurance upon retirement, you will not be able to elect life insurance if you join the plan on or after January 1, 2007. If you were eligible for non-contributory life insurance, that coverage went into effect upon your retirement, even if you deferred participation in the Retiree Medical Plan.**

If you are rehired as an active benefit-eligible employee and you subsequently re-retire, you will be eligible to reelect any retiree life in effect at the time of your initial retirement. You must have been covered under the life insurance plan at the time you were rehired, in order to have coverage upon re-retirement.

The ES-Westinghouse Dependent Life plan was terminated December 31, 2005, for all retirees (except PJS retirees) regardless of the date of retirement.

** Special rules apply for people identified as HII Employees in the Employee Matters Agreement but who returned to work with Northrop Grumman Corporation on or before May 15, 2011.*

***For life insurance to be effective on December 1, 2006, you must have terminated on or before December 1, 2006. If you retire after December 1, 2006, you cannot participate in the retiree life insurance plan. (For example, if you retired on December 15, 2006, which is prior to January 1, 2007, you will not be a participant in the retiree life insurance plan.)*

GENERAL INFORMATION ABOUT LIFE INSURANCE

Accelerated Death Benefit Option

The retiree 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 amount, up to \$500,000. Ordinarily, this benefit would be paid your beneficiary only upon death.

To receive this benefit, the plan requires medical documentation of your 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.

Beneficiary Designation

Your beneficiary is the person or persons you choose to receive life 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.

To verify your beneficiary or to make a new designation you may contact MetLife at 1-866-492-6983 or Benefits Outsourcing Services at 1-800-410-6605.

Any benefits paid for loss of life under your life insurance coverage will be paid in the following order:

- To the beneficiary or beneficiaries you have designated
- To your surviving spouse, 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 you have not designated a beneficiary or there is no surviving beneficiary or spouse at the time of your death
- To your estate, if you do not have a surviving spouse or child(ren) and have not designated a beneficiary or there is no surviving beneficiary at the time of your death.

Steps to Report a Death

To receive benefits under the life insurance plan, your beneficiary must report your death. In order for your beneficiary to initiate the payment of life insurance benefits, he or she may contact MetLife at 1-866-492-6983 or Benefits Outsourcing Services at 1-800-410-6605. He or she may also contact the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 for assistance.

He or she will be asked to provide a certified copy of the death certificate of the deceased. This must be certified; photocopied certificates are not valid. He or she may also be required to provide other information, as requested by the insurance carrier.

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 life insurance carrier. 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.

GENERAL PLAN ADMINISTRATION

This section contains information on the administration of the Northrop Grumman benefit plans, 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 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 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 the Benefit Plans Administrative Committee 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
- The responsibility to act as claims administrator and to review claims and claim denials under the plan to the extent an insurer or administrator is not empowered with such responsibility.

The Benefit Plans Administrative Committee 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 a beneficiary you are covering knowingly makes a claim that contains or is based on false, incomplete, or misleading information, with the intention of obtaining benefits for which you or your beneficiary are not entitled, the Northrop Grumman Retiree Medical Plan may terminate your and your beneficiaries' eligibility for benefits, or may demand that you repay benefits or offset future benefits, and you and your beneficiary 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/the Plan and an HMO. With respect to fully insured benefits, claims for benefits are sent to the HMO. The HMO is responsible for paying claims — not the Plan or Northrop Grumman.

The HMO is also responsible for the following:

- 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.

Liability of Insurer

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. The Plan and Northrop Grumman do 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 care (including prescription drugs or mental health and/or chemical dependency) 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 (EOB) from that plan. Be sure to keep a copy of everything for your records.

You must submit medical claims that you incur during the benefit plan year within 15 months after the benefit plan year ends. For example, assume you incur a claim on April 20, 2017. Since the benefits plan year ends on December 31, 2017, you have until March 31, 2018 to submit your claim for reimbursement. The medical plan option does not pay claims that are submitted after the 15-month deadline.

If your prescription drug coverage is administered by CVS/caremark, 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.

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. Contact the claims administrator for information about what you need to do. The claim administrator 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 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.

Assignment of Benefits and Other Rights

As of September 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 September 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 benefits varies depending on the benefit and the type of claim. In this table, “Medical” benefit claims include medical, prescription drug, and mental health and substance abuse treatment benefit claims.

Type of Claim	Initial Deadline for Claims Review	Time for You to Provide Additional Information	Extensions for Claims Review, If Necessary
Medical: Urgent	72 hours	48 hours	None
Medical: Urgent, concurrent care	24 hours*	48 hours	None
Medical: Pre-Service	15 days	45 days	15 days
Medical: Post-Service	30 days	45 days	15 days
Life Insurance	90 days	45 days	90 days
Administrative	90 days	45 days	90 days

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

- **Medical 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”).
- **Medical 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, “urgent”, “pre-service” or “post-service” time limits will apply, as described below.
- **Medical 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.

- Medical post-service claims: A “post-service” determination is made for benefits after you have already received care or treatment. A “post-service” determination does not require advance approval of benefits.

In the case of pre-service determinations and urgent claims, if you fail to follow the specified procedure for filing your claim, the claims administrator will notify you of the failure and of the proper procedure. This notice will be provided to you no later than five days after your incorrectly filed claim is received (24 hours in the case of an urgent claim). The notice from the claims administrator may be an oral notice, unless you specifically request written notice.

Example: If you have an urgent medical situation, the claims administrator must respond to your initial request for benefits within 72 hours, and no extensions are permitted. If the administrator needs more information from you to make a determination, you will have 48 hours from the time you are notified to supply that information. The time period during which you are gathering that additional information does not count toward the time limits that apply to the claims administrator.

If Your 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 reason for the denial
- References to specific plan provisions on which the denial is based
- If a medical claim, the date of service, name of the health care provider, and claim amount
- If a medical claim, the denial code and its corresponding meaning, as well as 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
- 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 process.

Depending on the type of claim, the explanation will also contain the following information:

- If the denial is based on an internal rule, guideline, protocol, or standard, the denial will say so and state that you can obtain a copy of the guideline or protocol, free of charge upon request
- If the denial is based on an exclusion for medical necessity or experimental treatment, 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

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.
- You may write 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 claims appropriate Level 2 appeals review committee as indicated in the chart titled “Claims and Appeal 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 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 following 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.

Rescissions of Coverage

A Rescission of Coverage is a cancellation or discontinuance of medical coverage that is effective retroactively and that is not due to a failure to timely pay required contributions toward the cost of coverage. You do not need to file a claim regarding a Rescission of Coverage. If you are notified by the plan administrator or 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 within 180 days after your receipt of the notice of Rescission of Coverage. Your appeal will be considered within 60 days after the claims administrator receives your appeal, with a 60-day extension permitted if necessary.

Timing of Your Appeal

If you make a Benefit or Administrative Claim for benefits 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 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 date of the claim denial notice to file an appeal. Following are the timeframes that apply when you file an appeal.

Type of Claim	Time to Appeal	Time for Decision on Appeal	Extensions for Claims Administrator, If Necessary
Health: Urgent claims	180 days from date you receive a claim denial	72 hours	None
Health: Pre-Service claims	180 days from date you receive a claim denial 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 from date you receive a claim denial for each level of appeal	Two levels of appeal: 30 days from the receipt of the appeal for each level*	None
Life Insurance	60 days from date you receive a claim denial	One level of appeal: 60 days	60 days
Administrative claims	65 days from date of claim denial letter	One level of appeal: 90 days from the receipt of the appeal	60 days
Rescissions of Coverage	180 days from date you receive the notice of Rescission of Coverage	One level of appeal: 60 days from the receipt of the appeal	60 days

**For CVS/caremark, there is 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). Your claim denial letter from CVS/caremark will inform you whether there is 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 claims 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 your 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 there is 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, Value and Medigap-type plan options. Your claim denial letter from CVS/caremark will inform you whether there is one level or two levels of appeal.
 - Level 1 appeal:** You may file a level 1 appeal with the claims administrator within 180 days after you receive the claim denial. Your appeal must be considered within 30 days (60 days when there is 1 level of appeal for prescription drug claims under the Plan's Premium, Value and Medigap-type 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 after you receive the denial of your level 1 appeal. Your appeal must be considered within 30 days, with no extensions.
- **Life Insurance Claims.** There is one level of appeal. If your initial claim for benefits is denied, you may appeal that denial within 60 days after you receive the claim denial and you will be notified of the decision on your appeal within 60 days, with a 60-day extension permitted, if necessary. If your claim is wholly or partially denied after your appeal, you may request a final review of your claim within 60 days after you receive the notification that your appeal has been denied. The insurance company will provide its final decision in writing within 60 days after receipt of your request for final review.
- **Administrative Claims.** There is one level of appeal:

- You may file an 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.

Claims and Appeals Contact Information

Claims Administrator	Claims	Level 1 Appeals	Level 2 Appeals
Anthem Blue Cross <ul style="list-style-type: none"> • Premium plan • Value plan • Medigap-type 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 P.O. Box 54159 Los Angeles, CA 90054	Anthem Blue Cross P.O. Box 54159 Los Angeles, CA 90054
CVS/caremark (includes prescription drug coverage under the Medigap-type option, if elected)	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
MetLife (Life Insurance)	MetLife Group Life Claims Oneida County Industrial Park 5950 Airport Road Oriskany, NY 13424	MetLife Group Life Claims P.O. Box 6100 Scranton, PA 18505-6100	N/A
Benefit Plans Administrative Committee Administrative Claims	Plan Administrator – Northrop Grumman Retiree Medical Plan Northrop Grumman Corporation P.O. Box 770003 Cincinnati, OH 45277-1060	Benefit Plans Administrative Committee – Northrop Grumman Retiree Medical Plan Northrop Grumman Corporation P.O. Box 770003 Cincinnati, OH 45277-1060	N/A
Benefit Plans Administrative Committee Rescissions of Coverage	N/A	Benefit Plans Administrative Committee – Northrop Grumman Retiree Medical Plan Northrop Grumman Corporation P.O. Box 770003 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 benefit claims:

- The decision on the appeal will be made by a person or persons at the claims 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 medical claim, the date of the service, name of the health care provider, and claim amount
- If a medical claim, the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the appeal, including a discussing of the decision

- If a medical claim, 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.)
- 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 process.

Depending on the type of claim, the notice that you receive from the claims administrator 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 related to medical necessity or experimental treatment, 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

Overview

If your medical claim is denied, you may be eligible to have your claim reviewed by an Independent Review Organization (IRO) pursuant to a process called “External Review.” Generally, External Review is available only after your claim denial has been upheld after the final level of appeal under the Plan. You may, however, in limited circumstances have the right to have your claim reviewed by an IRO prior to exhausting the Plan’s appeal process. See *Expedited External Review* for further details.

External Review is only available for certain claims:

- External Review is available only for medical claims that involve medical judgment (including, for example, those based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination as to whether a treatment is experimental or investigational) and for Rescissions of Coverage.

Federal government agency guidance may further limit or broaden the scope of External Review. The Plan will provide an External Review process in accordance with applicable guidance.

The External Review Process

Your request for External Review must be filed in accordance with the instructions contained in your appeal denial notice and must be received not 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 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.

You will have at least 10 days to submit additional information to the IRO. If you submit additional information, the IRO will send that information to the Plan and the Plan may reconsider its determination. If the Plan does not reverse its determination, 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. If the IRO reverses the Plan's determination, the Plan must immediately provide coverage or payment for the claim.

Expedited External Review

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 appeal 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 External Review. Immediately after completion of the preliminary review, the claims administrator will issue you a written notification of your eligibility for 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 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.

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 of 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.

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 benefit plans.

What ERISA Means to You

ERISA sets standards that a plan sponsor must follow if it maintains a covered employee benefit plan. With some exceptions, covered employee benefit plans include plans sponsored by an employer to provide employees and retirees with certain pension, savings, and health and welfare benefits.

ERISA does not require any company to offer an employee benefit 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 benefit 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 benefit 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 benefit 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 benefit plan, or employees who make decisions about funding plan benefits.

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, 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 SPD. 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 qualified event. You or your dependents may have to pay for such coverage. Review the "COBRA" section and the documents governing the plan for rules about your COBRA continuation coverage rights.

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 person, may 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. In addition, if you disagree with the plan's decision (or lack thereof) concerning the qualified status of a medical child support order, you may file a suit in 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).

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)

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 Retiree Medical 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 medical (including health reimbursement account and prescription drug) component of the Plan is subject to the HIPAA privacy rule. The life insurance component of the Plan is not subject to the HIPAA privacy rules.

Protected health information, includes all individually identifiable health information held by the components of the Northrop Grumman Retiree Medical 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 (the fact that you and/or a family member participates in the Plan and the required contribution toward the cost of coverage) held by Northrop Grumman or the Northrop Grumman Benefits Center is treated as employer information and is not considered protected health information.

Permitted Uses and Disclosures of Protected Health Information

The Health Insurance Portability and Accountability Act (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 Retiree Medical Plan has been amended to permit Northrop Grumman to use and disclose protected health information for plan administration functions. This means that the Plan or its health insurer or HMO may disclose your health information without your written authorization to Northrop Grumman for plan administration purposes. Northrop Grumman may need 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 Retiree Medical Plan and Northrop Grumman, as allowed under the HIPAA rules:

- The Northrop Grumman Retiree Medical 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) have been removed.
- The Northrop Grumman Retiree Medical 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 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 Retiree Medical 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 allow you 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?

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, your enrolled family members are eligible to pay for continued group health care (medical and prescription drug) coverage if they lose their coverage under certain circumstances, known as COBRA qualified events. Under the Retiree Medical Plan, the qualified events are your (the retiree's) death, your divorce from your spouse, or your dependent child's loss of eligible dependent child status. In addition, you and your enrolled family members are eligible to pay for continued coverage if coverage under the plan is substantially eliminated in the event that Northrop Grumman files for bankruptcy protection under Title 11 of the United States Code.

If the qualified event is divorce or loss of eligible dependent status, your enrolled family members who lose coverage will be considered qualified beneficiaries and can continue coverage for a maximum of 36 months. In the case of a Northrop Grumman bankruptcy qualified event, you and your enrolled family members will be considered qualified beneficiaries. In that case, you (the retiree) can continue coverage until the date of your death. Your enrolled family members can continue coverage for 36 months after the date of your death.

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 before the qualified event (for example, Premium plan, Value plan or HMO)
- You may keep the same coverage category you had before the qualified event 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 rate change event 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 retirees

- 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

Qualified Event	Maximum Continuation Period		
	Retiree	Spouse	Child
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 Northrop Grumman retiree, 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 contacting the Northrop Grumman Benefits Center. 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 Northrop Grumman Benefits Center 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 for COBRA

COBRA participants pay monthly premiums for their coverage based on the full group rate per enrolled person set at the beginning of the benefit 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 if you were electing retiree-only coverage.

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

If your dependents lose coverage due to divorce, legal separation, or loss of dependent status, you (or a family member) must notify the Northrop Grumman Benefits Center (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.

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 preexisting 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 30 days after the first day of the month (the “grace period”), coverage will be terminated effective as of the last day of the period for which payment was made. For example, if payment for May coverage is due May 1, and you fail to make the applicable payment by May 30, your coverage will be terminated retroactive to April 30.
- Northrop Grumman ceases to provide medical benefits to any employee.

Questions About COBRA

If you have any questions about COBRA coverage or the application of the law, please contact your local human resources representative 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 Web site 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 the Northrop Grumman Benefits Center 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.

SURVIVOR OPTIONS

There are two types of survivor options available for medical benefits when the retiree dies:

- Surviving spouse and/or dependents of a retiree
- Surviving spouse and/or dependents of a deceased active employee who met the eligibility requirements for retiree medical on or before his or her date of death.

The requirements for each are described below:

- In the event of the retiree's death, the covered spouse and dependent children may elect to either continue medical coverage under the plan or suspend coverage to a later date
 - If coverage is continued, the spouse will be covered as the participant under the plan with any children covered as his or her dependents. Any required contributions will be based on the dependent cost, not the retiree cost. Any required contributions will be deducted from the survivor's pension check if sufficient, or the survivor will be direct-billed.
 - If coverage is suspended, the surviving spouse and dependent children may reelect coverage during the next retiree annual enrollment or if he or she experiences a qualified life event.
- In the event of the death of an active employee covered under the Northrop Grumman Health Plan, the surviving spouse and dependent children covered at the time of the active employee's death may continue their medical, dental and/or vision coverage to the end of the month in which the employee dies, plus an additional 12 months, at no cost to the survivors. At the end of that period, the surviving spouse and dependent children will have the option of continuing coverage under COBRA for the balance of the 36-month COBRA continuation period at the full 102% rates. Alternatively, if the active employee had met the age and service requirements for this Plan at the time of death, the survivors will be eligible to participate in this Plan, at subsidized heritage rates, as available. The eligible survivors may elect to participate in this Plan effective the first of any month following the free period.

Notes: *Dependent children may be covered as survivors under the plan in the absence or ineligibility of a surviving spouse. This includes disabled children whose coverage continues as long as they remain incapable of self-support.*

Surviving spouses who remarry are eligible to continue coverage in this plan as long as the required premiums are paid. The new spouse may be added to the Retiree Medical Plan provided that the surviving spouse pays the full cost.

FUTURE OF THE PLANS

Northrop Grumman has the absolute right in its sole discretion to amend or terminate any plan or plan provision in whole or in part at any time, including any cost-sharing arrangements.

Amendments to or termination of a plan may apply to active, inactive or former employees. A plan change may transfer plan assets to another plan, or split a 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 may be adopted by a person authorized to take such action by Northrop Grumman. 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 a welfare benefit plan is terminated, you have no further rights other than payment of claims for eligible expenses that you incurred before the plan terminated. The amount and form of any final benefit you may receive under a welfare benefit plan depend on plan assets, any contract or insurance provisions affecting the plan, and decisions made by Northrop Grumman.

If a 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 honored.

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 benefit plan
Type of Administration	Insured and self-insured
Plan Administrator	Benefit Plans Administrative Committee Northrop Grumman Retiree Medical 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.
Benefit Plan Year	January 1 through December 31
Plan Number	The Northrop Grumman Retiree Medical Plan is a component plan of the Northrop Grumman Corporation Retiree Welfare Benefits Plan. For annual reporting purposes, the Northrop Grumman Retiree Medical Plan is treated as part of the Northrop Grumman Corporation Retiree Welfare Benefits Plan, plan number 715. This summary plan description is considered part of the written instrument for the Plan for purposes of section 402(a)(1) of ERISA.

Specific Plan Facts

Medical Plan	
Insured by:	The Premium, Value and Medigap-type medical plan options are self-insured. All other medical plan options are fully insured under contracts with insurers. Insurers are listed below.
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 contributions¹:	Depending on the benefits selected by the participant and the participant's heritage status, the cost of benefits will either be covered by contributions from Northrop Grumman or will be shared by Northrop Grumman and the participant.
Prescription Drug Benefits	
Insured by:	The Prescription Drug benefits in the Premium and Value plan options and the Medigap-type plan option (if elected) are self-insured. Prescription Drug benefits under all other medical plan options are provided under contracts between the medical plan and prescription drug providers
Claims administered by:	For Prescription Drug benefits in the Premium and Value plan options and the Medigap-type option (f elected), claims are administered by: CVS/caremark (initial claim determinations) Claims Department P.O. Box 52136 Phoenix, AZ 85072-2136 CVS/caremark (appeals determinations) Appeals Department MC 109 P.O. Box 52084 Phoenix, AZ 85027-2084 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 the Northrop Grumman Retiree Medical Plan Summary

	Plan Description (SPD), or 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
Funded by¹:	Northrop Grumman and participant contributions
Life Insurance	
Insured by:	MetLife One Madison Avenue New York, NY 10010
Claims administered by:	MetLife Group Life Claims Oneida County Industrial Park 5950 Airport Road Oriskany, NY 15424
Trustee²:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Northrop Grumman and retiree contributions
Retiree Health Reimbursement Arrangement	
Claims administered by:	Willis Towers Watson 10975 Sterling View Drive, Suite 1A South Jordan, UT 84095
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by:	Northrop Grumman

1 The Northrop Grumman contributions may be held in a type of trust called a Voluntary Employee Beneficiary Association (VEBA).

2 Northrop Grumman contributions are deposited into the trust, and the trust pays the premiums.

CARRIER CONTACT INFORMATION

Plan Option/Carrier	Phone	Web Site
Anthem Blue Cross	1-800-894-1374	www.anthem.com/ca
CVS/caremark	1-855-361-8565	www.caremark.com
Emblem Health	1-800-447-8255 (current members) 1-800-447-8632 (prospective members)	www.emblemhealth.com/
Kaiser of California	1-800-464-4000 (Non-Medicare) 1-800-443-0815 (Medicare)	www.kaiserpermanente.org/california
Kaiser of Mid-Atlantic	1-800-777-7902 or 1-301-468-6000 (Non-Medicare) 1-888-777-5536 (Medicare)	www.kaiserpermanente.org/mid-atlantic
MetLife — life insurance	1-866-492-6983	www.metlife.com
OneExchange	1-855-832-0976	https://medicare.oneexchange.com/NGC
TRICARE Supplement	1-800-638-2610, ext. 255	www.selmantricareresource.com

GLOSSARY

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 pension check after federal, state, and local taxes are withheld.

Alternative care — Unconventional health care procedures, services or courses of treatment, such as Rolwing. 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 benefit plan year. Annual maximums vary by benefit plan.

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

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

Beneficiary — The person(s) whom you designate to receive your life 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 benefit plan year maximums.

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

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, you agree to resolve all differences between you or your dependents and the claims administrator through binding arbitration.

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

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 if you use an in-network provider is 80%/20%, in which case Northrop Grumman pays 80% of the Maximum Allowed Amount 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 retirees and their dependents when their eligibility for group health insurance coverage ends, such as at termination of employment, divorce, or death.

Contributions — The amount you pay toward the cost of the benefits in which you enroll.

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 employer's plan.

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

Coverage categories — The categories or tiers that determine your cost of coverage.

Deductible — The amount of money you pay each benefit 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 and your certain children.

Eligible expenses — Charges for services or supplies for which the medical plan option pays 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 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.

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 (FDA), 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 plan option.

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.

Generic drug — A copy of a brand 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 (HRA) — In the Premium plan option, 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 the cost of covered medical and prescription drug expenses. Any unused funds credited to your HRA roll over from benefit plan year to benefit plan year when you reenroll in the Premium plan option, and can be used to reduce your future out-of-pocket cost.

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.

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

In-network (or network) provider — A health care provider (such as a physician, 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 a network provider.

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

Investigational — See Experimental.

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

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 Plan 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.

Medicare — A federally administered, nationwide health insurance program that covers the cost of health care for individuals who are eligible for Social Security 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 contracts 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 plan options, to receive in-network benefits, you must receive a referral from your 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 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.

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 Monday through Friday from 8:30 a.m. to 8:30 p.m. Eastern time. The NGBC is closed on most New York Stock Exchange holidays. If you are calling for outside the U.S., dial the AT&T out-of-country access code, then dial 800-894-4194 TTY service is available at 1-888-343-0860.

Northrop Grumman Benefits Service Center (NGBSC) — The benefits service center for retirees whose retiree medical benefits are administered by Benefits Outsourcing Solutions. You can reach the NGBSC at 1-800-410-6605.

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

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 benefit plan option and is paid by you. Out-of-pocket costs typically include copayments, deductibles and coinsurance.

Out-of-pocket maximum — The limit on your total copayments, deductibles and coinsurance under a benefit plan option. The maximum does not include ineligible expenses.

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.

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 Benefit Plans Administrative Committee is the plan administrator.

Plan year — The 12-month period from January 1 through December 31. The plan year applies in determining when you can become a participant in the benefit plan options. For the medical plan option, the plan year is the period during which your deductible, out-of-pocket maximum, and annual maximums are tracked.

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

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 benefit plans. The health plans have one premium rate for you only and another, separate premium rate or rates for you with dependents. 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, or pediatricians under the HMO options. PCPs arrange referrals and supervise other care, such as specialist services and hospitalization. All PCPs meet HMO qualification standards and are subject to periodic review.

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

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. Term applies to medical benefits.

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

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.

Retiree Health Reimbursement Arrangement (RHRA)—A health reimbursement arrangement available to certain retirees (and in some cases, their eligible spouses/domestic partners) who were eligible for subsidized coverage under the Northrop Grumman Retiree Medical Plan as a member of an eligible heritage company group and who ceased to be eligible for medical and prescription drug coverage under the Plan as of his/her Medicare Eligibility Date. To establish an RHRA, you must enroll in Medicare Parts A & B and enroll in individual Medicare supplemental coverage through OneExchange or enroll in individual Medicare supplemental and/or prescription drug coverage through Kaiser and notify OneExchange of your enrollment. See the Summary Plan Description for the Northrop Grumman Retiree Medical Plan Retiree Health Reimbursement Arrangement for details on how to establish an RHRA.

Secondary plan — If you are enrolled in more than one medical 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.

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

Spouse — The individual to whom you are legally married, including a common law spouse if common-law status is recognized in your state of legal residency. To be eligible, your spouse must have been married to you at the time you terminated employment or retired.

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 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 part of the SPD for the Northrop Grumman Retiree Medical Plan.

Voluntary Employee Beneficiary Association (VEBA) — A trust or other organization created under Internal Revenue Code Section 501(c)(9), serving as the basis of an employer-sponsored employee benefit plan.

***Northrop Grumman Retiree Medical Plan
Premium Plan Option***

January 2017

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PREMIUM PLAN

This section of the Northrop Grumman Retiree Medical Plan Summary Plan Description (SPD) describes features of the 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 Premium plan benefit description section.

OVERVIEW OF PREMIUM PLAN COVERAGE

The Premium plan is considered a consumer-driven health plan that puts you in charge of the money you spend for health care services.

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

Here are the components of the 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 credited to 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 medical and prescription drug 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 certain preventive care.

- **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.

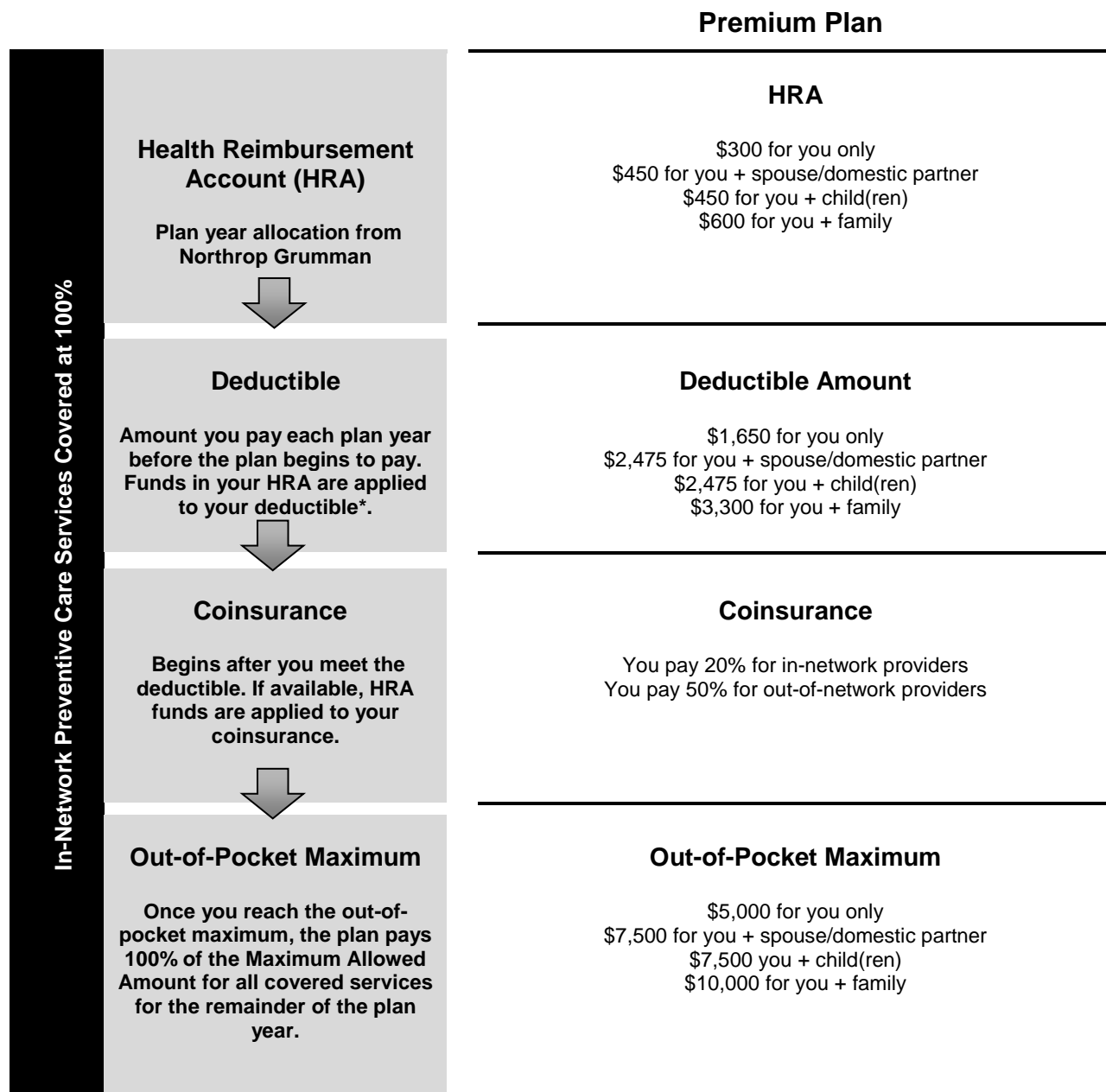
■ **Out-of-Pocket Maximum**

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 Premium plan covers in-network 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 Premium plan. For details, refer to the section called "How the Premium Plan Works."



*HRA funds used for HRA extras will not count toward the deductible.

HOW THE 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	Premium Plan
You only	\$300
You + spouse/domestic partner	\$450
You + child(ren)	\$450
You + family	\$600

These 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.

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.

Funds in your HRA may be used to pay for Internal Revenue Code Section 213 Qualified Medical Expenses. However, you will need to refer to the list under “HRA Extras (Qualified Health Expenses)” for those expenses eligible to be paid under the Northrop Grumman Retiree Medical Plan. You cannot receive a cash reimbursement of the funds credited in your account for anything other than the benefits covered under the Premium plan.

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 covered medical services and/or HRA Extras (Qualified Health Expenses). However, please note that money you spend from your HRA for HRA Extras (Qualified Health Expenses) will not be available to cover the cost of future medical services you might need. If your future medical expenses exceed the money remaining in your HRA, you will have to pay out of your pocket for those services.

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. From the Anthem site, go to My Benefits, and then Forms Library.

Note: *Qualified medical expenses are defined under section 213 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

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 and prescription drug expenses before the plan begins to pay for your services. The same deductible applies to both medical and prescription drug expenses. In other words, you do not have to meet separate deductibles for medical and pharmacy services. You do not have to meet the deductible before the plan begins to pay for certain preventive care services.

You must meet the deductible for your coverage level before the plan begins paying. 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.

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 (see “Telemedicine” section)
- Ineligible prescription drug charges including costs you incur for not complying with CVS/caremark’s prescription drug policies (See “Prescription Drug Coverage” for details).

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

The Deductible amounts for each plan year are as follows:

Coverage Level	Premium Plan
You only	\$1,650
You + spouse/domestic partner	\$2,475
You + child(ren)	\$2,475
You + family	\$3,300

These amounts include the HRA, which will be used first and automatically when medical and prescription drug claims are submitted. You pay the difference between the HRA and the deductible out of your pocket.

The deductible amounts may be prorated if you participate in the 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

After you satisfy the annual deductible, you pay a certain percentage of the cost of covered services through coinsurance. Generally, the 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 Maximum Allowed Amount, and you the remaining pay 50%, up to the 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 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. Claim amounts in excess of Maximum Allowed 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 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	Premium Plan
You only	\$5,000
You + spouse/domestic partner	\$7,500*
You + child(ren)	\$7,500*
You + family	\$10,000*

**This is the family out-of-pocket maximum. The maximum out-of-pocket maximum for an individual is \$5,000*

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 or experimental procedures
- HRA Extras using funds from your HRA
- 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 Plan Works

Let’s assume that this is your first year in the Premium plan option, and you have retiree plus spouse coverage. Your deductible is \$2,475 and you receive an HRA allocation of \$450 to use toward the deductible. Here are examples of how the plan will cover expenses.

You incur \$200 in covered expenses: a doctor visit at \$80 and prescription drugs at \$120.

	Plan/HRA pays	You pay
The HRA is used to pay your \$80 doctor visit and \$120 prescription drug expense (total \$200)	\$200 This amount is applied toward the deductible.	\$0

Next, your spouse has outpatient surgery, and the in-network covered expenses are \$8,000.

	Plan/HRA pays	You pay
The remaining \$250 HRA balance is used. This leaves \$7,750 in unpaid expenses from the outpatient surgery.	\$250 This amount is applied toward the deductible.	Not applicable
Of the \$7,750, you pay \$2,025 to satisfy the remaining deductible (\$2,475 - \$200 - \$250).	Not applicable	\$2,025
Now that you have met the deductible, the plan will cover the remaining \$5,725 at 80%. The plan pays 80% of \$5,725 (or \$4,580) and you pay the remaining 20% or \$1,145	\$4,580	\$1,145
Total	\$5,030	\$3,170

In this example, your total out-of-pocket expense is the \$2,025 paid toward the deductible plus \$1,145 in coinsurance, for a total of \$3,170

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.

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 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 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 Allowed 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 Customer Service.
- 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 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 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 Member Services 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 Premium plan offers a comprehensive suite of health and wellness programs that help retirees 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 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 that can help you find cost - 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

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
- 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.

Retirees 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 retirees 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 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 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%, 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 and plan options under the Northrop Grumman Health Plan.
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 retirees 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
- 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 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, the Anthem online tools and health resources deliver the information and support you need around these topics and more.

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

COVERED MEDICAL SERVICES

Services for which 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 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. The dietary formulary must be the sole nutritional source 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 assistance 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 Premium 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 retirees 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 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 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).
- 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

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.

In-network preventive care is covered at 100%. Out-of-network preventive care is covered at 80% of the maximum allowed amount.

Please note that all in-network 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%. For certain other preventive prescription drugs, the deductible

will not apply and you will only be responsible for coinsurance. See “Prescription Drug Coverage” section.

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
- 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.

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 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:

- **Radiation Therapy** — the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes
- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents (the cost of the antineoplastic agent is included)
- **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*
- **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
- **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.

**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
- Expenses related to artificial organs — other than limbs, larynx, and eyes — including surgery and related expenses for any type of artificial organ transplant
- 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.)

- 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.
- Expenses related to gender reassignment surgery
- 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 treatment

- Expenses for non-human organs, including services and supplies related to non-human organs
- 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 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.

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 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

Since medical and prescription drug coverage are combined in the Premium plan, deductibles and out-of-pocket maximums are shared between medical and prescription drug coverage. However, prescription drug coverage is provided through CVS/caremark and not Anthem and you will receive a separate ID card from CVS/caremark.

Your pharmacy costs will be based on where you are within the Premium plan.

- While you have money credited in the HRA, you will not pay for any covered prescription drugs at the pharmacy. The cost of the prescription will be deducted from your HRA. (If using an in-network pharmacy*, the cost is the CVS/caremark contracted or negotiated rate.)
- Until you meet the plan deductible, you will need to pay the cost of the covered drug
- Once the plan deductible is met, you will pay 20% of the cost if using an in-network pharmacy*. (If using an out-of-network pharmacy, CVS/caremark reimburses 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 other preventive prescription drugs through in-network pharmacies of the CVS Retail Pharmacy Program. A comprehensive list of preventive drugs can be found on the CVS/caremark website (www.caremark.com).

**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. 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 Retiree Medical 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, 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 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 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. Please note Walgreens is not an in-network pharmacy.

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 plan deductible or coinsurance at the pharmacy.

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 up to a maximum of \$200. (This maximum does not apply until you have met the deductible.) 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.

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. Any HRA funds you may have may be used to cover this charge. However, the charge will not apply toward your deductible or out-of-pocket maximum.

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 you 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.

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

CVS/caremark Specialty Pharmacy

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

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

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

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

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with the patient and doctor
- Direct delivery to the patient or doctor’s office
- Medicine-specific and disease-specific education and counseling

- Online support through 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 (which includes amounts paid from the HRA), 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) 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
- 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.

***Northrop Grumman Retiree Medical Plan
Value Plan Option***

January 2017

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VALUE PLAN

This section of the Northrop Grumman Retiree Medical 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 an 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 Most 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	\$3,200	\$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
Your Out-of-Pocket Maximum	\$6,000	\$12,000	\$9,000	\$18,000	\$12,000	\$24,000
	After you reach you 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.

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 the "Prescription Drug Coverage" section 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 benefit 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.

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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 family out-of-pocket maximum. The in-network out-of-pocket maximum for an individual is \$6,000*

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

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” section 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 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
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 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 Member Services 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.

INTEGRATED HEALTH MANAGEMENT

The Value plan offers a comprehensive suite of health and wellness programs that help retirees 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

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.

Retirees 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 retirees 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 and including options under the Northrop Grumman Health Plan. 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 retirees 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
- 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, the Anthem online tools and health resources can deliver the information and support you need around these topics and more.

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.

- **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 and select Find Urgent Care.

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 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. The dietary formulary must be the sole nutritional source 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. Hearing aid batteries are not covered. Contact Anthem for help with locating an in-network Durable Medical Equipment (DME) provider.

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 retirees 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
- 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
- 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.

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:

- **Radiation Therapy** — the treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium, or radioactive isotopes

- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents (the cost of the antineoplastic agent is included)
- **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*)
- **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
- **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.

**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
- Expenses related to artificial organs — other than limbs, larynx, and eyes — including surgery and related expenses for any type of artificial organ transplant
- 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.)
- 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 for non-human organs, including services and supplies related to non-human organs
- 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 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
- Expenses related to gender reassignment surgery
- Expenses related to infertility treatment

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 the CVS/caremark website (www.caremark.com).

**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. 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 Retiree Medical 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, 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 or the CVS/caremark Mail Service Pharmacy. You will receive a 90-day supply of medication. 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 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.

When you use a CVS/caremark participating pharmacy:

5. Ask your doctor to write a prescription for up to a 30-day supply of your medication, plus refills, if appropriate
6. Take your prescription to a CVS/caremark participating pharmacy
7. 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.)
8. Pay the appropriate deductible or coinsurance at the pharmacy.

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 approve reimbursement 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/caremarkCVS/caremark:

5. Take your prescription to a CVS/pharmacy location
6. Phone: Call CVS/caremark Customer Care at 1-855-361-8565
7. 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
8. 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.

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.

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.

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

CVS/caremark Specialty Pharmacy

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

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

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

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

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with the patient and doctor
- Direct delivery to the patient or doctor’s office
- Medicine-specific and disease-specific education and counseling
- Online support through 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, 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 Retiree Medical Plan SPD
Medigap-Type Plan
January 2017**

***Northrop Grumman Retiree Medical Plan
Medigap-type Medical Plan Option***

January 2017

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MEDIGAP-TYPE MEDICAL PLAN

This section of the Northrop Grumman Retiree Medical Plan Summary Plan Description (SPD) describes features of the Medigap-type 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 Medigap-type plan description section.

OVERVIEW OF MEDIGAP-TYPE PLAN COVERAGE

The Medigap-type option is offered nationwide and helps pay some medical costs that aren't covered by Medicare (e.g., deductible for hospitalization and coinsurance for physicians' services).

This option is available to retirees and their covered dependents who are eligible for Medicare prior to reaching age 65, and to certain retirees after reaching age 65, based on their heritage company status. It is important that you (or your dependent) enroll in Medicare Parts A and B as soon as you become eligible for Medicare, which is generally the first day of the month during which you turn age 65. For example, if you turn age 65 on September 22, you should enroll in Medicare Parts A and B effective September 1. You may also be eligible for Medicare if you become disabled before turning age 65 or you have End-Stage Renal Disease. The Northrop Grumman Medigap-type option pays claims as if you are enrolled in Medicare Parts A and B.

You may elect the Medigap-type plan option with or without prescription drug coverage. Anthem administers the Medigap-type coverage. The prescription drug benefit, if elected, is administered by CVS/caremark[®]. Note: If you enroll in a Medicare Prescription Drug Plan (Medicare Part D), you cannot enroll in prescription drug coverage through the Medigap-type option.

Below is a summary of some of the Medigap-type plan benefits provided by Northrop Grumman and how the Medigap-type option coordinates with Medicare Parts A and B. In general, if a benefit or service is not covered by Medicare, it will not be covered by the Plan. However, if Medicare Part B covers a benefit or service, including Medicare Part B eligible prescription drugs, the Northrop Grumman Medigap-type option may cover the balance not paid by Medicare. The deductible amounts in the summary below are determined by Medicare and are subject to change each year. Deductible amounts and coverages shown are for 2017. For up-to-date deductible amounts and coverages, please contact Anthem or visit the Medicare Web site at www.medicare.gov.

SUMMARY OF MEDIGAP-TYPE BENEFITS

2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Ambulance Services (covered only when medically necessary)	Part B covers 80% of Medicare-approved amounts or applicable fee schedule charge.	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.
Bone Mass Measurement	Part B covers 80% of Medicare-approved amounts if: <ul style="list-style-type: none"> ■ The test is ordered by a qualified physician who is treating you ■ You meet certain criteria (review your Medicare coverage) 	The remaining 20% of Medicare-approved amounts if you meet the criteria outlined by your Medicare coverage.	100% covered for Medicare-approved amounts if you meet the criteria outlined by your Medicare coverage.
Chiropractic Services (covered only for manual manipulation of the spine to correct subluxation when provided by a chiropractor or other qualified provider; routine care is not covered)	Part B covers 80% of Medicare-approved amounts.	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.
Colorectal Cancer Screening (for participants age 50 and over)	Part B covers colonoscopies and flexible sigmoidoscopies at 100% if the doctor accepts Medicare assignments. Barium enemas covered at 80% if performed in place of the other two tests. Part B covers 100% of Medicare-approved amounts for fecal occult blood tests every 12 months, but you generally have to pay 20% of the Medicare-approved amount for the doctor visit. Review your Medicare coverage for rules and limitations.	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.

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 Medigap-Type Plan
 January 2017**

2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Diabetes Services	<p>Parts A and B cover 80% of Medicare-approved amounts of outpatient facility charges or physician services for diabetes self-management.</p> <p>Part B covers 80% of Medicare-approved amounts for:</p> <ul style="list-style-type: none"> ■ Foot exam ■ Glaucoma screening ■ Medical nutrition therapy services. <p>Review your Medicare coverage for rules and limitations.</p>	<p>The remaining 20% of Medicare-approved amounts.</p> <p>The remaining 20% of Medicare-approved amounts.</p>	<p>100% covered for Medicare-approved amounts.</p> <p>100% covered for Medicare-approved amounts</p>
Diabetes Supplies	<p>Part B covers 80% of Medicare-approved amounts for certain diabetic supplies, such as:</p> <ul style="list-style-type: none"> ■ Blood glucose test strips ■ Blood glucose monitors ■ Lancet devices and lancets ■ Glucose control solutions for checking the accuracy of test strips and monitors. ■ Insulin if used with an external insulin pump <p>Part B covers:</p> <p>80% of Medicare-approved amounts for self-management training</p> <p>Review your Medicare coverage for rules.</p>	<p>The remaining 20% of Medicare-approved amounts for supplies.</p> <p>No additional benefits.</p>	<p>100% covered for Medicare-approved amounts for supplies.</p> <p>80% covered for Medicare-approved amounts.</p>

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Diabetes Supplies-Insulin, Syringes, and Needles	Covered under Medicare Part D. If you enroll in Medicare Part D, you may not select prescription drug coverage through Northrop Grumman.	Not covered. You must be enrolled in Medicare Part D or the Medigap-type option with prescription drug coverage for prescription drug coverage. Consult the Prescription Drug Benefits section for details.	Not covered. You must be enrolled in Medicare Part D or the Medigap-type option with prescription drug coverage for prescription drug coverage. Consult the Prescription Drug Benefits section for details.
Diagnostic Tests, X-rays, and Lab Services	Part B covers 80% of Medicare-approved amounts for covered diagnostic tests and x-rays. Part B covers 100% of Medicare-approved amounts for Medicare-covered lab services.	The remaining 20% of Medicare-approved amounts. No additional benefits.	100% covered for Medicare-approved amounts. 100% covered for Medicare-approved amounts.
Doctor Services	Services that are medically necessary (includes outpatient and some doctor services you get when you're a hospital inpatient) or covered preventive services. Except for certain preventive services Part B covers 80% of Medicare-approved amounts.	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.
Durable Medical Equipment	Part B coverage varies. Call your Durable Medical Equipment Regional Carrier (DMERC) for more information.	Covers amounts not covered by Medicare, up to the Medicare-approved amounts.	100% covered for Medicare-approved amounts.

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Emergency Care in United States (U.S.) (You may go to an emergency room if you reasonably believe you need emergency care)	Part A covers 100% after the required copayment for hospital emergency department visit. Part B covers 80% of Medicare-approved amounts for emergency room doctor services.	Part A copayment for hospital emergency department visit. The remaining 20% of Medicare-approved amounts for applicable doctor services.	100% covered for Medicare-approved amounts for emergency room visits. 100% covered for applicable doctor services.
Emergency Care Outside U.S.	Emergency care outside of the U.S. is not covered.	After you pay a \$250 deductible, the plan covers 80% of the cost of emergency care obtained outside of the U.S. during the first 60 days of each trip. (Emergency care obtained after the first 60 days of each trip is not covered.)	80% covered after deductible for services obtained outside the U.S. up to a lifetime maximum of \$50,000.
Hearing Services	Part B covers 80% of Medicare-approved amounts for diagnostic hearing exams.	The remaining 20% of Medicare-approved amounts for diagnostic hearing exams. 100% covered for: <ul style="list-style-type: none"> ■ Hearing aid repair as needed ■ New hearing aids every three years. Maximum benefit of \$1,000 per year.	100% covered for eligible expenses, up to \$1,000 per year.

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Home Health Care	<p>Parts A and B cover 100% of all covered home health visits (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services).</p> <p>Deductible does not apply to this service.</p>	No additional coverage.	<p>100% covered for all covered home health visits.</p> <p>Deductible does not apply to this service.</p>
Hospice Care	<p>Part A covers 100% for hospice care, including physical care and counseling. Room and board generally are not covered, unless for inpatient respite care or during a short-term hospital stay.</p> <p>Part A covers 95% of Medicare-approved amounts for inpatient respite care (maximum of five days per episode). Prescription drugs covered after patient pays up to \$5 copay per prescription during respite care.</p> <p>You must receive care from a Medicare-certified hospice program.</p> <p>Deductible does not apply to this service.</p>	<p>No additional benefits.</p> <p>The remaining 5% of Medicare-approved amounts for inpatient respite care.</p>	<p>100% covered for physical care and counseling.</p> <p>100% covered for respite care (excluding the prescription drug copay). Maximum of five days per episode.</p> <p>Deductible does not apply to this service.</p>

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Hospital Care — Inpatient (includes Substance Abuse and Rehabilitation Services)	<p>Part A covers 100% of inpatient hospital care expenses per benefit period after you pay an initial deductible of \$1,316* and the required copays:</p> <ul style="list-style-type: none"> ■ \$0 copay for days 1–60 ■ \$329* per day for days 61–90 ■ \$658* per day for days 91–150 (lifetime reserve days, which can only be used once). <p>A benefit period begins on the day you go to the hospital and ends when you have not received hospital care for 60 days in a row. There is no limit to the number of benefit periods you can have.</p> <p><i>*Deductibles for 2017</i></p>	<p>All of the Part A deductibles and copayments for days 1–150 of a hospital stay per benefit period.</p> <p>The plan also covers 100% of the cost for up to 365 more days of a hospital stay during your lifetime after you use up all Medicare hospital benefits.</p>	<p>100% covered for days 1–150 of a hospital stay per benefit period.</p> <p>100% covered for an additional 365 days.</p>
Immunizations	Part B covers 100% for pneumonia, Hepatitis B, and annual flu vaccinations. (Deductible does not apply to this service.)	No additional benefits.	100% covered. (Deductible does not apply to this service.)
Mammograms (Annual Screening)	Part B covers 100% of Medicare-approved amounts every 12 months for women age 40 and older.	No additional benefit.	100% covered for Medicare-approved amounts. Deductible does not apply to this service
Mental Health — Inpatient	Same coverage, deductible and copayments as inpatient hospital care. 190-day lifetime limit in a psychiatric hospital.	All of the Part A deductibles and copayments for days 1–150 of a hospital stay per benefit period. The plan also covers 100% of the cost for up to 40 more days of a hospital stay during your lifetime.	100% covered for days 1-190 per lifetime.

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Mental Health — Outpatient	Part B typically covers 80% of Medicare-approved amounts for visits to diagnose condition and 60% for outpatient treatment of your condition.	The remaining 20% or 40% of Medicare-approved amounts. If the provider does not accept Medicare's Assignment, this policy will cover up to 15% over the Medicare allowed amount (not to exceed the charge).	100% covered for Medicare-approved amounts.
Outpatient Hospital Services	Part B covers 80% of Medicare-approved amounts for physician charges. Part B covers 100% of Medicare-approved amounts for outpatient hospital services after a set copayment. Access www.medicare.gov to order a free booklet of outpatient services and copayments.	The remaining 20% of Medicare-approved amounts for physician charges (unless otherwise noted under other specific benefits). All of the Medicare-approved copayments for covered services.	100% covered for Medicare-approved amounts. 100% covered for Medicare-approved amounts.
Pap Test and Pelvic Exams	Part B covers 100% of Medicare-approved amounts for a lab Pap test and pelvic exam. One Pap test and pelvic exam covered every two years; one every year for those at high risk for cervical or vaginal cancer.	No additional benefits.	100% covered for Medicare-approved amounts.
Physical/ Occupational/ Speech Therapy	Part B covers 80% of Medicare-approved amounts for medically necessary outpatient physical and occupational therapy and speech pathology services.	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.
Podiatry Services (covered only for medically necessary foot care; routine foot care not covered)	Part B covers 80% of Medicare-approved amounts.	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
Prescription Drugs	Includes a limited number of drugs such as injections you receive in a doctor's office, certain oral cancer drugs, and drugs used with certain types of durable medical equipment (like a nebulizer) and under very limited circumstances, certain drugs you receive in a hospital outpatient setting. You pay 20% of the Medicare-approved amount for these covered drugs. You pay 100% for all other prescription drug. Coverage is available through Medicare Part D. If you enroll in Medicare Part D, you may not select prescription drug coverage through Northrop Grumman.	The remaining 20% of Medicare-approved amounts for the select drugs covered under Part B. No other prescription drug coverage in the Medigap-type option. You must enroll in Medigap-type option with prescription drug coverage or a Medicare Part D plan for prescription drug benefits.	100% covered for limited number of drugs. Part B deductible does not apply. You must enroll in the Medigap-type with prescription drug coverage or a Medicare Part D Plan for prescription drug benefits.
Prostate Cancer Screening (for men age 50 and older)	Part B covers 80% of Medicare-approved amounts for a digital rectal exam every 12 months and other related services. Part B covers 100% of Medicare-approved amounts for a prostate specific antigen (PSA) test.	The remaining 20% of Medicare-approved amounts. No additional benefit.	100% covered for Medicare-approved amounts. 100% covered for Medicare-approved amounts.
Prosthetic Devices	Part B covers 80% of Medicare-approved amounts for prosthetic devices needed to replace a body part or function. (Includes braces, artificial limbs and eyes, etc.)	The remaining 20% of Medicare-approved amounts.	100% covered for Medicare-approved amounts.
Routine Physical Exams	Medicare will cover at 100% a one-time "Welcome to Medicare" physical exam within the first twelve months you have Part B and a yearly "Wellness" exam if the doctor accepts Medicare assignment.	100% covered for an annual exam, up to \$300 per year. Deductible does not apply to this service.	100% covered for an annual exam, up to \$300 per year. Deductible does not apply to this service.

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
<p>Skilled Nursing Facility Care (in a Medicare-certified skilled nursing facility)</p>	<p>Part A covers 100% of Medicare-approved amounts for skilled care in a skilled nursing facility for the first 20 days of care following a related covered hospital stay for at least 3 days.</p> <p>For days 21–100, you pay \$164.50 per day and Part A covers the remaining expenses. *</p> <p>Maximum of 100 days of skilled nursing facility care per benefit period covered — not covered beyond 100 days. A benefit period begins on the day you go to the skilled nursing facility and ends when you have not received skilled nursing facility care for 60 days in a row. There is no limit to the number of benefit periods you can have.</p> <p><i>*Deductible for 2017</i></p>	<p>No additional benefits.</p> <p>Your Medicare copayment for days 21–100 of skilled nursing facility care.</p>	<p>100% covered for Medicare-approved amounts for days 1-100 in a skilled nursing facility.</p> <p>Deductible does not apply to this service.</p>
<p>Substance Abuse Care (Outpatient)</p>	<p>Part B typically covers 80% of Medicare-approved amounts.</p>	<p>The remaining 20% of Medicare-approved amounts. If the provider does not accept Medicare's Assignment, this policy will cover up to 15% over the Medicare allowed amount (not to exceed the charge).</p>	<p>100% covered for Medicare-approved amounts.</p>

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2017 Medigap – Anthem			
Benefit	What Medicare A and B cover...	What the Medigap-type option covers...	Maximum combined benefit (Medicare + Medigap-type coverage) after Part B deductible
<p>Vision Services (routine eye exams, glasses, and contact lenses not covered)</p>	<p>Part B covers 100% of Medicare-approved amounts for expenses for:</p> <ul style="list-style-type: none"> ■ One pair of eyeglasses or contact lenses after each cataract surgery ■ An annual glaucoma screening for those at risk. <p>Ocular therapy may be covered under certain conditions. Review your Medicare benefits for details.</p> <p>80% covered for Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Deductible does not apply to this service</p>	<p>No additional benefits.</p> <p>The remaining 20% of Medicare-approved amounts.</p>	<p>100% covered for Medicare-approved amounts for:</p> <ul style="list-style-type: none"> ■ One pair of eyeglasses or contact lenses after each cataract surgery ■ An annual glaucoma screening for those at risk. <p>100% covered for Medicare-approved amounts for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Deductible does not apply to this service.</p>

For specific questions about these benefits, contact Anthem at 1-866-504-9638 or www.anthem.com/ca.

For additional information about Medicare in general, go to www.medicare.gov.

BENEFITS FOR SPECIFIC SERVICES

Emergency Care

You pay 0% of the Medicare-approved amounts of the facility charge or physician charges or applicable copayment for each emergency room visit.

For emergency care outside of the U.S., you pay a \$250 deductible then 20% of the cost for emergency care during the first 60 days of each trip (care obtained after 60 days is not covered). The lifetime benefit maximum is \$50,000.

What Is an Emergency?

An emergency medical condition is a condition exhibited by acute symptoms of sufficient severity (including severe pain) such that a prudent person (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily function, or
- Serious dysfunction of any bodily organ or part.

If you are admitted to the hospital immediately after an emergency room visit, your visit is always considered an emergency. Each medical situation is considered individually to determine whether it is an emergency.

Hearing Care

The Medigap-type medical plan option pays 100% up to \$1,000 each plan year for eligible expenses. This includes annual hearing exams, hearing aid repair, or new hearing aids every three years. Hearing aid batteries are not covered.

MEDICAL NECESSITY

The Medigap-type medical plan option 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 Blue Cross
- 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.

PRESCRIPTION DRUG BENEFITS

You may enroll in the Medigap-type option with or without prescription drug benefits. If you elect prescription drug coverage, this section describes the features of the benefits administered by CVS/caremark,

Your Prescription Drug Costs

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

- How you purchase your prescription — at a retail pharmacy in the CVS/caremark pharmacy network or out-of-network or through the CVS/caremark Maintenance Choice® Program (see “How to Purchase Your Prescription Drugs” for details).
- The type of medication (generic, preferred brand, or non-preferred brand; see “Understanding the Different Types of Medications” for details). When available and appropriate, your prescription will automatically be filled with a generic drug. See “Mandatory Generics Program” for details.

You pay a fixed copay for your medication or a percentage of the total cost (the coinsurance), whichever is greater. The chart below describes how the prescription drug benefit works.

Prescription Drug Benefit Features		
	Retail Program (up to 30-day supply)	Maintenance Choice* (up to 90-day supply)
Refill limit	None	2 refills per prescription
CVS/caremark Pharmacies		
Generic drugs	\$5 copay or 20% coinsurance, whichever is greater	\$15 copay or 20% coinsurance, whichever is greater, with a \$200 maximum copay
Preferred brand drugs and compounded prescription medications	\$20 copay or 20% coinsurance, whichever is greater	\$60 copay or 20% coinsurance, whichever is greater, with a \$200 maximum copay
Non-preferred brand drugs	\$40 copay or 20% coinsurance, whichever is greater	\$120 copay or 20% coinsurance, whichever is greater, with a \$200 maximum copay
Non-CVS/caremark Pharmacies		
All prescription drugs	50% coinsurance after annual \$50 individual/\$100 family deductible	N/A

**Up to two fills of a maintenance medication at a retail pharmacy are covered. After that, you must use the Maintenance Choice® Program which allows you to fill a 90-day supply either at a CVS/pharmacy location or through mail order using the CVS Mail Service Pharmacy.*

Copayments (Copays)

The copayment, or copay, is the flat-dollar amount you pay directly to the pharmacy for prescription drugs; the plan pays the rest of the cost.

Coinsurance

The plan pays a percentage of your eligible expenses, and you pay the remaining amount. The amount you pay is called coinsurance. Coinsurance amounts apply to your out-of-pocket maximum.

How to Purchase Your Prescription Drugs

You have the following 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 if 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 “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, which allows you to fill a 90-day supply at a CVS/pharmacy location, or through mail order using CVS Mail Service Pharmacy. (See “CVS/caremark Maintenance Choice” for details.)

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 location; 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 CVS/caremark network pharmacies, to confirm that a particular pharmacy participates in the network, and to find the pharmacy closest to you, contact CVS/caremark at 1-855-361-8565 or go to the CVS/caremark website at www.caremark.com. Note that Walgreens is not an in-network pharmacy.

When You Use a Pharmacy in the CVS/caremark Pharmacy Network

When you use a participating CVS/caremark pharmacy to purchase your prescription drugs, follow these steps:

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 participating CVS/caremark pharmacy.
3. Show your prescription drug plan ID card to the pharmacist. If you do not have your ID card, your coverage may be limited to 50% of your eligible expense. (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 ID card.)

4. Pay the appropriate copayment or coinsurance at the pharmacy.

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 approve reimbursement for 50% of your eligible expenses, after you pay the \$50 individual/\$100 family annual deductible.

The deductible is the amount of money you pay before your prescription drug plan option begins to pay your eligible prescription drug expenses. Each plan year, you have a new deductible. Expenses credited to your deductible do not carry over from one benefit plan year to the next.

To meet the family deductible, you can combine eligible expenses incurred by you and your enrolled family members. However, the maximum you can count from each of you is the individual deductible (\$50).

CVS/caremark Maintenance Choice® Program

If you take any prescriptions on a on a regular basis — such as medications for high blood pressure or diabetes — you can save time by using the CVS/caremark Maintenance Choice® Program. With Maintenance Choice, you can have a 90-day supply of your medication filled directly at a CVS/pharmacy location or you can use the CVS Mail Service Pharmacy. 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 Maintenance Choice, you pay the appropriate copay or coinsurance and receive up to a 90-day supply of your medication. Choose one of four ways to start using Maintenance Choice:

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 the CVS/caremark Maintenance Choice® program 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 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, you will pay the full cost of the medication at your participating 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 plus the difference in cost between the generic and the brand-name prescription drug.

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.** 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.

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

CVS/caremark Specialty Pharmacy

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

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

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

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

- Access to an on-call pharmacist 24 hours a day, seven days a week
- Coordination of care with the patient and doctor
- Direct delivery to the patient or doctor's office
- Medicine-specific and disease-specific education and counseling
- Online support through 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 *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.)

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 web site for the lists of prescription drugs that are eligible and ineligible for reimbursement. 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 Retiree Medical 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.

Understanding the Different Types of Medications

Under the prescription drug program, you have access to a wide range of covered prescriptions. Your share of the cost is based on the actual cost of the medication to the plan, which depends on the type of drug — generic, preferred brand, or non-preferred brand.

Generic vs. Brand Drugs

Once the patent on a brand drug expires, its generic form can be made available to patients. This means that a generic medication is a copy of its brand equivalent — they are identical in dosage, safety, strength, how they are taken, effectiveness, and intended use. Each brand drug and its generic equivalent share the same active ingredients and are often made by the same manufacturer. For most patients, the generic drug works just as well as the brand drug because the active ingredients are the same.

However, brand drugs are more expensive because their prices include the cost of research and development, as well as marketing and advertising. Once the generic form is available, it is priced at a lower cost — which can save you and the plan money.

All prescription drugs — including generics — must be researched, tested, and approved by the Food and Drug Administration (FDA).

Preferred Brand vs. Non-preferred Brand

Often, more than one brand medication can treat a condition. The plan's physician and pharmacist advisors have approved a list of specific preferred brand drugs — something called a formulary or a primary drug list. Preferred brand drugs are selected based on their success in effectively treating certain conditions, as well as their relative cost-effectiveness.

You have access to brand drugs that are not on the preferred list, but your share of the cost is greater because they are not as cost effective for the plan.

You can also request a copy of CVS/caremark's preferred drug list, or check a specific prescription drug, by calling CVS/caremark or accessing the CVS/caremark web site at www.caremark.com. If you currently have a prescription for a brand drug that is not preferred,

there may be an alternative preferred brand drug that may work just as well for you. Check with your doctor and share the list of preferred drugs with him or her.

Over-the-Counter Medications

An over-the-counter medication is one that you can obtain without a prescription. The prescription drug benefit in the Medigap-type plan option does not cover over-the-counter medications, including those that previously required a prescription (e.g., Claritin, Zantac, and Tagamet).

In some cases, certain over-the-counter medications may have similar prescription medications that may be used as an alternative. For example, Clarinex, which is a prescription medication, may be an alternative to over-the-counter Claritin or Allegra. Although the prescription drug benefit may cover the prescription alternative (usually at the non-preferred brand level), it often will cost you more than the over-the-counter drug.

Special Information for Diabetics

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
- 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.

Northrop Grumman Retiree Medical Plan SPD
Retiree Health Reimbursement Arrangement
January 2017

***Northrop Grumman Retiree Medical Plan
Retiree Health Reimbursement Arrangement***

January 2017

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RETIREE HEALTH REIMBURSEMENT ARRANGEMENT

This guide provides information about the Retiree Health Reimbursement Arrangement (“RHRA”) component of the Northrop Grumman Retiree Medical Plan. If you have questions not answered in this guide, contact Willis Towers Watson’s OneExchange at 1-855-832-076 or visit the OneExchange website at <https://medicare.oneexchange.com/ngc>. You may also call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194

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

This guide is the summary plan description (SPD) for the Retiree Health Reimbursement Arrangement (“RHRA”) component of the Northrop Grumman Retiree Medical Plan. The original effective date of the Northrop Grumman Retiree Medical Plan was January 1, 2006. The Retiree Health Reimbursement Arrangement became effective August 1, 2014. This SPD describes terms of the RHRA as of January 1, 2017.

The benefits described in this SPD are offered to certain retired employees of Northrop Grumman Corporation. Northrop Grumman reserves the right to amend, modify or terminate any and all parts of the Northrop Grumman Retiree Medical Plan, including the RHRA, at any time and for any reason.

This SPD is considered part of, and must be read together with, the “main” portion of the SPD for the Northrop Grumman Retiree Medical Plan, which contains the plan rules regarding eligibility, participation, costs, administration, COBRA continuation coverage and other important information regarding the Plan that applies to the benefits described in this document.

References to the “Company” in this guide include Northrop Grumman Corporation and Northrop Grumman’s affiliates that participate in the Plan.

OVERVIEW OF RETIREE HEALTH REIMBURSEMENT ARRANGEMENT (RHRA)

As described in the “main” portion of the Summary Plan Description for the Northrop Grumman Retiree Medical Plan (Plan), when an eligible retiree reaches age 65, the eligible retiree’s medical and prescription drug coverage under the Plan terminates. The same rule applies to an eligible retiree’s spouse/domestic partner.

If you are eligible for subsidized coverage under the Northrop Grumman Retiree Medical Plan as a member of an eligible heritage company group as described in the “main” portion of the Summary Plan Description, you are eligible for the Company-paid retiree health reimbursement arrangement (RHRA) described in this guide. In some cases, your spouse/domestic partner may also be eligible for a Company-paid credit to your RHRA. Your spouse/domestic partner must have been your spouse/domestic partner at the time you retired in order for your spouse/domestic partner to qualify for an RHRA credit.

The RHRA reimburses you for some or all of the cost of your and/or your spouse/domestic partner’s individual Medicare supplemental and prescription drug plan premiums, as well as dental, vision and Medicare Part B premiums, as described below in the “Eligible Premium Expenses” section. In addition, if you are eligible for subsidized coverage under the Plan as a member of an eligible heritage company group, you are also eligible for a supplemental prescription drug benefit to mitigate the cost of Medicare Part D prescription drug benefits if you and/or your spouse/domestic partner have drug expenses that reach the “catastrophic” level of your Part D coverage. The supplemental prescription drug benefit is described in more detail below in the “Supplemental Prescription Drug Benefit” section. Retirees who are not eligible for subsidized coverage as a member of an eligible heritage company group are not eligible for the supplemental prescription drug benefit.

ESTABLISHMENT OF RHRA

An RHRA may be established for you and/or your spouse/domestic partner with annual Company-paid credits if you are eligible for subsidized retiree coverage based on heritage company status.

Annual RHRA Credits

Annual RHRA credits are available only if you are eligible for subsidized retiree coverage based on your heritage company status. If you are eligible for subsidized coverage, you and/or your spouse/domestic partner will be eligible for annual Company-paid credits to an RHRA beginning on the first date that you (or they) could enroll in Medicare as a result of reaching age 65 (“Medicare Eligibility Date”). The RHRA can be established as early as your or your spouse/domestic partner’s Medicare Eligibility Date, if you timely take the steps described below.

You and your spouse/domestic partner do not both have to be age 65 in order for an RHRA to be established. As long as one of you reaches your Medicare Eligibility Date and takes the steps described below, the RHRA will be established and credited with the specific RHRA credit

attributable to that person. In the case of Grumman heritage retirees, only the retiree is eligible for an RHRA; no RHRA credits are available for the retiree's spouse/domestic partner. In addition, as described below in the "Amount of RHRA Credit" section, in the case of Grumman heritage retirees, annual Company-paid credits cease after a specific number of years.

Under Medicare rules, your Medicare Eligibility Date is the first day of the month in which you reach age 65. So, for example, if your 65th birthday is on June 15th, you can enroll in Medicare effective June 1st. Medicare considers you to turn age 65 on the day *before* your 65th birthday, so if your birthday is on the first day of a month, Medicare will consider you to turn age 65 on the last day of the preceding month, which impacts your Medicare Eligibility Date. For example, if your 65th birthday is on June 1st, Medicare will consider you to reach age 65 on May 31st and you can enroll in Medicare effective May 1st.

Because medical and prescription drug coverage under the Plan terminates for you or your spouse/domestic partner when you or they reach their Medicare Eligibility Date, it is important that you and/or your spouse/domestic partner take the steps described below so that your RHRA is established on your/their Medicare Eligibility Date to assist in paying for Eligible Premium Expenses and provide the supplemental prescription drug benefit.

In order for your RHRA to be established and credited with funds effective as of your or your spouse/domestic partner's Medicare Eligibility Date (or, in your case, after your retirement date, if you retire after your Medicare Eligibility Date), you and/or your eligible spouse/domestic partner will need to do the following:

- Enroll in Medicare Part A and B for coverage to be effective on your/their Medicare Eligibility Date (or, in your case, on your retirement date, if you retire after your Medicare Eligibility Date). Contact your local Social Security Administration office for information about how to enroll in Medicare.
- Timely enroll in individual Medicare supplemental and/or prescription drug coverage through OneExchange (see below for further information) or enroll in individual Medicare supplemental and/or prescription drug coverage through Kaiser and notify OneExchange of your enrollment. You may be required to provide proof of your enrollment in an individual Kaiser plan.

If you or your spouse/domestic partner do not complete these steps at your/their Medicare Eligibility Date, an RHRA will not be established until the steps are completed.

Example 1: You retire at age 63 and are eligible for subsidized coverage based on your heritage company status. Your 65th birthday is June 1, 2017. You are not married and have no domestic partner. You are enrolled in coverage under the Northrop Grumman Retiree Medical Plan. Because your 65th birthday falls on the first day of June, you will be eligible to enroll in Medicare as of May 1, 2017. Your last day of medical and prescription drug coverage under the Plan will be April 30, 2017. If you timely enroll in Medicare Part A and B so that coverage is effective May 1, 2017 and by that date enroll in individual Medicare supplemental coverage through OneExchange or Kaiser (and notify OneExchange of your enrollment in individual Kaiser Medicare supplemental coverage), an RHRA will be established for you effective as of May 1, 2017.

Example 2: You retire at age 63 and you and your spouse are eligible for subsidized coverage based on your heritage company status. You and your spouse are enrolled in coverage under the Plan. Your spouse is age 64 and his 65th birthday is August 15, 2017. Under Medicare rules, your spouse will be eligible to enroll in Medicare as of August 1, 2017. Your spouse's medical and prescription drug coverage under the Plan will terminate. The last day of coverage under the Plan would be July 31, 2017. If your spouse timely enrolls in Medicare Part A and B so that coverage is effective August 1, 2017 and by that date enrolls in individual Medicare supplemental coverage through OneExchange or Kaiser (and notifies OneExchange of his enrollment in individual Kaiser Medicare supplemental coverage), an RHRA will be established with a credit for your spouse effective as of August 1, 2017. You would continue to be eligible for medical and prescription drug coverage under the Plan until your Medicare Eligibility Date (as described in Example 1).

Example 3: You retire on November 30, 2017 at age 68 and are eligible for subsidized coverage based on your heritage company status. You have an eligible domestic partner who is age 61. Her 65th birthday is March 24, 2021. Because you are eligible for Medicare based on your age at the time you retire, you are not eligible for medical and prescription drug coverage under the Plan on your retirement. If you timely enroll in Medicare Part A and B so that coverage is effective December 1, 2017 and by that date enroll in individual Medicare supplemental coverage through OneExchange or Kaiser (and notify OneExchange of your enrollment in individual Kaiser Medicare supplemental coverage), an RHRA will be established with a credit for you effective as of December 1, 2017. Your domestic partner would be eligible for medical and prescription drug coverage under the Plan until her Medicare Eligibility Date (March 1, 2021). If she timely enrolls in Medicare Part A and B so that coverage is effective March 1, 2021 and by that date enrolls in individual Medicare supplemental coverage through OneExchange or Kaiser (and notifies OneExchange of her enrollment in individual Kaiser Medicare supplemental coverage), the RHRA will be credited with an amount for your domestic partner effective as of March 1, 2021.

AMOUNT OF ANNUAL RHRA CREDIT

Retirees who are eligible for subsidized coverage under the Northrop Grumman Retiree Medical Plan based on their heritage company status are eligible for an annual RHRA credit. The Company, in its sole discretion, determines the amount of the annual RHRA credit that a retiree and/or his or her spouse/domestic partner will receive. The Company may, but is not required to, vary the amount and/or duration of RHRA annual credits based on a retiree's heritage company status. As noted above, in some cases (for example, Grumman heritage retirees), only the retiree (and not his/her spouse/domestic partner) is eligible for an annual RHRA credit, or the annual RHRA credit may be provided for only a limited period of time. The Company may at any time choose to cease providing RHRA credits and reduce all RHRA accounts to zero. As noted above, retirees who are not eligible for subsidized coverage under the Plan based on their heritage company status do not receive annual RHRA credits from the Company.

Prior to your and/or your spouse/domestic partner's Medicare Eligibility Date, you will receive information from the NGBC regarding the amount of your and/or your spouse/domestic partner's RHRA credit and, if applicable, the duration of the RHRA credit. If you retire after your Medicare Eligibility Date (for example, you retire at age 68), you will receive this information as part of

your retiree enrollment kit. The annual RHRA credit amount will be pro-rated at establishment to reflect the number of months you and/or your spouse/domestic partner will be enrolled in eligible Medicare supplemental coverage through OneExchange (or Kaiser) for the calendar year of establishment (see Examples 4 and 5 below). The entire pro-rated amount is available as of the date of establishment of your RHRA.

The annual credit amount for you and/or your eligible spouse/domestic partner (if he/she is eligible for RHRA credits) will be credited to your RHRA each January 1, provided that you remain enrolled in eligible Medicare supplemental coverage through OneExchange (or Kaiser). As noted above, both of you do not have to be enrolled in eligible Medicare supplemental coverage through OneExchange (or Kaiser) in order for the person who is enrolled to get the annual RHRA credit. An annual RHRA credit will be made for the person who is enrolled. For example, if you and your spouse are each eligible for a \$2,000 annual RHRA credit, but your spouse drops her Medicare supplemental coverage because she returns to work, you will continue to receive your \$2,000 annual RHRA credit while you remain enrolled in eligible Medicare supplemental coverage through OneExchange (or Kaiser).

Unused credits that remain in your RHRA at the end of a calendar year will carry over into the next calendar year.

Eligible Premium Expenses

Amounts credited to your RHRA can reimburse you for amounts you pay for the following for yourself and/or your eligible spouse/domestic partner:

- Medicare Part B premiums;
- Premiums for individual Medicare supplemental coverage and/or Medicare Part D coverage purchased through OneExchange or Kaiser (this includes Medigap coverage, Medicare Advantage (MA) coverage, Medicare Part D coverage and Medicare Advantage with Part D coverage (MA-PD)); and
- Premiums for dental and vision insurance.

To be eligible for reimbursement, the premium expenses must be incurred after your RHRA is established.

The RHRA will be set up as a “joint account” and the full amount credited to the RHRA for both you and your spouse/domestic partner will be available to reimburse Eligible Premium Expenses for both of you. For Grumman heritage retirees, only the retiree is eligible for an RHRA and the RHRA only reimburses Eligible Premium Expenses for the retiree; premium expenses for the spouse/domestic partner are not eligible for reimbursement. This applies to annual RHRA credits and any amount that was transferred to the RHRA in the one-time CDHP HRA balance transfer that was available when the RHRA component was established on August 1, 2014. If both you and your spouse/domestic partner are retired from Northrop Grumman, separately enrolled in Northrop Grumman health care coverage, and both are eligible for an RHRA, your accounts will be set up as “individual accounts” and each of you will only be able to be reimbursed for Eligible Premium Expenses from your own RHRA.

Example 4: *You retire on July 1, 2017 at age 66 and are eligible for subsidized coverage based on your heritage company status (you are not Grumman heritage). Your spouse is also age 66. You and your spouse timely enroll in Medicare Part A and B so that coverage is effective July 1, 2017 and by that date enroll in individual Medicare supplemental coverage through OneExchange. Based on your heritage company status, the annual RHRA credit for each of you is \$2,000. Your RHRA will be set up as a joint account, effective July 1, 2017 and will be credited with a total of \$2,000 on that date. The \$2,000 amount is equal to the sum of your pro-rated annual credit ($\$2,000 \times 6/12 = \$1,000$) plus your spouse's pro-rated annual credit (also $\$2,000 \times 6/12 = \$1,000$). The full \$2,000 is available to reimburse Eligible Premium Expenses incurred by either of you. The next January 1, an additional \$4,000 would be credited to the RHRA (the full \$2,000 annual credit for each of you) and the entire balance would be available to reimburse Eligible Premium Expenses incurred by either of you.*

Example 5: *The same facts as Example 4, but each of you is a Northrop Grumman retiree and separately enrolled in coverage. Each of your RHRAs would be established as an individual account, credited with \$1,000 (the pro-rated annual contribution) on July 1st. You would be eligible to obtain reimbursement for your Eligible Premium Expenses of up to \$1,000 from your RHRA and your spouse would be eligible to obtain reimbursement for his/her Eligible Premium Expenses of up to \$1,000 from his/her RHRA. Neither you nor your spouse could obtain reimbursements from the other's RHRA. The next January 1, an additional \$2,000 would be credited to each of your RHRAs.*

Please note that premium expenses for your eligible domestic partner may be considered taxable reimbursements if your domestic partner doesn't qualify as your dependent for purposes of section 105 of the Internal Revenue Code ("accident and health plan" coverage). Contact your tax advisor with questions.

CLAIMING REIMBURSEMENT

After you or your eligible spouse/domestic partner has paid an Eligible Premium Expense (as described above), you must complete a reimbursement form (available by contacting OneExchange at 1-855-832-0976) and mail or fax it to OneExchange at the address or fax number specified on the form. You must include a copy of your paid receipts or other documentation showing that you paid the Eligible Premium Expense (keep a copy for your records, as well). Certain insurance carriers offered through OneExchange offer you the opportunity to sign up for an automatic reimbursement program that eliminates the need for you to submit claims for reimbursement. If you sign up, after you have paid your premium to the carrier for your individual coverage, the carrier notifies OneExchange, which then processes your reimbursement check (if you have funds available).

Effective January 1, 2017, requests for reimbursement must be submitted no later than the March 31st following the end of the plan year in which the expense was incurred or the request for reimbursement will be denied. If you do not meet the claim filing deadline for the previous plan year's expenses, your unused RHRA credits will still be available to reimburse you for current and future year expenses. The deadline to submit reimbursement requests for expenses incurred August 1, 2014 through December 31, 2016 is June 30, 2017, as a one-time exception.

If your claim for reimbursement is wholly or partially denied, you will be notified in writing within 30 days after OneExchange receives your claim. If OneExchange determines that an extension of this time period is necessary due to matters beyond the control of the Plan, OneExchange will notify you within the initial 30-day period that an extension of up to an additional 15 days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have at least 45 days to provide the additional information. The notice of denial will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request all documentation relevant to your claim.

If your request for reimbursement under the Plan is denied in whole or in part and you do not agree with the decision of the Claims Submission Agent, you may file a written appeal. All appeals must be made in writing within 180 days after the receipt of the denial notice. Appeals should be addressed to:

Benefit Plans Administrative Committee – Northrop Grumman Retiree Medical Plan
Northrop Grumman Corporation
P.O. Box 770003
Cincinnati, OH 45277-1060

You may submit written comments, documents, records and other information relating to your claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. The review of your appeal will take into account all comments, documents, records and other information you submit, without regard to whether such information was considered in the initial benefit determination. The review will be conducted by the Committee or its delegate and will not afford deference to the initial claim determination made by OneExchange.

You will be notified in writing of the Committee's decision on your appeal not later than 60 days after the Committee receives your request for review. The Committee will provide you with any new or additional evidence that it considers, relies on or generates in connection with the claim. It will provide the evidence as soon as possible and sufficiently in advance of the date on which the Committee must render a decision on your appeal so that you have a reasonable opportunity to respond before that date. If the Committee intends to issue a decision on appeal based on a new or additional rationale, the Committee will provide you with the new or additional rationale as soon as possible and sufficiently in advance of the date on which the Committee may render a decision on your appeal so that you have a reasonable opportunity to respond before that date. If the decision is adverse, the notification will set forth: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the benefit determination is based; (3) a statement that you are entitled to receive, upon

request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; (4) a statement of your right to bring an action under section 502(a) of ERISA; and (5) the following statement: “You and 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.” Note that you cannot file suit in federal court until you have exhausted these appeals procedures.

SUPPLEMENTAL PRESCRIPTION DRUG BENEFIT

If you are eligible for subsidized retiree coverage under the Northrop Grumman Retiree Medical Plan and take the steps necessary to have an RHRA established for you as described in this guide, you may be eligible for a supplemental prescription drug benefit to help offset your out of pocket drug costs if they exceed a specified threshold, as described below. Amounts paid under this supplemental prescription drug benefit are separate from your RHRA and do not reduce the amount of your RHRA balance that is available to pay for Eligible Premium Expenses.

To be eligible for this additional benefit, you and/or your eligible spouse/domestic partner must enroll in Medicare Part D prescription drug coverage through OneExchange or Kaiser. If the amount of your or your eligible spouse/domestic partner’s Medicare Part D prescription drug expenses that you pay out of pocket (including copays and coinsurance; excludes premiums) reach the “catastrophic” level of a Medicare Part D or MA-PD plan — which is defined by Medicare as being when you meet the annual out-of-pocket maximum (referred to as TrOOP) — the supplemental prescription drug benefit will reimburse your copays for eligible Part D prescription drug expenses in the catastrophic level for the remainder of the plan year, up to \$5,000 per year. This benefit is available on an individual basis to the person whose Medicare Part D prescription drug expenses reach the catastrophic level. Your and your spouse/domestic partner’s expenses are not combined to satisfy this requirement and each person who satisfies the requirement is eligible for a reimbursement of up to \$5,000 per year. In the unlikely event that you or your spouse/domestic partner incurs substantially greater out-of-pocket costs than \$5,000 while in the catastrophic level, he or she can file a claim for additional reimbursement by contacting OneExchange. This limit may be adjusted based on future changes to Medicare legislation.

Below is the process for receiving reimbursement under the supplemental prescription drug benefit:

- Once the individual has reached the Medicare prescription drug “catastrophic” threshold, he or she can call OneExchange at 1-855-832-0976 and request a reimbursement kit for prescription drug assistance. The kit will include a special claim form for this benefit, a direct deposit form and instructions for substantiating each eligible prescription drug expense. The completed forms and requested documentation should be returned to OneExchange.
- The claim administration and appeal process described above will apply to claims for the supplemental prescription drug benefit. Claims must be submitted by the March 31 that follows the year in which the claims were incurred.

TERMINATION OF RHRA

In addition to the rules regarding termination of coverage under the Northrop Grumman Retiree Medical Plan that are contained in the “main” portion of the SPD for the Plan, your/your spouse/domestic partner’s participation in the RHRA will terminate when neither you nor your spouse/domestic partner are purchasing individual Medicare supplemental or prescription drug coverage through OneExchange or Kaiser. At that time, any RHRA balance will be suspended. You and/or your spouse/domestic partner will be eligible to re-enroll in individual Medicare supplemental or prescription drug coverage through OneExchange (or Kaiser) at a later date (subject to Medicare enrollment rules) and (if you were eligible for subsidized retiree medical coverage based on your heritage company status and your re-enrollment occurs in a calendar year after your RHRA participation terminated) qualify for a pro-rated annual RHRA contribution at that time. In addition, your previously suspended RHRA balance would be reactivated at that time.

In the event that you (the retiree) die while you are participating in an RHRA, your spouse/domestic partner will be eligible to continue participating in the RHRA as a surviving spouse/domestic partner, as described below. If you were not eligible for annual RHRA contributions (in other words, your RHRA resulted from the one-time CDHP HRA balance transfer that was available when the RHRA component was established August 1, 2014), your surviving spouse/domestic partner will be eligible to claim reimbursements for Eligible Premium Expenses until the balance is exhausted as long as he/she remains enrolled in individual Medicare supplemental or prescription drug coverage through OneExchange (or Kaiser). If your spouse/domestic partner was eligible for annual RHRA contributions based on your heritage company status, the RHRA would be a joint account and your surviving spouse/domestic partner will continue to be eligible to access the balance of the RHRA and will continue to be eligible for his/her individual annual RHRA credits while he/she remains enrolled in individual Medicare supplemental or prescription drug coverage through OneExchange (or Kaiser). If you and your spouse/domestic partner had separate RHRAs (you were both retired from Northrop Grumman and separately enrolled in coverage), your surviving spouse/domestic partner will continue to be eligible to access the balance only in his/her RHRA and will continue to be eligible for his/her individual annual RHRA credits while he/she remains enrolled in individual Medicare supplemental or prescription drug coverage through OneExchange (or Kaiser). The amount of those annual RHRA credits will be the amount that he/she was eligible for prior to your death. The surviving spouse/domestic partner rules described in this paragraph do not apply to surviving spouses/domestic partners of Grumman heritage retirees, because spouses/domestic partners of Grumman heritage retirees are not eligible to participate in an RHRA.