2023

Huntington Ingalls Industries, Inc. Group Benefits Plan: Ingalls Operations Hourly Health and Disability Plan

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About this SPD

Huntington Ingalls Industries, Inc. (also referred to as the "Company" in this booklet) maintains the Huntington Ingalls Industries, Inc. Group Benefits Plan (the "Group Benefits Plan"), which allows eligible employees to choose from a variety of health and welfare benefit options to meet their individual and family needs, and, for some of these benefits, to pay for them on a pre-tax basis.

As an employee of the Company (or a participating affiliate), you and your family have a wide range of health and welfare benefits available. This booklet provides a summary of the Ingalls Operations Hourly Health and Disability Plan (the "Plan"), a component plan under the Group Benefits Plan, which offers the following health and welfare benefits (which are referred to in this booklet as the "benefit options," the "component plans" or simply the "plans"):

- Medical Plans
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Loss of Time Benefits
- Life and AD&D Plan
- HERO (HII Employee Reach Out) – formerly EAP

The Plan gives you access to meaningful benefit choices at competitive rates. You have the flexibility to choose the benefits and coverage levels that are right for you — based on your personal situation. Understanding the benefits is the key to getting the most out of all the offerings.

This booklet describes the benefit options available under the Plan, which have been jointly negotiated by the Company and the various unions representing employees employed by the Ingalls Shipbuilding Division or Huntington Ingalls Industries International Shipbuilding, Inc. at the Company's Ingalls facilities located on the East and West Bank of the Pascagoula River, Pascagoula, Mississippi.

Each of the benefit options listed above is summarized in a separate document prepared by the Company or a certificate of insurance booklet, brochure, benefit description, evidence of coverage document or other material prepared by the third-party administrator or insurance carrier that administers and provides services to such plan (which are referred to collectively in this booklet as the "Benefit Booklets"), and which are incorporated by reference and are considered a part of this booklet. The Benefit Booklets contain the Plan rules regarding eligibility, participation, costs, administration and other important information that applies to the benefit option being described therein. In the event of any discrepancy between a Benefits Booklet and the summary provided in this document, the Benefits Booklet will control. A listing of the applicable Benefit Booklets can be found on the Appendix and are available by contacting the HII Benefits Center (see "Questions?" below for contact information).

This booklet, along with each of the Benefit Booklets, constitutes the Plan's "summary plan description" ("SPD") required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), for the benefit options subject to ERISA. It is important, when reviewing the information in this SPD, to refer to the Benefit Booklets to get a complete picture of the benefit plans.

The Company reserves the right to amend, modify or terminate any and all parts of the Plan at any time and for any reason (subject to any relevant collective bargaining agreements). This SPD is not a contract for, nor a guarantee of, present or continued employment between you and the Company. If there are any differences between the information contained in this SPD and the Group Benefits Plan document, the Group Benefits Plan document will always govern.

At the end of this handbook is an Appendix, which provides you with a complete list of all of the Benefit Booklets. You can access these documents directly at *www.hiibenefits.com*.

Questions?

Please read the information in this SPD carefully and share it with your family. If you have questions not answered in this guide, contact the HII Benefits Center at 1 877-216-3222 (International: 408-916-9765). Benefits service representatives are available to answer your questions Monday through Friday, 9:00 a.m. to 6:00 p.m. Eastern time, excluding holidays. If you are hearing impaired, you will need to use a relay service through your TTY/TDD service provider.

Benefits Highlights

The Plan provides you and your family with health care coverage and financial protection. It also offers a great deal of flexibility by allowing you to select the benefits that best meet your needs and the ability to change your benefit elections annually as those needs change.

The Plan includes medical and prescription drug coverage, as well as loss of time and life and accident insurance benefits. In addition, you can elect to participate in the health care and dependent care flexible spending accounts.

Health Care Benefits

The Plan is designed to promote good health and wellness. If you select medical coverage, you choose from the following coverage categories:

- You only
- You + family

Important Note! The Consolidated Appropriations Act of 2021 ("CAA"), including the No Surprises Act, made significant changes regarding how group health plans cover and process certain medical claims (e.g., specified coverage of emergency, non-emergency and air ambulance services from nonparticipating providers, continuity of care requirements where certain participating providers or facilities terminate the contractual, network relationship with the plan, advanced explanation of benefits). This SPD provides an overview of select aspects of your group health plan coverage – for additional details regarding your group health plan coverage, including any applicable CAA/No Surprises Act requirements, please consult your group health plan Benefits Booklet and/or contact the applicable carrier/third-party administrator using the information in the "Contacts" section of this document.

Medical Plan

The Anthem PPO medical plan option provides comprehensive coverage for a broad range of covered services, including 100% coverage for preventive care when you use an in-network provider, as well as prescription drug coverage. The Plan provides access to quality care and protection from the high cost of medical services and supplies.

With the PPO medical plan, provided through Anthem, you have access to both in-network and out-of-network providers. However, you will generally have higher out-of-pocket costs when you use an out-of-network provider.

Flexible Spending Accounts

Health care and dependent care flexible spending accounts (FSAs) let you contribute to an account you can use to reimburse yourself for eligible health care or dependent care expenses. Your FSA contributions are deducted from each paycheck before taxes and deposited into your account.

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

- Set aside $0 to $3,050 (based on current IRS guidelines, which may be adjusted annually for cost of living increases) of before-tax dollars annually in the **health care FSA** for reimbursement of you and your dependent(s)'s eligible health care expenses
- Set aside $0 to $5,000 of before-tax dollars annually in the **dependent care FSA** for reimbursement of your eligible dependent care expenses. Note, however, that if your annual salary is more than $135,000, your annual dependent care FSA contributions are capped at $2,600 (rather than $5,000).

You can enroll in one or both of the FSAs — or you can choose not to participate. The choice is yours! FSAs are sometimes referred to as "use it or lose it" accounts, as you will lose any FSA money you don't use within the eligible period. So plan carefully.

Life and Accident Insurance

The Plan's life and accidental death & dismemberment (AD&D) insurance plans provide income protection in the case of death or accidental injury.

You automatically receive the following basic benefits at no cost to you:

- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance

Life and Accidental Death & Dismemberment Insurance

Highlights of your basic life and AD&D insurance include:

Survivor Benefit Plan	Enrollment	Cost Sharing	Coverage
Basic Life Insurance	Automatic	The Company pays the full cost	$50,000
Basic Accidental Death & Dismemberment Insurance	Automatic	The Company pays the full cost	$50,000

Loss of Time Coverage

In the event that you are unable to work due to a disability, the Plan offers benefits that provide you with a source of income during that time.

- You are eligible for loss of time benefits that provide a weekly benefit equal to $345 in the event that you are unable to work due to illness or injury.
- The plan provides a weekly benefit beginning on the first day of an accidental injury, or on the 8th day of sickness (including pregnancy) for up to 26 weeks.

Additional Benefits

The Plan also includes additional benefits to provide support and peace of mind to you and your family for health or personal matters:

Program	Benefits Offered	Enrollment Required to Participate
HERO (EAP)	A free, confidential source for information, referrals and counseling for you and your family/household members.	No

Health Care Benefits

Your overall health and well-being is important. To help support your wellness needs, Huntington Ingalls offers quality health care benefits consisting of medical (including prescription drug) coverage and health care flexible spending accounts.

Huntington Ingalls provides the resources to help you get the most out of your benefits. It's your responsibility to stay informed, use the appropriate resources and take charge of your health.

For additional information about your health care benefits, see "Administrative Information".

More Information

For specific details about each health care plan, please refer to the supplemental documents. You can access these from the "Appendix" section.

Participating in Healthcare Benefits

Huntington Ingalls provides medical (including prescription drug) benefits, as well as health care flexible spending accounts. The healthcare plans offer valuable financial protection against the high cost of illness and injury, and benefits to help keep you well.

This section includes information about who is eligible for healthcare benefits, how to enroll or make changes to your benefit elections, when coverage is effective, and when it ends.

Eligibility and Enrollment

You must meet certain eligibility requirements and follow specific enrollment rules in order to receive your healthcare benefits.

Eligibility

You are eligible for the benefits described in this booklet on the first day of the month following the date you complete 30 days (31 days for life insurance) of continuous service if you are a regular full-time employee of the Company in a collective bargaining unit covered by the agreement.

Dependent Eligibility

You may enroll your eligible dependents for coverage in the medical care programs. Coverage for your eligible, enrolled dependent(s) generally begins at the same time as your coverage. Your eligible dependents include your:

Your legal same-sex or opposite-sex spouse. Keep in mind that legal separation or divorce terminates the spousal relationship for purposes of the Plan.

Your dependent children who are under 26 years of age, including:

- biological children,
- stepchildren,
- adopted children (who are legally adopted by you or lawfully placed with you for adoption), and
- foster children (placed with you by an authorized placement agency or by judgment, decree, or other order of a court of competent jurisdiction).
- Your unmarried child shall remain an eligible dependent beyond age 26 if he or she is incapable of self-sustaining employment by reason of mental or physical handicap; provided the child became incapacitated prior to age 26. You must provide satisfactory proof of the child's incapacity to Anthem Blue Cross before they reach age 26.

Dependent Verification Required

Keep in mind, that you must provide verification of dependent eligibility each year, as requested, in order for a dependent to remain eligible under the Plan. Failure to comply with any such request for documentation will result in loss of coverage for the dependent.

Important Rules about Covering Dependents

- All covered dependents must be properly listed with the HII Benefits Center to be covered under the Plan.
- If a covered dependent becomes ineligible for medical coverage for any reason and you do not properly notify the HII Benefits Center in a timely manner, you will be responsible for reimbursing the Plan for any claims paid on behalf of that dependent.
- If your dependent children become employed by the Company, they shall remain eligible for dependent coverage until the end of the month of their 26th birthday.
- If both spouses are employed at Huntington Ingalls Incorporated or at a Huntington Ingalls Incorporated subsidiary or affiliate and the employee electing the health coverage loses that coverage, the spouse and eligible dependent children will have the right to choose available health coverage without a waiting period.

Qualified Medical Child Support Orders

A qualified medical child support order (QMCSO) is an order or judgment from a state court or administrative agency. This order directs the Plan Administrator to cover a child for benefits under a health care plan.

Here are a few examples of individuals who may be covered under a QMCSO:

- A child born to a single parent
- A child who is not claimed as a dependent on the parent's federal income tax return
- A child who does not live with the parent.

If you are subject to an order, Huntington Ingalls Industries will notify 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 Huntington Ingalls Industries verifies that an order is a QMCSO, Huntington Ingalls Industries will enroll the child according to the terms of the order.

Judgment, Decree, or Order Including QMCSOs

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, and the amount deducted from your pay may increase. 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.

Enrollment

It is very important that you understand how to enroll, and that you enroll for the coverage you want when you become eligible. Once your coverage begins, it will remain in effect for the remainder of the plan year. You cannot change your elected coverage during the year unless you meet certain criteria described in "Changing Your Coverage during the Year".

Annual Enrollment

Each year, the Company conducts an annual enrollment period. During this time, you may make changes to your benefit elections. These changes will become effective on the July 1 of the upcoming benefit plan year (July 1 through June 30 each year).

Annual enrollment gives you the opportunity to review your benefit options and your personal situation. You may then change your benefit elections as necessary to ensure that your coverage continues to meet your needs. This is the only time you can make changes in your benefit elections without a Qualified Life Event (or a Special Enrollment or other permitted election change event).

If you are enrolled in the flexible spending accounts but do not re-enroll during annual enrollment, your contributions will not continue beyond June 30 of the year in which you are enrolled. You are required to make a positive election for these spending accounts each plan year.

If you are a tobacco user (that means you smoke cigarettes or use other tobacco products or e-cigarettes), a tobacco user surcharge will be added to your medical plan option contribution amount. More specifically, a tobacco surcharge will be added to your weekly premium contribution for medical coverage *unless* you satisfy one of the following conditions:

(1) during the annual enrollment period (and *prior to July 1*) you report that you have been tobacco-free for six months; or (2) during the annual enrollment period (and *prior to July 1*) you report that you have completed a tobacco cessation program (if you do not otherwise satisfy condition (1) (i.e., report that you are tobacco-free). If you satisfy one of these conditions during the annual enrollment period (and *prior to July 1*), then the tobacco surcharge *will not* be added to your weekly premium contribution for the current plan year. <u>You will need to report your tobacco-free status each year during annual enrollment</u>.

Please note that if you *do not* take any action when you become eligible for and enroll in medical coverage, the tobacco surcharge *will apply* for the current plan year.

If you become tobacco-free (or complete a tobacco cessation program) *after* July 1 *but before* December 31, you may change your tobacco status before the end of the calendar year to avoid having the tobacco surcharge added to your premium contribution for the period beginning on January 1 of the current plan year and ending on the last day of the plan year (i.e., June 30). You will not receive a refund for any tobacco surcharge amounts paid before January 1st. For example, on November 1, you report that you have been tobacco-free for six months (and you did not report such tobacco-free status or complete a tobacco cessation program during annual enrollment). Your weekly premium contribution will continue to include the tobacco surcharge until January 1. From January 1 to June 30, your weekly premium contribution *will not* include the tobacco surcharge since you reported your tobacco-free status *before* the end of the calendar year.

Alternatively, as indicated above, if during the annual enrollment period you report that you have been tobacco-free for six months, then the tobacco surcharge *will not* be added to your weekly premium contribution for the upcoming plan year (i.e., July 1 — June 30). Please contact the HII Benefits Center at (877) 216-3222 if you have questions regarding how to change your tobacco status and / or what tobacco cessation programs are available to you. You may also visit *www.HIIBenefits.com* and "click" Physical Wellbeing in the top menu and then select the Tobacco Free Incentive Program Tile to obtain information on the tobacco cessation programs and additional information regarding the tobacco surcharge.

Enrollment for New Hires

If you are new hire, you will automatically be enrolled in you-only medical coverage as a tobacco user and loss of time coverage effective the 1st of the month following 30 days of employment.

In order to waive medical or loss of time coverage, update tobacco status, add eligible dependents to your coverage, or enroll in the flexible spending accounts, you must go online at *hiibenefits.com* or contact the HII Benefits Center at 1-877-216-3222 to make the election within 31 days of your eligibility date.

If you are on a leave of absence on your eligibility date, you will become covered for medical and/or loss of time benefits on the date you return to active work.

Loss of time benefit coverage may be elected separately if you choose to waive medical coverage, or if you are covered as a dependent under your spouse or parent's medical coverage.

If you enroll your eligible dependents at the same time you enroll in the medical plan, dependent coverage will become effective on the same date your coverage begins. You may add a newly eligible dependent under your medical coverage within 31 days of acquiring an eligible dependent or experiencing a Qualified Life Event.

You are automatically eligible for HERO and basic life and AD&D insurance on the 1st of the month following 30 days of employment without any enrollment action.

Special Enrollment Rules

If you waive medical coverage for yourself or your spouse or eligible dependents during enrollment because you or they have other health insurance coverage, and then you or they lose that coverage, you may be able to enroll yourself or your dependents in medical benefits before the next annual enrollment. Specifically, you may enroll in the Plan within 31 days of the date you or your dependents:

- Lose eligibility for coverage under another group health plan,
- Lose the employer contribution toward another group plan's coverage, or
- Exhaust COBRA coverage under another group health plan (your COBRA coverage ends, but not because you failed to make the premium payment).

Once you enroll, your coverage is effective retroactive to the date you lost coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Coverage for new dependents due to marriage will be effective no later than the first month following the date of enrollment. Coverage for new dependents as a result of birth, adoption, or placement for adoption will be effective on the date of the event.

Finally, you may enroll in the Plan at a time other than the annual enrollment period in the following situations:

- If you (and/or your eligible dependent) are not enrolled and are covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act and your (and/or your eligible dependent's) coverage under that Medicaid or State child health plan terminates because you (and/or your Dependent) lose eligibility for that coverage, you may enroll in coverage if you request enrollment within 60 days after coverage under the Medicaid plan or State child health plan terminates.
- If you (and/or your eligible dependent) are not enrolled and become eligible for assistance with the cost of health coverage under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of the Social Security Act, you may enroll in coverage if you request enrollment within 60 days after the date you (and/or your eligible dependent) are determined to be eligible for such assistance.

To request special enrollment or obtain more information, contact the HII Benefits Center at 1-877-216-3222.

Changing Your Coverage During the Year

In exchange for the advantages offered by paying for coverage with before-tax dollars, the Internal Revenue Service (IRS) limits your ability to make changes to your benefit elections during the year. You may not change your medical or FSA plan elections until the next annual enrollment period, unless you have a Qualified Life Event, another permitted election change, or you are eligible for Special Enrollment (not applicable to the FSAs).

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 Plan option, your spouse's employer's plan, or your dependent's employer's plan. Qualified Life Events include:

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

The benefit change you make must be on account of and consistent with the Qualified Life Event. For example, if your dependent spouse who is enrolled in a Huntington Ingalls Industries, Inc. medical plan option gains benefit coverage through his or her employer, you are allowed to discontinue his or her coverage (as well as your own coverage and that of your dependent child(ren)), but you are not allowed to change from one Huntington Ingalls Industries, Inc. medical plan option to another.

Qualified Life Events Resulting in a Loss of Eligibility

If a Qualified Life Event results in a loss of eligibility for the Plan, you must immediately report the Qualified Life Event through the life events link on Worklife (formerly known as UPoint) at www.hiibenefits.com or by calling the HII Benefits Center at 1-877-216-3222. If you do not report the

Qualified Life Event within 31 days after the Qualified Life Event, any premiums you have paid will not be refunded.

Other Qualified Life Events

For all other Qualified Life Events, you may only make permissible changes within 31 days after the Qualified Life Event. You may make such changes by clicking on the life events link on Worklife at www.hiibenefits.com or by calling the HII Benefits Center at 1-877-216-3222.

When Coverage Begins

You are automatically enrolled in self-only medical coverage and loss of time benefits effective the first of the month following 30 days of employment. To waive coverage, add dependents, or participate in the FSAs, you must enroll within 31 days of your hire date. Coverage for your dependents becomes effective on the same date that your coverage begins. If you are on a leave of absence on your eligibility date, you will become covered for medical and/or loss of time benefits on the date you return to active work.

Cost of Coverage

You and the Company share the cost of your medical care coverage.

Your contributions are paid with before-tax dollars through payroll deductions. Since your contributions are deducted from your pay before taxes are withheld, you will not pay federal, Social Security, and, in many cases, state or local income taxes on this money.

Paying with before-tax dollars may slightly impact your Social Security benefits because you may be paying lower Social Security taxes. Generally, the tax savings you receive now far outweighs any nominal decrease in future Social Security benefits. However, if you have questions, check with a personal tax advisor.

When Coverage Ends

If your employment with Huntington Ingalls Industries, Inc. ends, the date your medical coverage will end is as follows:

If the event:	Your coverage...
You voluntarily quit or are discharged	Continues to the end of the month of your termination date
Of a temporary layoff or leave of absence (other than disability)	Continues to the end of the month
Of an approved leave of absence due to disability	Continues to the end of the leave period (up to a maximum of one year) as long as premium payments are made
You retire	Continues to the end of the month in which you retire

Coverage also will end when any of the following occurs:

- You no longer meet the programs' eligibility requirements
- You cancel your coverage
- You fail to make any required contribution

Your coverage also will end if the Plan or a program that is part of the Plan is terminated for all employees of the category of employees to which you belong.

Coverage for a dependent will end when any of the following occurs:

- Your coverage ends
- He or she no longer meets the definition of an eligible dependent, which occurs at the earliest of the applicable dates below:
  - The last day of the calendar month in which your dependent turns 26
  - For children covered pursuant to a QMCSO, the date the child is no longer required to be covered under a QMCSO
- You cancel your dependent coverage
- You fail to make any required contribution
- All dependent coverage under the Plan is terminated or a program that is part of the Plan is terminated

Flexible Spending Account (FSA)

If you terminate employment, your participation in the health care and/or dependent care flexible spending accounts ends on the last day of employment unless you are eligible for COBRA coverage (not applicable to the dependent care flexible spending account).

Your contributions will end if the Plan is terminated or if either of the following occurs:

- You elect not to re-enroll for the following year during the annual enrollment period
- You no longer meet the eligibility requirements

However, you can submit eligible expenses for reimbursement of expenses incurred through the date your participation ends.

Rescission of Coverage

Group health plans and insurers may generally not rescind coverage once you are covered under the plan, unless you perform an act, practice or omission that constitutes fraud or make an intentional misrepresentation of material fact, as prohibited by the terms of such plan. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect (other than one based on nonpayment of premiums or contributions). If rescission is permitted, the plan must provide you with 30 days advance written notice prior to such rescission. Any such rescission of coverage is subject to the claims and appeals procedures.

What Happens to Your Benefits in Special Situations

In the case of absence from active work because of sickness or accidental injury, authorized leave of absence, layoff, and retirement, the medical coverage may be extended as follows provided you continue the required payment of the cost of coverage.

- **Absence Due to an Industrial Injury or Sickness** —If you are absent from work because of a disability due to your employment with Huntington Ingalls Incorporated which occurred before March 11, 1996 for which benefits are payable under any Workers' Compensation or Occupational Disease Law, medical benefits shall be continued, without contribution from you,

during the entire period of absence from work due to such disability, including dependent coverage, if any. If you are absent from work due to a disability occurring on or after March 11, 1996, you will be required to make employee contributions for coverage during the entire period that you are on industrial leave of absence. The first 30 months of such extended coverage shall include coverage under the provisions of COBRA. See "Continuing Your Coverage".

- **Approved Medical Leave of Absence for Any Non-industrial Injury or Sickness** — During the first 6 months of approved leave, you may continue medical coverage on the same basis as other active participants provided the required employee portion of the cost of coverage is paid. During the next 6 months, you may continue the coverage by paying the full cost (employee and Company share) of medical coverage.
- **Temporary Layoff and Approved Leave of Absence for Reasons Other Than Disability** — Medical benefit coverage may be continued for a period not to exceed 12 months following the date such layoff or leave of absence commences provided you pay the required contribution costs.
- **Military Leave** — If you leave employment to serve in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act (USERRA) may provide you with certain rights under the Plan. If your employment is interrupted because of uniformed services, Huntington Ingalls Industries, Inc. will supply you with additional information regarding your rights tocoverage under this Plan and other USERRA rights
- **Retirement** — Participants who retire at age 60 or later and their dependents who are covered immediately prior to the date of retirement may elect to continue their medical coverage by paying the required cost for up to 60 months after their eligibility would otherwise have terminated. If you fail to elect such continuance when first eligible to do so, it may not be elected at a later date. Once enrolled, if the retiree cancels coverage for any reason, they are not eligible to re-enroll in the Plan at a later date. If the covered retiree experiences a Qualified Life Event he/she may add a dependent to coverage as long as the HII Benefits Center is notified of the event within 31 days. A Qualified Life Event is a change in your personal situation such as a change in marital status or change in the number of dependents, including birth or adoption of a dependent. Dependent coverage will continue for the balance of the 60-month period the retiree was eligible in the event of a retiree death. When you or a covered dependent becomes eligible for Medicare, it will be the primary carrier and this Plan will be secondary payer and coordinate benefits. For additional information about retiree benefits, contact the HII Benefits Center at 1-877-216-3222.

Retiree Medical Coverage

As indicated above, certain participants who retire from the Company at age 60 (or later) and their eligible dependents who are covered under the Plan immediately prior to the date of retirement may be eligible for retiree coverage for up to 60 months (the "5-Year Retiree Coverage Period") after their Plan eligibility would otherwise have terminated - provided his or her share of the required cost for coverage is timely paid. If you are eligible for retiree coverage but you fail to elect such coverage when first eligible to do so, it may **not** be elected at a later date. Once enrolled, if you cancel your retiree coverage for any reason, you are **not** eligible to re-enroll in retiree coverage at a later date.

Note! You are not eligible for retiree coverage unless you are classified by the Company as a former employee who satisfies the requisite eligibility requirements, even if you are later determined by a court or governmental agency to be or to have been a former employee of the Company. Eligibility for retiree coverage under any Company plan is subject to the Company's right to amend or terminate such coverage at any time and for any reason, subject only to applicable laws and the terms of any collective bargaining agreement requiring such retiree coverage. Failure to timely elect coverage for yourself, your spouse and/or an eligible dependent will result in a loss of retiree coverage for that individual.

Important Changes for Medicare-Eligible Participants

Prior to January 1, 2022, retiree coverage was provided under the Plan to all eligible retirees. Beginning January 1, 2022, the eligibility rules were amended for Medicare-eligible participants as follows:

- If a Plan participant is under the age of 65 as of his or her eligibility date, then he or she is eligible for retiree coverage under the Plan until his or her 65th birthday. Upon attaining age 65, the participant becomes eligible for retiree coverage under the Ingalls Represented Retiree Reimbursement Account Plan (the "RRA Plan") for the remainder of the 5-Year Retiree Coverage Period, if any.
- If a Plan participant has attained age 65 as of his or her eligibility date, he or she is eligible for retiree coverage under the RRA Plan for the 5-Year Retiree Coverage Period, subject to RRA Plan rules.

This change impacts (i) former employees who retired from the Company prior to January 1, 2022 (and their covered dependents) to the extent they elected retiree coverage and their 5-Year Retiree Coverage Period had not expired as of January 1, 2022, and (ii) those eligible employees who retire from the Company on or after January 1, 2022 (and their eligible dependents). As a result, if you were an eligible retiree covered under the Plan on December 31, 2021 and you turn age 65 during your 5-Year Retiree Coverage Period, your eligibility for retiree coverage will transition to the RRA Plan, in accordance with plan rules.

The RRA Plan. The Company adopted the RRA Plan for certain Medicare-eligible individuals, effective January 1, 2022. The purpose of the RRA Plan is to reimburse eligible retirees and/or their eligible spouses for certain health insurance premiums and medical expenses that are not otherwise reimbursed. Each year, the Company credits a specific dollar amount to a participant's RRA Plan account (an "RRA") to help cover the cost of eligible expenses. The RRA Plan also provides a catastrophic Rx benefit. You and your eligible spouse must enroll in an individual Medicare supplemental health plan through Via Benefits within the applicable timeframes and timely complete any required enrollment forms or procedures to be eligible for RRA Plan benefits. To enroll in an individual Medicare supplemental plan through Via Benefits, you must be enrolled in both Medicare Part A and Part B. Failure to timely enroll in Medicare Part A and Part B could result in a loss of RRA Plan benefits. More information about the RRA Plan can be found in that plan's summary plan description.

Spouse eligibility. If you are an eligible retiree and you timely elect retiree coverage, your spouse may be eligible for retiree coverage during your 5-Year Retiree Coverage Period, provided your spouse is an active Plan participant as of your retirement date, you have timely elected spousal retiree coverage and you have not dropped coverage for your spouse.

- If your eligible spouse has not attained age 65 as of his/her eligibility date, his or her retiree coverage will be provided under the Plan.
- Should he or she attain age 65 during your 5-Year Retiree Coverage Period, his or her eligibility for retiree coverage will transition to RRA Plan coverage for the remainder of such period. When he or she attains age 65, an RRA will be established on his or her behalf and your spouse will be eligible for Company credits provided your spouse timely enrolls in an individual Medicare supplemental plan through Via Benefits.

Should you die during your 5-Year Retiree Coverage Period, your spouse is eligible to continue retiree coverage for the balance of your 5-Year Retiree Coverage Period, subject to Plan and RRA Plan rules, as applicable.

Dependent child eligibility. If you are an eligible retiree and you timely elect retiree coverage, your dependent children may be eligible for retiree coverage during your 5-Year Retiree Coverage Period, provided your children are active Plan participants as of your retirement date, you have timely elected dependent child retiree coverage and you have not dropped coverage for your children. Eligible dependent children must be timely enrolled to be eligible for this retiree coverage. Your dependent children are generally not eligible to participate in the RRA Plan. In addition, you are generally not permitted to receive reimbursement from your RRA for their expenses as well as expenses incurred by other individuals who may qualify as your dependent for federal income tax purposes. Should you die during your 5-Year Retiree Coverage Period, your dependent is eligible to continue Plan coverage for the balance of your 5-Year Retiree Coverage Period, subject to Plan rules.

Adding a new spouse or child. If you experience a Qualified Life Event during your 5-Year Retiree Coverage Period, you may add an eligible dependent to your retiree coverage as long as the HII Benefits Center is timely notified. A Qualified Life Event is a change in your personal situation - such as a change in marital status or a change in the number of your dependents, including the birth of or adoption of a child (see "Changing Your Coverage during the Year" for details).

WARNING! Eligible retirees and/or their eligible spouses who become Medicare-eligible due to attaining age 65 are not eligible to continue participating in the Plan. As a result, ***retiree coverage under the Plan will end on the last day of the month that includes the participant's 65th birthday – even if he or she fails to timely enroll in an individual Medicare Supplemental Plan through Via Benefits and, as a result, is not eligible for RRA Plan benefits***.

If you have any questions regarding retiree coverage (the pre-65 and post-65 components) and the changes that went into effect on January 1, 2022, please contact the HII Benefits Center.

Continuing Your Coverage

According to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, you and your enrolled family members are eligible to pay for continued group health care coverage if you lose your benefits under certain circumstances, including termination of employment (unless due to gross misconduct). Continued coverage rights apply only to health care coverage (medical and health care flexible spending account), not to other types of benefits (dependent care flexible spending account, life insurance and loss of time benefits).

You and your enrolled family members will be considered qualified beneficiaries and can continue coverage for a maximum of 18, 29, or 36 months, depending on the reason your coverage ended, as shown in the chart below. If multiple circumstances occur, the maximum period is a total of 36 months. For the health care flexible spending account, you can continue participation until the end of the benefit plan year in which you lose your benefits.

You and your eligible dependents have 60 days from the date coverage ends or the date of receipt of your COBRA notice, whichever is later, to elect continued participation under COBRA. (Each family member who is a qualified beneficiary may make a separate COBRA election.) You have an additional 45 days from the date of your election to pay your first COBRA premium. After that time, your premium payments are due as of the first of the month, with a 30-day grace period. If you do not make a timely election, COBRA rights are waived.

If you elect COBRA continuation:

- Initially, you and your dependents will keep the same type of plan coverage you were enrolled in while an active employee. This includes access to Teladoc and the Family Health Center if you enroll in the Anthem PPO medical plan.
- You may keep the same coverage category you had as an active employee or choose a different category. For example, if your spouse and all of your dependents were enrolled under the Huntington Ingalls Industries, Inc. medical plan, you could choose to enroll all, some or none under COBRA.
- Coverage is effective on the date of the event that qualified you for COBRA coverage, unless you waive COBRA coverage and subsequently revoke your waiver within the 60-day election period. In that case, your coverage begins on the date you revoke your waiver.
- You may change plan coverage and coverage category (including adding eligible dependents) during the annual enrollment period or if you have a Qualified Life Event.
- You may add newly acquired dependents during the benefit plan year.
- You can enroll your newly eligible spouse or child under the same guidelines that apply to active employees.
- If you or a covered dependent is Medicare eligible, Medicare pays primary for that individual, regardless of whether the individual enrolls in Medicare Parts A and/or B.

For details, call the HII Benefits Center at 1-877-216-3222.

COBRA Continuation Period

Qualifying Event	Maximum Continuation Period		
	Employee	*Spouse*	*Child*
You lose coverage because you reduce your work hours or take unpaid leave	18 months	18 months	18 months
You terminate employment for any reason (except gross misconduct)	18 months	18 months	18 months
You or your dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days after COBRA begins	29 months	29 months	29 months

Qualifying Event	Maximum Continuation Period		
	Employee	*Spouse*	*Child*
You die	N/A	36 months	36 months
You and your spouse divorce	N/A	36 months	36 months
You are already on COBRA and become disabled and entitled to Medicare, which causes your dependents to lose coverage	N/A	18 months	18 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

Newly Eligible Child

If you, the former Huntington Ingalls Industries, Inc. employee, elect continuation coverage and then have a child (by either 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 Huntington Ingalls Industries, Inc.-sponsored group health plan and the requirement of the federal law, these qualified beneficiaries can be added to COBRA coverage by providing the HII Benefits Center with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 31 days of birth, adoption, placement for adoption, or appointment as a legal guardian. The notice must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify Huntington Ingalls Industries, Inc. 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 on the following basis:

- For health care coverage (medical and HERO), premiums are 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 a single employee.
- Health care flexible spending account contributions can be continued through the end of the benefit plan year on an after- tax basis, plus the 2% administrative charge.

If you or your enrolled dependent is disabled, as defined by Social Security, COBRA premiums for months 19 through 29 may be increased to reflect 150% of the full group cost per person.

Notification

You are notified by mail of your COBRA election rights and enrollment instructions when you qualify due to a reduction in hours or termination of employment (other than for gross misconduct). Your spouse and dependent children are notified of their COBRA election rights when they lose health coverage with Huntington Ingalls Industries, Inc. as a result of your death or Medicare entitlement.

If your dependents lose coverage due to divorce, legal separation, or loss of dependent status, you (or a family member) must notify the HII Benefits Center at 1-877-216-3222 within 60 days of the event so that COBRA can be offered and information on election rights can be mailed. Also, to extend coverage beyond 18 months because of disability, you must provide notice of the Social Security Administration's determination during the initial 18-month period and within 60 days of the date you receive your determination letter.

Your Duties Upon a Second Qualifying Event

If an employee or covered family member experiences a second qualifying event that would entitle him or her to additional months of continuation coverage, he or she must notify the HII Benefits Center. This notice must be provided in writing and must include the name of the employee, the name of the qualified beneficiary receiving COBRA coverage, and the type and date of second qualifying event.

This notice *must* be provided within 60 days from the date of the second qualifying event (or, if later, the date coverage would normally be lost because of the second qualifying event). In addition, the employee or covered family member may also be required to provide a copy of a death certificate, divorce decree, separation agreement, and dependent child(ren)'s birth certificate(s).

When Huntington Ingalls Industries, Inc. is notified that one of these events has happened, the covered family member will automatically be entitled to the extended period of continuation coverage. If an employee or covered family member fails to provide the appropriate notice and supporting documentation to Huntington Ingalls Industries, Inc. during this 60-day notice period, the covered family member will not be entitled to extended continuation coverage.

Special Rules for Disability

The 18 months of COBRA coverage may be extended for up to 29 months if the employee or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at the time of the qualifying event or at any time during the first 60 days of COBRA continuation coverage. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must notify the HII Benefits Center, within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. The notice must be provided in writing and must include the name of the employee or qualified beneficiary receiving COBRA coverage, information about his or her disability, and a copy of a letter from the Social Security Administration indicating a disability determination.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the local human resource representative of this determination within 30 days of the date it is made, and COBRA coverage will end. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

If a qualified beneficiary is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months from the termination of employment or reduction in hours.

Medicare

If you experience a qualifying event due to termination of employment or reduction of hours within 18 months after you have enrolled in Medicare, your spouse and dependent children who are qualified beneficiaries may elect COBRA for medical coverage for up to 18 months measured from the date of your Medicare enrollment.

Trade Reform Act of 2002

The Trade Reform act of 2002 created a special COBRA right applicable to employees who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance." These individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance coverage, including COBRA continuation coverage. These individuals are also entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage). This election must be made within the 60-day period that begins on the first day of the month in which the individual becomes eligible for assistance under the Trade Reform Act of 2002. However, this election may not be made more than six months after the date the individual's group health plan coverage ends.

When COBRA Ends

COBRA coverage ends before the maximum continuation period ends if one of the following occurs:

- You or your dependent becomes covered under another group health plan not offered by Huntington Ingalls Industries, Inc. after the date of your COBRA election (unless the Plan has pre-existing condition limitations that affect the enrolled person)
- You or your dependent becomes enrolled in Medicare after the date of your COBRA election (if you or your dependent is not entitled to or enrolled in Medicare, you or your dependent can continue coverage under COBRA until the maximum continuation period ends)
- You or your dependent fails to make a timely monthly payment. After the initial COBRA premium payment, payments are due on the first day of each month and, if your payment is not received within 31 days after the first day of the month (the "grace period"), coverage will be terminated effective as of the last day of the period for which payment was made. For example, if payment for May coverage is due May 1, and you fail to make the applicable payment by May 31, your coverage will be terminated retroactive to April 30.
- After your initial 18-month period, you or your dependent ceases to be considered disabled for Social Security purposes and is not otherwise eligible for a longer continuation coverage period
- Huntington Ingalls Industries, Inc. ceases to provide medical benefits to any employee.

COBRA and FMLA

For purposes of a Family and Medical Leave Act (FMLA) leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave begins (or if you or your dependent becomes covered during the FMLA leave); and
- You do not return to employment at the end of the FMLA leave.

A leave that qualifies under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you are still eligible for COBRA on the last day of the FMLA leave if you decide not to return to active employment. Your COBRA continuation coverage will begin on the earliest of the following to occur:

- When you definitively inform Huntington Ingalls Industries, Inc. that you are not returning at the end of the leave, or
- The end of the leave, assuming you do not return to work.

Questions About COBRA

If you have any questions about COBRA coverage or the application of the law, please contact the HII Benefits Center or contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your and your family's rights, you should keep your local human resources representative or Payroll Department informed of any changes in your address. Notify the HII Benefits Center if there are any changes in your family member's address, if different from yours. You should also keep a copy, for your records, of any notices you send.

If You Have Other Coverage or Benefits

Other coverage includes coordination of benefits, Medicare and right of recovery.

Coordination of Benefits

Remember, the benefits you receive from a Huntington Ingalls Industries, Inc. 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 Huntington Ingalls Industries, Inc. medical plan option and his or her employer's plan). When this happens, the Huntington Ingalls Industries, Inc. 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 Huntington Ingalls Industries, Inc. medical plan options consider the benefit payments you receive from another group plan. When Huntington Ingalls Industries, Inc. is the secondary payer, the Huntington Ingalls Industries, Inc. medical plan makes up the difference between the amount the other plan pays and the benefit that otherwise would be payable under the Huntington Ingalls Industries, Inc. medical plan option.

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

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

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

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

- If a plan does not have a coordination of benefits provision, that plan will always be primary.
- The plan that covers the person as an employee (or retiree) is primary over a plan covering the person as a dependent, unless the person is enrolled in Medicare. If the person is enrolled in Medicare (and if under the Medicare rules, Medicare is secondary to the plan that covers the person as a dependent and primary to the plan that covers the person as an employee or retiree), the plan that covers the individual as a dependent is primary, Medicare is secondary, and the plan that covers the claimant as an employee or as a retiree pays third.
- The plan covering the person as an active employee, or as that employee's dependent, is primary over the plan covering the person as a retiree (or laid-off employee) or as that person's dependent. However, if the other plan does not determine the order of benefits in this same way and, as a result, does not agree on the order of benefits, this rule will be ignored.
- If two or more plans cover the person receiving care as a dependent, then the plan of the parent whose birthday (month and day) falls earlier in the calendar year is primary unless the other plan uses a rule based on the person's gender and — as a result — the plans do not agree on the order of benefits. In that case, the rule in the other plan will be used to determine which plan is primary. If the birthday rule applies and both parents have the same birthday, the plan covering a parent longer will be primary.
- If you are divorced or not married to your child's parent and your child is enrolled in both a Huntington Ingalls Industries, Inc. 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, Huntington Ingalls Industries, Inc. may ask you to confirm your other coverage, if any. Your claims administrator will send you a coordination of benefits (COB) questionnaire, usually after your claims administrator receives the first claim for your enrolled spouse or children, and annually thereafter.

The COB questionnaire requests information about any other insurance under which your spouse or 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 "pended" or put on hold. If your claims

administrator does not receive a completed questionnaire, the claim is denied and you are sent an explanation of benefits (EOB) statement. The statement provides the reason for the denial and instructs you to complete the COB questionnaire and submit it to your claims administrator along with the denied claim. In other cases, the claims administrator will pay the claim while the questionnaire is being processed. If a determination is made that you received benefits that should not have been paid, or that you have failed or refused to reimburse the Plan as required, the Plan may (in addition to taking other action) withhold future benefit payments.

Coordination with Medicare

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

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

- Apply for Medicare when you become age 65, or
- Decide to wait until you retire to apply for Medicare, if you are enrolled in one of the Huntington Ingalls Industries, Inc. medical plan options. You do not have to enroll in Medicare while you are still an active employee and covered under a Huntington Ingalls Industries, Inc. medical plan option as an active employee (or spouse of an active employee).

When your active employment ends, you and/or any Medicare eligible dependent must enroll in Medicare Part B for coverage to be effective as soon as your employment ends, even if you are continuing coverage under COBRA or a severance plan. If you and/or your dependent does not enroll in Medicare Part B (Supplementary Medical Insurance) as soon as you (and/or they) become eligible you and/or they may pay higher Medicare premiums. In addition, the Plan will pay benefits as if the Medicare-eligible individual has enrolled in Medicare, whether or not the individual has enrolled in Medicare, so you could be responsible for paying significant medical expenses not covered by Medicare or the Plan.

Remember! As a result of changes made to the retiree medical program that went into effect on January 1, 2022, if you are eligible for and elect retiree medical coverage and you (or your spouse) attain age 65 during your 5-Year Retiree Coverage Period, your retiree coverage under the Plan will end and you will transition to the RRA Plan. To be eligible for RRA Plan benefits you (or your eligible spouse) must enroll in an individual Medicare supplemental health plan through Via Benefits within the applicable timeframes and timely complete any required enrollment forms or procedures to be eligible for RRA Plan benefits. To enroll in an individual Medicare supplemental plan through Via Benefits, you must be enrolled in both Medicare Part A and Part B. ***Failure to timely enroll in Medicare Part A and Part B could result in a loss of benefits***.

End-Stage Renal Disease

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

Disability

If you (or a covered dependent) are eligible for Medicare coverage due to disability, the order in which your Huntington Ingalls Industries, Inc. medical plan option pays benefits depends on whether the disabled person is the employee or a dependent, as follows:

If you are a disabled employee, your Huntington Ingalls Industries, Inc. medical plan option pays secondary to Medicare if all of the following apply:

- You no longer work due to your disability
- You qualify for Social Security benefits because of a disability
- You are eligible for Medicare
- You are not enrolled in another group health plan as an active employee.

When you meet these criteria, any payments that the Huntington Ingalls Industries, Inc. medical plan makes are calculated as if you are enrolled in Medicare, regardless of your actual enrollment status (unless your disability is due to End Stage Renal Disease and you have been eligible for Medicare for at least 30 months). If you are on a leave of absence, your Huntington Ingalls Industries, Inc. medical plan option pays primary through the end of the leave.

If you are a disabled dependent covered through the active employment of an employee, your Huntington Ingalls Industries, Inc. medical plan option pays primary to Medicare (unless the dependent's disability is due to end-stage renal disease and the dependent has been eligible for Medicare for at least 30 months).

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions set forth above. 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 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.

Right of Recovery

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

- Reimburse the Plan for the full amount of benefit payments made on your behalf
- 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.

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.

Medical Coverage

The Anthem Preferred PPO medical plan offered by Huntington Ingalls Industries provides coverage for a broad range of benefits, including doctor's visits, prescription drugs, hospitalizations and surgery.

When you elect medical coverage, your plan includes prescription drug coverage.

While this guide provides an overview of the Anthem Preferred PPO, additional medical plan information, can be found in the applicable Benefit Booklet listed in the Appendix.

More Information

You will find information about your medical benefits throughout this handbook:

- *Eligibility and Enrollment* subsection of the Health Care Benefits section — Contains important information about eligibility and enrollment rules for participation in the medical plan.
- *Administrative Information* section — Contains information about your rights under the medical plan, including information about the claims appeals process.
- "Continuing Your Coverage" in the *Eligibility and Enrollment* subsection — Contains information about your right to continue your medical plan participation under COBRA.

The Medical Option at a Glance

Huntington Ingalls Industries offers you comprehensive medical coverage for a broad range of covered services, including 100% coverage for preventive care when you use an in-network provider, as well as prescription drug coverage. The Plan provides access to quality care and protection from the high cost of medical services and supplies.

With the Anthem PPO medical plan, you have access to both in-network and out-of-network providers. However, you will generally have higher out-of-pocket costs when you use an out-of-network provider.

The Anthem PPO Medical Plan at a Glance

Highlights of the Anthem PPO medical plan include:

	In-Network	Out-of-Network
Annual Deductible		
▪ Individual	$300	$800
▪ Family	$600	$1,600
Annual Out-of-Pocket Maximum (includes deductible)		
▪ Individual	$2,000 (Separate oop max of $4,600 per Individual for prescription drugs)	$5,000 (Separate oop max of $4,600 per Individual for prescription drugs)
▪ Family	$4,000 (Separate oop max of $9,200 per family for prescription drugs)	$10,000 (Separate oop max of $9,200 per family for prescription drugs)

Covered Services	What You Pay In-Network (based on PPO negotiated fee)	What You Pay Out-Of-Network (based on lesser of PPO negotiated fee or actual charges)
Preventive Care	Free	Free
Office Visit	$15 per visit (no deductible)	40% after deductible
Specialist Office Visit	$30 per visit (no deductible)	40% after deductible
Emergency Room	$250 copay per visit unless admitted or coded by treating physician as an "emergency" then 10% after deductible	$250 copay per visit unless admitted or coded by treating physician as an "emergency" then 10% after deductible
Hospital ▪ Outpatient ▪ Inpatient (room and board, physician charges, services	▪ 10% after deductible ▪ 10% after deductible	▪ 40% after deductible ▪ 40% after deductible

Covered Services	What You Pay In-Network (based on PPO negotiated fee)	What You Pay Out-Of-Network (based on lesser of PPO negotiated fee or actual charges)
and supplies) Note: Hospital admissions must be pre-certified. Otherwise, a $300 penalty applies.		
Preadmission Testing	$0 up to $1,000 per confinement, then 10% after deductible	40% after deductible
Second and Third Surgical Opinion	Free (up to a maximum of $300 per opinion)	Free (up to a maximum of $300 per opinion)
Diagnostic Lab and X-Ray	10% after deductible	40% after deductible
CAT scan/MRI	Free up to $850 per person per calendar year; then, 10% after deductible	40% after deductible
Manipulative Therapy (Chiropractor)	$30 copay office visit; no copay for manipulations; max. of 37 visits per calendar year	$30 copay office visit; no copay for manipulations; max. of 37 visits per calendar year
Supplementary Accident	Up to $300 per accident	Up to $300 per accident

Prescription Drug Coverage at a Glance

Highlights of the prescription drug coverage are as follows:

Prescription Drugs	PPO Medical Plan (in-network)	PPO Medical Plan (out-of-network)
	Amount You Pay After Deductible...	
Retail (CVS/Caremark Network) (30-day supply)		
Generic	$5 copayment ($3 copayment at Health Center)	Reimbursement of allowable expenses less: $5 copayment ($3 copayment at Health Center)
Preferred Brand Name	$20 copayment	Reimbursement of allowable expenses less: $20 copayment

Prescription Drugs	PPO Medical Plan (in-network)	PPO Medical Plan (out-of-network)
Non-Preferred Brand Name	$30 copayment	Reimbursement of allowable expenses less $30 copayment
CVS/caremark Network Retail 90 Pharmacy or Mail Service Pharmacy (Up to 90-day supply)		
Generic	$5 copayment ($6 copayment at Health Center)	$5 copayment ($6 copayment at Health Center)
Preferred Brand Name	$20 copayment	$20 copayment
Non-Preferred Brand Name	$30 copayment, plus the difference between generic and brand name prices, unless brand name required by physician	$30 copayment, plus the difference between the generic and brand name prices, unless brand name required by physician
Prescription Annual Out-of-Pocket Maximum	$4,600 per individual $9,200 per family	$4,600 per individual $9,200 per family

Mental Health and Substance Abuse Coverage at a Glance

Highlights of the mental health and substance abuse coverage under the medical plan are as follows:

Mental Health and Substance Abuse	PPO Medical Plan (in-network)	PPO Medical Plan (out-of-network)
Inpatient Care ***(includes partial hospitalization, residential treatment and intensive outpatient treatment)***	10% after deductible; $300 penalty for failure to pre-certify; Non-accredited Residential Treatment Centers are not covered. If a member uses a non-accredited RTC there are no benefits at all (not even out-of-network benefits)	40% after deductible
Outpatient Care (individual, group or family therapy)	$15 copayment per office visit, 10% after deductible for facility visits	40% after deductible

How the Anthem Medical Plan Works

The Huntington Ingalls medical plan option provides comprehensive coverage for a broad range of covered services, including 100% coverage for preventive care when you use an in-network provider, as well as prescription drug coverage. The plan provides access to quality care and protection from the high cost of medical services and supplies. Additional information about your medical and prescription drug plan can be found in the applicable Benefit Booklet listed in the Appendix.

How the Anthem PPO Medical Plan Works

If you elect the Anthem Preferred Provider Organization (PPO) medical plan, you can go to any licensed provider for your health care, but you save money when you access care through PPO network providers.

To locate a network provider or find out if your current provider is in the PPO network, access the Find a Doctor tool on the Anthem.com/ca web site, which is accessible from the *Provider Link* at www.hiibenefits.com. You also can call Anthem directly to request assistance in finding a provider.

The PPO network is a group of physicians, hospitals, and other health care providers that agree to:

- Undergo a quality screening process
- Comply with the PPO's quality measures and protocols
- Provide care at discounted rates.

For the medical PPO plan:

- Prescription drug coverage is provided through CVS/Caremark
- Coverage for mental health and substance abuse treatment is provided through Anthem.

More Information

For a description of the benefits offered under the Anthem PPO medical plan, please refer to the applicable Benefit Booklet listed in the "Appendix". You can also find information at www.hiibenefits.com

Anthem Benefit Management Features

The benefit management features apply to the Anthem PPO plan. It is very important that you understand how these features work and use them if the need arises. If you receive certain services without following the procedures outlined here, your benefits will be reduced — resulting in a greater, and unnecessary, out-of-pocket cost to you.

Some Plan Highlights:

- All in-network and out-of-network deductibles and out of pocket maximums are completely independent of each other.
- Deductibles and copayments apply toward the annual out of pocket maximum.
- Copayments do not apply toward the annual deductible.
- Expenses incurred due to non-compliance with plan provisions do not apply toward the coinsurance maximums or deductible.
- You are responsible for all non-covered medical expenses and any amount of non-network charges that exceed the fee schedules or usual and customary charges.
- $300 penalty per admission for any hospital admission that is not pre-certified with Anthem Blue Cross.

Utilization Review Program

The Anthem PPO plan includes the process of utilization review to decide when services are medically necessary or experimental/investigative, as defined in this guide. Utilization review aids the delivery of cost-effective health care by reviewing the use of treatments and, when proper, level of care and/or the setting or place of service that they are performed. A service must be medically necessary to be a covered service.

When level of care, setting or place of service is part of the review, services that can be safely given to you in a lower level of care or lower cost setting/place of care, will not be medically necessary if they are given in a higher level of care, or higher cost setting / place of care.

Certain services must be reviewed to determine medical necessity in order for you to get benefits. Utilization review criteria will be based on many sources including medical policy and clinical guidelines. The claims administrator may decide that a service that was asked for is not medically necessary if you have not tried other treatments that are more cost-effective.

If you have any questions about the information in this section, you may call the Member Services phone number on the back of your Identification Card.

Coverage for or payment of the service or treatment reviewed is not guaranteed. For benefits to be covered, on the date you get service:

1. You must be eligible for benefits;
2. The service or supply must be a covered service under your plan;
3. The service cannot be subject to an exclusion under your plan; and
4. You must not have exceeded any applicable limits under your plan.

Types of Reviews

- **Pre-service Review** – A review of a service, treatment or admission for a coverage determination that is done before the service or treatment begins or admission date.
- **Precertification** – A required pre-service review for a benefit coverage determination for a service or treatment. Certain services require precertification in order for you to get benefits. For details, see Precertification.
- **Continued Stay / Concurrent Review** – A utilization review of a service, treatment or admission for a benefit coverage determination that must be done during an ongoing stay in a facility or course of treatment.
- Both pre-service and continued stay/concurrent reviews may be considered urgent when, in the view of the treating provider or any physician with knowledge of your medical condition, without such care or treatment, your life or health or your ability to regain maximum function could be seriously threatened or you could be subjected to severe pain that cannot be adequately managed without such care or treatment. Urgent reviews are conducted under a shorter timeframe than standard reviews.
- **Post-service Review** – A review of a service, treatment or admission for a benefit coverage that is conducted after the service has been provided. Post-service reviews are performed when a

service, treatment or admission did not need a precertification, or when a needed precertification was not obtained. Post-service reviews are done for a service, treatment or admission in which the plan has a related clinical coverage guideline and are typically initiated by the claims administrator.

Precertification

With the Anthem PPO plan, precertification is required for the following medical services:

- Hospital admissions and increases in lengths of stay (except for maternity, as described under "Statement of Rights Under the Newborns' and Mothers' Health Protection Act" on pg. 70). 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. Precertification is required if there is an increase in the length of stay.
- Inpatient surgery (inpatient hospital stays for mastectomy surgery, including the length of hospital stays associated with mastectomy, precertification is not needed)
- Skilled nursing facility care
- Private duty nursing
- Home health care
- Home infusion therapy
- 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
- Precertification is also required within 24 hours or as soon as reasonably possible of an emergency-based hospital admission or surgery.

If you fail to pre-certify inpatient hospital care, home health care, skilled nursing facility, home infusion therapy, and inpatient mental health and substance abuse services, you may be responsible for a $300 non-compliance penalty in addition to your normal coinsurance and deductible.

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. Precertification helps manage medical costs by confirming the need for things like medical necessity and duration.

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

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

Health Resources and Tools

The Anthem PPO plan offers online financial tools to help you keep track of your health care dollars. You can review what you have spent on health care or look up the status of a particular claim any time of the day.

Anthem also offers several resources designed to help you stay healthy, deal with an illness or injury, and prepare for a medical procedure or treatment, including:

- Care & Cost Finder (provider and facility)
- MyHealth Assessment
- MyHealth Record
- Teledoc

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

MyHealth Assessment

Evaluate your overall health, help identify risks and find out how to help optimize your health. Use MyHealth Assessment to prepare for a routine physical — evaluate your health online, print out your family health history to share with your doctor, and find out what questions you should ask and what tests your doctor should perform.

MyHealth Record

MyHealth Record combines treatment and preventive care services, doctors' appointments, and your medications list into one convenient personal health record. Member education, health management programs, health news and tools are all customized based on your unique health profile. Your personal health record allows you to track doctor visits, vaccinations and other wellness services. Stay organized by consolidating your health history in one secure location.

Teladoc

Teladoc provides access to a national network of board-certified doctors, including psychiatrists and pediatricians, in the U.S. who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. Teladoc does not replace existing physician relationships, but supplements them as a convenient, affordable alternative for medical care.

Teladoc is available to all employees and their covered dependents who are enrolled in the Aetna PPO plan. You pay just $10 per consultation, including:

- Visits with a board-certified doctor for many common conditions, such as cold symptoms, flu, allergies, bronchitis and more. Prescriptions can be provided if medically necessary.
- Behavioral health visits, such as therapist sessions, psychiatrist evaluation and ongoing sessions, as well as support for stress, anxiety, depression and more. Confidential counseling is available seven days a week from any location.
- Tobacco cessation is available for a one-time $10 payment. This multi-faceted program combines nurse coach support, physician treatment, and tobacco cessation support materials to give you a proven plan to quit using tobacco for good. To get started, simply request a general medical visit and tell the doctor you're interested in the Tobacco Cessation program.

HII Family Health Center

The HII Family Health Centers are available to employees and dependents covered by an eligible HII health plan. The center provides a convenient alternative to quality health care. Whether you'd like

help managing a chronic condition such as high blood pressure, you need a physical or you have a sore throat that needs immediate attention — the HII Family Health Center can help. Wellness visits and preventive visits, such as physicals, preventive health screenings and immunizations, are provided to you at no cost. All other services and treatments received during your visit cost $15. Generic medications at CVS pharmacy cost $3 for a 30-day supply and $6 for a 90-day supply.

Covered services include:

- Physicals including school and sports
- Preventive health screenings
- Immunizations (including flu shots)
- Treatment for illnesses and injuries (such as sore throats, ear/eye infections, headaches, minor burns, coughs, cuts and contusions)
- Lab work including urinalysis, strep screen, pregnancy testing, cholesterol, glucose, potassium, thyroid
- Weight and/or blood pressure checks
- Skin checks/minor procedures (such as removals of skin tags, moles and warts)
- Basic X-ray
- Pediatric care
- Physical therapy such as general orthopedic and sports injury treatment, post-operative care, work conditioning, chronic pain management and injury prevention education
- Wellness care (goal setting and motivation, smoking cessation and management of weight, stress and time)
- Nutrition guidance for (weight management, healthy eating, sports performance enhancement, menu planning and lifestyle changes)
- Employee Assistance Program
- CVS/CarePlus Pharmacy
- HII Family Vision Center

The HII Family Health Center is available at the following location:

Location	***Hours***
2105 Old Spanish Trail Gautier, MS 39553	Monday to Friday from 7 a.m. to 6 p.m. Saturday from 8 a.m. to noon

For more information or to schedule an appointment, visit myquadmedical.com/hii or call 1-228-205-7700. You can download the MyQuadMed mobile app from the app store (search for "MyQuadMed").

Prescription Drug Coverage

Prescription drug benefits are automatically provided when you are enroll in a medical plan. Benefits are provided by CVS/Caremark at retail pharmacies and through a convenient home delivery program.

How Prescription Drugs Are Covered

Generally, the amount you pay for coverage depends on how you have the prescription filled and the type of drug: generic, preferred brand or non-preferred brand prescription drugs as follows:

Prescription Drugs	PPO Medical Plan (in-network)	PPO Medical Plan (out-of-network)
	Amount You Pay	
Retail (CVS/Caremark Network) (30-day supply)		
Generic	$5 copayment	Reimbursement of allowable expenses less: $5 copayment
Preferred Brand Name	$20 copayment	Reimbursement of allowable expenses less: $20 copayment
Non-Preferred Brand Name	$30 copayment	Reimbursement of allowable expenses less $30 copayment
CVS/Caremark Network Retail 90 Pharmacy or Mail Service Pharmacy (Up to 90-day supply)		
Generic	$5 copayment	$5 copayment
Preferred Brand Name	$20 copayment	$20 copayment
Non-Preferred Brand Name	$30 copayment, plus the difference between generic and brand name prices, unless brand name required by physician	$30 copayment, plus the difference between the generic and brand name prices, unless brand name required by physician
Prescription Annual Out-of-Pocket Maximum	$4,600 per individual $9,200 per family	$4,600 per individual $9,200 per family

- ***Generic.*** Drugs whose active ingredients, safety, quality and strength are the same as their brand-name counterparts.
- ***Preferred Brand.*** Drugs that generally have no generic equivalent. Within a class of drugs, there are often several brand- name drugs protected by separate patents. Each of these is equally effective for treating a particular condition. A list of preferred brand-name drugs, which identifies drug classes that may have generic availability that could save you money, is available from CVS/Caremark Customer Care or www.caremark.com.
- ***Non-Preferred Brand.*** Drugs that have equally effective and less costly generic equivalents and/or

have one or more preferred brand options.

Preferred Drug List

When you enroll in an eligible plan, CVS/Caremark will send you a copy of the Performance Drug List with your prescription drug booklet. Be sure to keep the booklet for your reference and for sharing with your doctor. You can also request a list, or check a specific prescription drug, by calling CVS/Caremark at 1-844-287-1289 or access the CVS/Caremark web site, which is accessible from the Provider List at www.hiibenefits.com. (The list of preferred drugs is called the Performance Drug List.)

Where to Fill Your Prescription

- Choose from more than 68,000 network pharmacies nationwide, including independent pharmacies, chain pharmacies and 7,700 CVS pharmacy locations.
- Find a participating pharmacy at www.caremark.com

Prior Authorization for Certain Drugs

Certain drugs, due to safety, health and cost concerns, require prior authorization by CVS/Caremark prior to dispensing. For a list of these drugs, log in to www.caremark.com or obtain a list from CVS/Caremark (visit www.caremark.com or call Customer Care at 1-800-386-0553).

Over-the-Counter Medications

An over-the-counter medication is one that you can obtain without a prescription. The prescription drug program does not cover over-the-counter medications, including those that previously required a prescription (for example, Claritin, Prilosec OTC, Nexium OTC).

In some cases, certain over-the-counter medications may have similar prescription medications that may be used as an alternative. For example, Protonix and Dexilant, which are prescription medications, may be alternatives to over-the-counter Prilosec. Although the prescription drug program may cover the prescription alternatives, (usually at the non-preferred brand- name level), the prescription drug often will cost you more than the over-the-counter drug.

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 prescriber, 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 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 1-844-287-1289. 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 plan. The PPO Administrator has the right to decide which drugs are covered and to what extent as well as the right to modify coverage, including the exclusion of any prescription drugs.

Special Information for Diabetics

The prescription drug benefit includes a special provision for diabetic kits. You pay nothing for diabetic supplies if:

- Your physician lists all of your diabetic supply requirements on one prescription, and
- You order all of the supplies at the same time through the CVS/caremark, and
- You fill a prescription for a diabetic drug at the same time Supplies include:
    - Alcohol wipes
    - Diagnostic strips
    - Lancets and syringes.

If you need a glucose monitor, you can order one at no charge by calling CVS/caremark at 1-844-287-1289.

What the Anthem Medical Plan Covers

The Anthem PPO medical plan provides important benefits that protect you and your family from catastrophic medical bills. A partial list of covered services is included below. For a more detailed list of covered services, see the applicable Benefit Booklet listed in the "Appendix".

Advanced Imaging Procedures

Advanced Imaging Procedures. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. Call the toll-free Member Services telephone number on your identification card to find out if an imaging procedure requires pre-service review.

Ambulance

Ambulance services are covered when you are transported by a state licensed vehicle that is designed, equipped, and used to transport the sick and injured and is staffed by Emergency Medical Technicians (EMTs), paramedics, or other licensed or certified medical professionals. You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility. Coverage includes medically necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a hospital.

Ground, air and water ambulance services are covered when one or more of the following criteria are met:

- For ground ambulance, you are transported:
- From your home, or from the scene of an accident or medical emergency, to a hospital,
- Between hospitals, including when you are required to move from a hospital that does not contract with the claims administrator to one that does, or
- Between a hospital and a skilled nursing facility or other approved facility.
- For air or water ambulance, you are transported:
- From the scene of an accident or medical emergency, to a hospital,
- Between hospitals, including when you are required to move from a hospital that does not contract with the claims administrator to one that does, or
- Between a hospital and another approved facility.

Non-emergency ambulance services are subject to medical necessity reviews. Emergency ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical emergency.

Limitations:
▪ Air ambulance services: limited to one trip per benefit year ▪ Air ambulance based on medical necessity and only to nearest facility ▪ Ground or air ambulance transportation of a newborn child: limited to $200 per illness or injury ▪ Ground ambulance covered only for emergencies and covered to and from facility only

Adult Preventive Services

Services and supplies provided in connection with all generally medically accepted cancer screening tests including FDA-approved cancer screenings for cervical cancer and human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer including BRCA testing if appropriate (in conjunction with genetic counseling and evaluation), prostate cancer screenings, colorectal cancer screenings, and the office visit related to those services. Also included is human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. The annual deductible will not apply to these services. Adult preventive services are considered to be preventive care services. No copayment will apply to these services.

Ambulatory Surgical Center

Services and supplies provided by an ambulatory surgical center in connection with outpatient surgery. Ambulatory surgical center services are subject to pre-service review to determine medical necessity. Bariatric Surgery Services and supplies in connection with medically necessary surgery for weight loss, only for morbid obesity.

Birth Center

Services and supplies provided by a birth center for pregnancy.

Blood Transfusions

Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.

Breast Cancer

Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

- Diagnostic mammogram examinations in connection with the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially under the adult preventive services benefit.
- Breast cancer (BRCA) testing, if appropriate, in conjunction with genetic counseling and evaluation. When done as a preventive care service, BRCA testing will be covered under the adult preventive services benefit.
- Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
- Reconstructive surgery of both breasts performed to restore and achieve symmetry following a medically necessary mastectomy.
- Breast prostheses following a mastectomy.

Chemotherapy

Chemotherapy includes the treatment of disease using chemical or antineoplastic agents and the cost of such agents in a professional or facility setting.

Dental Care

- **Admissions for Dental Care**. Listed inpatient hospital services for up to three days during a hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.).
- **General Anesthesia**. General anesthesia and associated facility charges when your clinical status or underlying medical condition requires that dental procedures be rendered in a hospital or ambulatory surgical center. This applies only if the member is less than seven years old, the member is developmentally disabled, or the member's health is compromised and general anesthesia is medically necessary. Charges for the dental procedure itself, including professional fees of a dentist, may not be covered.
- **Dental Injury**. Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not accidental injury unless the chewing or biting results from a medical or mental condition.
- **Cleft Palate**. Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. "Cleft palate" means a condition that may

include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

- **Orthognathic Surgery**. Orthognathic surgery for a physical abnormality that prevents normal function of the upper or lower jaw and is medically necessary to attain functional capacity of the affected part.

Diabetes

Services and supplies provided for the treatment of diabetes, including:

- Equipment and supplies, such as blood glucose monitors, blood glucose testing strips, insulin pumps, pen delivery systems, visual aids (but not sunglasses) to help the visually impaired to properly dose insulin, and podiatric devices, such as therapeutic shoes and shoe inserts, to treat diabetes-related complications
- Diabetes education programs
- Medical supplies, such as insulin syringes, disposable pen delivery systems for insulin administration. Charges for insulin and other prescriptive medications are not covered
- Screenings for gestational diabetes are covered under your physical exam benefit.

Diagnostic Services

Outpatient diagnostic imaging and laboratory services. This does not include services covered under the "Advanced Imaging Procedures" provision of this section.

Diagnostic X-ray and laboratory services ordered by a physician to diagnose an illness or injury.

Durable Medical Equipment

Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

- Of no further use when medical needs end
- For the exclusive use of the patient
- Not primarily for comfort or hygiene
- Not for environmental control or for exercise
- Manufactured specifically for medical use

Specific durable medical equipment is subject to pre-service review to determine medical necessity.

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.

Home Health Care

The following services provided by a home health agency:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.
2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.
3. Services of a medical social service worker.
4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.
5. Medically necessary supplies provided by the home health agency.

In no event will benefits exceed 120 visits during a benefit year. A visit of four hours or less by a home health aide shall be considered as one home health visit.

If covered charges is applied toward the deductible and payment is not provided, those visits will be included in the 120 visits for that year.

Home health care services are subject to pre-service review to determine medical necessity. Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision.

Limitations:
Limited to 120 visits per plan hear.

Hospital

- Inpatient services and supplies, provided by a hospital. The maximum allowed amount will not include charges in excess of the hospital's prevailing two-bed room rate unless there is a negotiated per diem rate between the claims administrator and the hospital, or unless your physician orders, and the claims administrator authorizes, a private room as medically necessary.
- Services in special care units
- Outpatient services and supplies provided by a hospital, including outpatient surgery Hospital services are subject to pre- service review to determine medical necessity.

Hospital Pre-Admission Testing

- Outpatient hospital services for pre-admission testing if the tests are:
- Made within five days prior to the date inpatient care begins;
- Made in the same hospital where the inpatient care is scheduled;
- Ordered by the same physician who ordered the inpatient care; and
- The same as would have been made as an inpatient, or admission is not appropriate or medically necessary.

Hospice Care

Services and supplies provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care is care that controls pain and relieves symptoms but is not intended to cure the illness. You must be suffering from a terminal illness for which the prognosis of life expectancy is one year or less, as certified by your physician and submitted to the claims administrator. Covered services are available on a 24-hour basis for the management of your condition. Services include:

- Interdisciplinary team care with the development and maintenance of an appropriate plan of care
- Short-term inpatient hospital care when required in periods of crisis or as respite care
- Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse
- Social services and counseling services provided by a qualified social worker
- Dietary and nutritional guidance
- Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist
- Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member
- Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies
- Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following your death or the death of a dependent
- Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Hemodialysis Treatment

Services related to renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis home continuous cycling peritoneal dialysis and home continuous ambulatory peritoneal dialysis.

Infusion Therapy

Services and supplies, when provided in your home by a home infusion therapy provider or in any other outpatient setting by a qualified health care provider, for the intravenous administration of your total daily nutritional intake or fluid requirements, including but not limited to Parenteral Therapy and Total Parenteral Nutrition (TPN), medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management.

Injectable Drugs and Implants for Birth Control

Injectable drugs and implants for birth control administered in a physician's office if medically necessary.

Mental Health Conditions or Substance Abuse

Academic or educational testing, counseling, and remediation. Any treatment of mental health conditions or substance abuse, including rehabilitative care in relation to these conditions, except as specifically described under eligible Mental Health and Substance Abuse expenses.

Osteoporosis

Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration (FDA) approved technologies, including bone mass measurement technologies as deemed medically necessary.

Pediatric Asthma Equipment and Services

The following items and services when required for the medically necessary treatment of asthma in a dependent child:

- Nebulizers, including face masks and tubing, inhaler spacers, and peak flow meters. These items are covered under the plan's medical benefits and are not subject to any limitations or maximums that apply to coverage for durable medical equipment.
- Education for pediatric asthma, including education to enable the child to properly use the items listed above. This education will be covered under the plan's benefits for office visits to a physician.

Phenylketonuria (PKU)

Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the claims administrator. The diet must be deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

Physical Exam (Members Age 7 or Older)

The plan will pay for the following preventive care services or supplies when provided for a member age 7 or over. Annual deductibles or copayments will not apply to these services or supplies.

Physical Therapy/Physical Medicine Therapy

The following services provided by a physician under a treatment plan:

- Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment.

Pregnancy and Maternity Care

- All medical benefits for an enrolled subscriber or spouse when provided for pregnancy or maternity care, including the following services:
  - Prenatal, postnatal and postpartum care. Prenatal care also includes participation in the California Prenatal Screening Program
  - Ambulatory care services (including ultrasounds, fetal non-stress tests, physician office visits, and other medically necessary maternity services performed outside of a hospital)
  - Involuntary complications of pregnancy
  - Diagnosis of genetic disorders in cases of high-risk pregnancy
  - Inpatient hospital care including labor and delivery

  Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge.
- Medical hospital benefits for routine nursery care of a newborn child, if the child's natural mother is a subscriber or an enrolled spouse.

Prescription Drugs for Abortion

Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

Prior Authorization

The plan includes certain criteria, called drug edits, to determine if a prescription drug is covered. These criteria include one or more of the following requirements:

- Quantity, dose, and frequency of administration
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease
- Specific physician qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies)
- Step therapy requiring one prescription drug, a prescription drug regimen or another treatment be used prior to use of another prescription drug or prescription drug regimen for safety and/or affordability when clinically similar results may be anticipated and one option is less costly than another
- Use of a prescription drug formulary

Private Duty Nursing

Private duty nursing services.

Limitations:
Limited to 120 days per plan hear.

Prosthetic Devices

Covered devices include:

- Breast prostheses following a mastectomy
- Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy
- Other medically necessary prosthetic devices, including:
    - Surgical implants
    - Artificial limbs or eyes
    - The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery
    - Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications
    - Orthopedic footwear used as an integral part of a brace; shoe inserts that are custom molded to the patient

Radiation Therapy

Includes treatment of disease using x-ray, radium or radioactive isotopes, other treatment methods (such as teletherapy, brachytherapy, intra operative radiation, photon or high energy particle sources), material and supplies used in the therapy process and treatment planning. These services can be provided in a facility or professional setting.

Reconstructive Surgery

Reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to either improve function; or create a normal appearance, to the extent possible. This includes surgery performed to restore and achieve symmetry following a medically necessary mastectomy. This also includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

Retail Health Clinic

Services and supplies provided by medical professionals who provide basic medical services in a retail health clinic including, but not limited to:

- Exams for minor illnesses and injuries
- Preventive services and vaccinations
- Health condition monitoring and testing

Screening for Blood Lead Levels

Services and supplies provided in connection with screening for blood lead levels if your dependent child is at risk for lead poisoning, as determined by your physician, when the screening is prescribed by your physician. This is considered to be a preventive care service.

Skilled Nursing Facility

Inpatient services and supplies provided by a skilled nursing facility, for up to 120 days per benefit year. The amount by which your room charge exceeds the prevailing two-bed room rate of the skilled nursing facility is not considered covered under this plan.

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity.

Sterilization Services

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or injury. Reversals of elective sterilizations are not covered.

Certain sterilizations for women are covered under the plan's physical exam benefit.

Supplementary Accident Benefits

The plan will pay a benefit for covered medical expenses for treatment of an accident in or out of a hospital. No benefit will be payable unless the initial treatment is obtained within 24 hours of the accident. Treatment must be given within 90 days after the date such injuries are sustained. Benefits are paid at 100% of allowable expenses (not subject to the deductible). Not more than the supplemental accident maximum of $300 is payable for all injuries sustained in any one accident. Expenses in excess of $300 are subject to the applicable benefits payable under the plan.

Note: No benefits are payable under this benefit for any charges related to manipulative therapy or outpatient prescription drugs.

Transplant Services

Services and supplies provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The recipient; or
2. The donor

Benefits for an organ donor are as follows:

- When both the person donating the organ and the person getting the organ are covered members under this plan, each will get benefits under their plans.
- When the person getting the organ is a member under this plan, but the person donating the organ is not, benefits under this Plan are limited to benefits not available to the donor from any other source.

  This includes, but is not limited to, other insurance, grants, foundations, and government programs.
- If a member covered under this plan is donating the organ to someone who is not a member, benefits are not available under this plan.

Transgender Services

Services and supplies provided in connection with gender transition when you have been diagnosed with gender identity disorder or gender dysphoria by a physician. This coverage is provided according to the terms and conditions of the plan that apply to all other covered medical conditions, including medical necessity requirements, utilization management, and exclusions for cosmetic services. Coverage includes, but is not limited to, medically necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training.

Travel Benefits

The Anthem PPO plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator (Anthem) up to $10,000 per occurrence when you are required to travel more than 100 miles from your residence to access plan covered services from either an in-network or an out-of-network provider. The member must submit itemized receipts to Anthem for transportation and lodging expenses in a form satisfactory to Anthem when claims are filed. Contact Anthem for detailed information. Anthem will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

Well Baby and Well Child Center

The plan will cover the preventive care services shown below when they are provided for a dependent child under 7 years of age. The benefit year deductible will not apply to these services when they are provided by a participating provider. No copayment will apply to these services when they are provided by a participating provider:

- A physician's services for routine physical examinations
- Immunizations given as standard medical practice for children
- Radiology and laboratory services in connection with routine physical examinations. This includes human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis

What's Not Covered

No payment will be made under the Anthem PPO plan for expenses incurred for or in connection with any of the following items.

- Services or supplies that are not medically necessary, as defined by the plan.
- Any experimental or investigative procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may request an independent medical review.
- Services rendered by providers located outside the United States, unless the services are for an emergency, emergency ambulance or urgent care.
- Conditions that result from: your commission of or attempt to commit a felony, as long as any injuries are not a result of a medical condition or an act of domestic violence; or any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Services received before your effective date or after your coverage ends, except as specifically stated under the plan's extension of benefits.

- Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by the claims administrator.
- Any amounts in excess of maximum allowed amounts or any Medical Benefit Maximum.
- Any service for which you are responsible under the terms of this plan to pay a co-payment or deductible, and the co-payment or deductible is waived by a non-participating provider.
- Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If the plan provides benefits for such injuries, conditions or diseases the claims administrator shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law.
- Any services you actually received that were provided by a local, state, or federal government agency, or by a public school system or school district, except when payment under this plan is expressly required by federal or state law. The plan will not cover payment for these services if you are not required to pay for them or they are given to you for free. You are not required to seek any such services prior to receiving medically necessary health care services that are covered by this plan.
- Professional services received from a person who lives in your home or who is related to you by blood or marriage, except as specifically described under the "Infusion Therapy" provision.
- Expenses related to:
  - Replacement or repair of purchased or rental equipment because of misuse, abuse, or loss/theft
  - Surgical supports, corsets, or articles of clothing unless needed to recover from surgery or injury
  - Enhancements to standard equipment and devices that is not medically necessary
  - Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is medically necessary in your situation
- Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:
  - It must be internationally known as being devoted mainly to medical research;
  - At least 10% of its yearly budget must be spent on research not directly related to patient care;
  - At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
  - It must accept patients who are unable to pay; and
  - Two-thirds of its patients must have conditions directly related to the hospital's research.
- Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in

Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

- Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
- Academic or educational testing, counseling, and remediation. Any treatment of mental health conditions or substance abuse, including rehabilitative care in relation to these conditions, except as specifically described under the "Mental Health Conditions or Substance Abuse" provision. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the claims administrator.
- Residential accommodations to treat medical or behavioral health conditions, except when provided in a hospital, hospice, skilled nursing facility or residential treatment center.
- Cost for braces and other orthodontic appliances or services, except as specifically stated under the plan.
- Dental treatment, regardless of origin or cause, except as specified below. "Dental treatment" includes but is not limited to preventive care and fluoride treatments; dental X-rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth
- Services to improve dental clinical outcomes This exclusion does not apply to the following:
- Services which are required by law to cover
- Services specified as covered under the plan
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer
- Gene therapy as well as any drugs, procedures, health care services related to it that introduce or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.
- Routine hearing tests, except as specifically described under preventive care services.
- Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions, except when provided as part of a routine exam.
- Eyeglasses or contact lenses, except as specifically described under the "Prosthetic Devices" provision.
- Outpatient occupational therapy, except as specifically described under the "Infusion Therapy," "Home Health Care," "Hospice Care" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions.
- Speech therapy except as stated in the "Speech Therapy and Speech Language Pathology (SLP)" provision.
- Scalp hair prostheses, including wigs or any form of hair replacement.
- Cosmetic surgery or other services performed to alter or reshape normal (including aged) structures or tissues of the body to improve appearance.
- Weight loss programs, whether or not they are pursued under medical or physician supervision,

unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as described in the "Bariatric Surgery" provision.

- Reversal of an elective sterilization.
- Services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
- Services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
- Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes, as specifically described under the "Prosthetic Devices" provision.
- Air purifiers, air conditioners, or humidifiers.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care, rest cures, except as specifically described under the "Hospice Care" or "Infusion Therapy" provision. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specifically described under the "Skilled Nursing Facility" provision.
- Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.
- Any supplies for comfort, hygiene or beautification.
- Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the claims administrator. Such services are provided under the "Infusion Therapy", "Pediatric Asthma Equipment and Supplies", or "Diabetes" provisions. This exclusion does not apply to counseling for the treatment of anorexia nervosa or bulimia nervosa.
- Nutritional and/or dietary supplements and counseling, except as provided in this plan or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist.
- Consultations provided using telephone, facsimile machine, or electronic mail.
- Routine physical exams or tests which do not directly treat an actual illness, injury or condition,

including those required by employment or government authority, except as specifically described under the preventive care provisions.

- Acupuncture treatment, acupressure, or massage to control pain, treat illness or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.
- Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.
- Physical Therapy or Physical Medicine. Services of a physician for physical therapy or physical medicine, except when provided during a covered inpatient confinement, or as specifically described under the "Home Health Care", "Hospice Care", "Infusion Therapy" or "Physical Therapy, Physical Medicine and Occupational Therapy" provisions.
- Outpatient prescription drugs or medications and insulin, except as specifically described under the "Infusion Therapy"/"Home Infusion Therapy" and "Prescription Drug for Abortion" provisions. Non-prescription, over-the-counter patent or proprietary drugs or medicines, except as specifically covered under the plan. Cosmetics, health or beauty aids. However, health aids that are medically necessary and meet the requirements for durable medical equipment as specifically described under the "Durable Medical Equipment" provision are covered, subject to all terms of this plan that apply to that benefit.
- Specialty drugs that must be obtained from the specialty drug program, but, which are obtained from a retail pharmacy are not covered by this plan. **You will have to pay the full cost of the specialty drugs you get from a retail pharmacy that you should have obtained from the specialty drug program.**
- Contraceptive devices prescribed for birth control except as specifically described under the "Injectable Drugs and Implants for Birth Control" provision.
- Private duty nursing services.
- Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.
- Programs to alter one's lifestyle which may include but are not limited to diet, exercise, imagery or nutrition. This exclusion will not apply to cardiac rehabilitation programs approved by the claims administrator.
- Services and supplies in connection with clinical trials, except as specifically described under the "Clinical Trials" provision.

For a full list of expenses not covered by the plan, see the applicable Benefit Booklet listed in the "Appendix".

Filing a Claim

If you receive services from a provider who offers an Anthem discount, your provider should submit the claim for reimbursement on your behalf. If you receive services from a provider who does not offer an Anthem discount, you must file your own claim. If you need to file your own claim you should take the claim form along with you when you see your provider.

When you need to file a claim for benefits, complete the appropriate form and mail them with all required documentation to the claims administrator at:

Medical Claims:

Anthem
P.O. Box 37690
Louisville, KY 40233-7690

Pharmacy Claims:

CVS/Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Note: When services are rendered by a provider who offers an Anthem discount, claims should be submitted by the provider to the address included on your Anthem identification card.

For more information on claim filing, please refer to the applicable Benefits Booklet listed in the "Appendix".

Flexible Spending Accounts

Flexible spending accounts (FSAs) allow you to set aside pre-tax dollars to use for eligible health and/or dependent care expenses. The following types of FSAs are available:

- Health care flexible spending accounts (FSA)
- Dependent care flexible spending account (FSA)

You can enroll in one or both of the FSAs — or you can choose not to participate — when you are first hired and during annual enrollment. Your choice remains in effect for the entire benefit plan year, and you cannot make changes until the next annual enrollment, unless you experience a Qualified Life Event. (See "Continuing Your Coverage" for details.)

For more information about the flexible spending accounts contact the Plan Administrator:

Smart Choice (formerly known as Your Spending Account (YSA™))
Phone number: 1-877-216-3222
Website: www.hiibenefits.com, Click on "Worklife Log On"

More Information
▪ You will find information about your flexible spending account benefits throughout this SPD: ▪ Eligibility and Enrollment subsection of the Health Care Benefits section — Contains important information about Huntington Ingalls eligibility and enrollment rules for participation in the Health Care FSA. ▪ Administrative Information section — Contains information about your rights under the health care FSA, including information about the claims appeals process. ▪ "Continuing Your Coverage" in the Eligibility and Enrollment subsection — Contains information about your right to continue your health care FSA participation under COBRA.

Health Care Flexible Spending Account (FSA) Plan

If you choose to participate in a health care flexible spending account (FSA) plan you set aside a certain amount of money for qualified health care expenses from your paycheck before federal income taxes and Social Security taxes are withheld. This reduces your taxable income, and therefore the amount of income taxes you pay.

The Health Care Flexible Spending Account at a Glance

Plan Year	Use money for expenses incurred during the plan year (July 1 through June 30) or applicable grace period (2 months and 15 days after the end of each plan year). Any remaining balances after the end of the calendar year will be forfeited.
Employee Pre-Tax Contribution Limit	$3,050 (2023 limit)**
Eligible Expenses	Medical, dental, vision and pharmacy expenses (including eligible over-the-counter medicines and medically necessary health care products), if applicable.
Debit Card	Yes, you will automatically receive a Smart Choice™ debit card to pay for eligible expenses.
Save Receipts	Yes, to get reimbursed for your eligible expenses you must save your receipts.

** Please note that this limit may be adjusted for cost of living in future years.

How the Health Care FSA Works

You can use the health care flexible spending account (FSA) for most health care expenses that are considered eligible medical expense deductions on your federal income tax return, but are not

reimbursed by another health plan. For example, you can use the account for your out-of-pocket costs, including deductibles, coinsurance, and copayments.

Note: Your premium contributions for coverage under the plan are not eligible for reimbursement through the health care FSA because your premium payments are already made on a before-tax basis.

Eligible health care expenses can be for:

- You
- Your spouse
- Any person you claim as a dependent on your tax return
- Any person you could have claimed as a dependent on your tax return except that:
  - The person filed a joint return,
  - The person had gross income of $4,150 or more, or
  - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's return.
- Your biological child, adopted child, stepchild or foster child who is under age 27 at the end of your tax year

You can contribute from $0 to $3,050 each year based on current IRS guidelines, which may be adjusted annually for cost of living increases to a health care flexible spending account (the limit was $2,850 for 2022). To determine your per-paycheck deduction, simply divide the annual amount you want to deposit by the number of pay periods from which benefit deductions are made during in the year (e.g., 12 for monthly, 52 for weekly).

Although your health care FSA will save you money by lowering your federal taxable income (and in most cases state and local taxable income), you may not take a deduction on your income tax return for health care expenses reimbursed through your account. Since you are responsible for the tax consequences of using an FSA, you should consider discussing your personal financial situation with a tax advisor before you enroll in a health care FSA. You cannot use funds from your health care FSA to pay for Dependent Care FSA expenses and vice versa. You cannot switch money from one fund to another.

Eligible Expenses

There are many health care expenses that currently qualify for reimbursement from a health care FSA. In general, an eligible health care expense meets all the following requirements:

- Is incurred during the plan year (or applicable grace period) for which you are participating
- Is not paid or reimbursed by a health plan or any insurance
- Is eligible for deduction as a medical expense on your federal income tax return. However, some expenses may be eligible for deduction on your tax return, but are not eligible under the health care FSA and vice versa.

Some examples of eligible health care expenses include your medical plan deductibles, coinsurance and copayment amounts, as well as expenses that are not covered at all, such as charges that exceed the plan's limits.

There are other health care expenses considered eligible under Internal Revenue Service guidelines. Below is a partial list of eligible health care expenses. In reviewing the list, keep in mind that it is subject to change.

Also keep in mind that the list is not all-inclusive. You can obtain Publications 969 and 502 from your local IRS office or the IRS web site at www.irs.gov for further information on health care expenses that are eligible for reimbursement from a health care FSA, or you can view a comprehensive list of eligible expenses by logging into your Smart Choice account.

Expenses Eligible for Reimbursement under Health Care FSA

- Chiropractor
- Physical therapist
- Physician (including podiatrist and osteopath) and dentist
- Practical or other nonprofessional nurse, for medical services only (not for care of a healthy person)
- Psychologist and psychoanalyst (medical care only)

Equipment and Supplies

- Athletic treatments/braces
- Car modifications (as required for a diagnosed medical condition)
- Contact lenses and solutions
- Eyeglasses (prescription)
- Hearing aids and batteries
- Home modifications (as required for a diagnosed medical condition)
- Orthodontia (braces and retainers)
- Orthopedic and surgical supports
- Orthopedic shoes and inserts
- Oxygen received for a medical condition
- Prescription drugs and insulin
- Wheelchair and repairs

Over-the-Counter Products

The following over-the-counter products will continue to be available without a doctor's prescription to the extent allowed by Internal Revenue Service (IRS) guidance*:

- Bandages and related items
- Braces and supports
- Family planning (birth control, pregnancy tests, ovulation predictor kits)
- First-aid kits
- Insulin and diabetic supplies

- Reading glasses
- Sleep aids and sedatives
- Walking aids

*IRS guidance is evolving so this list may change over time.

Products that require a Prescription Form

- Antacid
- Antibiotic ointment
- Aspirin or other pain reliever
- Allergy and sinus medications
- Alternative dietary supplements
- Cold sore remedies
- Cough, cold and flu products
- Dental and teething pain products
- Diaper rash and ointments
- Eye drops and treatments
- Motion sickness medication
- Nasal sprays
- Smoking cessation products

Medical Treatments

- Acupuncture
- Eye surgery, including surgeries to correct vision defects
- Sterilization
- Treatment for infertility
- Vasectomy

Miscellaneous

- Braille books (excess cost of Braille books over cost of regular edition)
- Nursing services (wages and taxes)
- Premiums for individual medical insurance policies
- Room and board charges for a sanitarium and similar institutions
- Guide dog (dog, training, care)
- Special school costs for physically and mentally handicapped children
- Weight loss program (for treatment of a medical condition)

Paying for Eligible Expenses

- There are a few ways you can use your health care FSA funds to pay for eligible expenses:
- When you enroll in a health care FSA, you will receive a Smart Choice debit card. You can use this card just like a bank card. Just swipe and go. The payment is drawn directly from your health care FSA.
- Reimbursement option—if you are unable to use your debit card, you will need to file a claim for reimbursement from your account. You will be reimbursed for eligible expenses in one of two ways:
  - Have a check mailed directly to your provider; or
  - Have your reimbursements deposited directly into your bank account through direct deposit. Note: You must set up the direct deposit from you Smart Choice online account in order to use this option.

How the Smart Choice Debit Card Works

Your Smart Choice debit card will be automatically mailed to you when you elect an annual contribution of $150 or more in the health care FSA. You can use your card to pay for eligible expenses and products on the same day you receive them. While most transactions are automatically verified, the card is regulated by IRS rules. The easiest way to comply with IRS rules when using your card is to save your receipts. Every time you use your card, make sure you get a receipt.

How to File a Claim for Reimbursement

If you are unable to use your Smart Choice debit card for health care expenses, you can file a claim for reimbursement. When you incur an eligible expense, you pay the provider and submit a claim form along with your receipts. Claim forms are available through the Smart Choice Service Center. Health care claims are reimbursed based on your annual contribution amount. You will be reimbursed through direct deposit with tax-free dollars from your account.

To submit a claim from your Smart Choice online account, go to www.hiibenefits.com, click on "Worklife Log On" and visit the Reimbursements Account page. You can also log on to your account through the Smart Choice mobile app.

- Select the "Get Reimbursed" tab in the Your Accounts section of home page (or "Get Reimbursed" from the drop down menu if using the Take Action tab).
  - Create Claim Step 1: Choose Account Type: Health Care, type of expense, date of service, and requested amount
  - Create Claim Step 2: Enter service provider and dependent name. Then elect "Pay Me Directly" or "Pay My Provider" (requires account number for this option)
  - Create Claim Step 3: Send receipts - Choose from Upload, Fax/Mail, or Send Later
  - Create Claim Step 4: Review Claim Information — Hit submit at the bottom of page
  - Create Claim Step 5: Print cover sheet or upload documents.

Along with the claim form, you will need to provide documentation to verify that the expense is eligible, such as an itemized receipt or explanation of benefits (EOB). Your documentation must include:

- Name of service provider or retailer
- Date of service or purchase
- Identification of drug or product, or description of service
- Purchase amount for each product or service
- Total purchase amount.

Your claim should be processed within one to two business days after it is received and verified. Payments are sent shortly thereafter.

Additional Rules

Deadline for Filing

You will be reimbursed for expenses incurred during the plan year (July 1 through June 30) or applicable grace period (2 months and 15 days after the end of each plan year). You have until the end of the calendar year to submit your request for reimbursement of these expenses.

For information on continuing your health care FSA after you become ineligible (for example, upon termination of employment), please see "Continuing Your Coverage".

Use It or Lose It

In exchange for the health care FSA tax benefits, the Internal Revenue Service (IRS) has strict rules governing the operation of an FSA. One of these is the "use it or lose it" rule, which states that any money remaining in your account after you submit all claims for the plan year and grace period is forfeited. Keep in mind that you have until the end of the calendar year (December 31 – the "run out" period) to submit claims for eligible health expenses incurred during the applicable plan year and/or grace period. Furthermore, you cannot transfer money between your health care and dependent care flexible spending accounts.

Forfeited amounts may be used to pay reasonable administrative costs of the plan. Because of these IRS rules, it is important that you carefully estimate the amount of eligible expenses you are likely to incur in a given year.

Remember - A run out period and grace period are two separate and distinct things. A run out period is a period following the end of the plan year during which expenses incurred during the previous plan year may be submitted for reimbursement. A grace period is a period following the end of the plan year during which expenses incurred may be reimbursed with contributions from the prior year.

Example: For the July 1, 2022 – June 30, 2023 plan year, you may submit claims for eligible health expenses incurred during the plan year and during the grace period (i.e., July 1, 2023 – September 15, 2023). You have until December 31, 2023 to submit claims incurred during these periods; after December 31, 2023, you will forfeit any balance remaining after subtracting all timely claims for eligible health expenses incurred during the plan year and/or grace period.

Eligible health expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding plan year and

then from any amounts that are available to reimburse expenses incurred during the current plan year.

- Example: Assume that you have $50 remaining in your health care FSA at the end of the 2022-2023 plan year. On July 15, 2023, you incur an eligible health expense of $150 and properly submit a claim for such expense. Your $50 balance from the 2022-2023 plan year is applied to reduce the outstanding balance of the expense to $100, and $100 is deducted from your current plan year balance to pay the rest of the expense.

Health Care FSA vs. Tax Deduction

Even though the health care flexible spending account (FSA) reimbursements can reduce your taxable income, the federal income tax deduction might provide greater savings for some employees. To claim such a deduction, your health care expenses must exceed a certain percentage of your adjusted gross income. Most employees find that their eligible health care expenses do not reach that amount. However, you should consult with your tax advisor to determine which method is best for your personal situation.

Dependent Care Flexible Spending Account

Federal tax law allows you to use the dependent care flexible spending account for charges relating to the care of an eligible dependent that are incurred to enable you — and your spouse, if you are married — to be gainfully employed or to look for work.

The Dependent Care Flexible Spending Account at a Glance

Who's Eligible	You may establish a Dependent Care FSA if you incur dependent care expenses that are necessary for your eligible dependents so you can work. (Refer to Eligible Dependents for more details).
Portability	Use money for expenses incurred during the plan year (July 1 through June 30) or applicable grace period (2 months and 15 days after the end of each plan year). Unused dollars will be forfeited.
Employee Pre-Tax Contribution Limit	$5,000 (or $2,500 if married filing separate federal tax returns). If your annual salary is more than $135,000, then your annual contributions under this plan will be limited to $2,600 (rather than $5,000).
Eligible Expenses	Licensed day care centers, day camps, home care and nursery school for children not yet in first grade, elder care and other related services to help care for your qualifying dependent.
Debit Card	No
Save Receipts	Yes, to get reimbursed for your eligible expenses you must save your receipts.

How the Dependent Care Flexible Spending Account Works

The dependent care flexible spending account (FSA) allows you to use before-tax dollars to pay for eligible dependent care expenses for a child, an incapacitated spouse, an elderly parent (who

resides with you) or any other individual who qualifies as your dependent for federal tax purposes and who is unable to care for him/herself.

The Dependent Care FSA cannot be used to pay for your dependents' health care expenses – the health care FSA plan is designed for those expenses.

If you elect to participate, you can set aside $0 up to $5,000* each year (depending on your marital status, your annual income and the way you file your income tax return).

Once your contributions reach the maximum allowed, your contributions will automatically stop. For purposes of calculating your maximum contribution, if your spouse is a full-time student, or mentally or physically incapable of self-care, tax laws allow you to assume your spouse's earned income to be $250 a month if you have one eligible dependent, or $500 a month if you have two or more eligible dependents.

*The amount you can deposit to a Dependent Care FSA account may also be limited due to requirements that contributions not discriminate in favor of highly compensated or key employees. To comply with IRS rules, this plan limits annual Dependent Care FSA contributions to $2,600 if your annual salary is greater than $135,000.

Tax Considerations

Although the Dependent Care FSA can save you money by lowering your taxable federal income (and, in most cases, your state and local taxable income as well), it is important to note that the IRS will not allow you to take the federal Dependent Care Tax Credit on your personal income tax return for expenses already reimbursed through your account.

You should determine whether the federal Dependent Care Tax Credit or the Dependent Care FSA is better for you. Keep in mind that the maximum amount of dependent care expenses that can be used in calculating your federal Dependent Care Tax Credit is $3,000 for one qualifying individual and $6,000 for two or more. The Dependent Care FSA permits reimbursements of up to $5,000 ($2,600 if your annual salary is greater than $135,000), even if you have only one qualifying individual.

In some cases, you may be able to use both the Tax Credit and the Dependent Care FSA. Again, keep in mind that any dependent care expenses otherwise eligible for the federal Dependent Care Tax Credit will be reduced, dollar for dollar, by the amounts you receive from your Dependent Care FSA.

Since you are responsible for the tax consequences of using an FSA, you should consider discussing your personal financial situation with a tax advisor before you open a Dependent Care FSA account.

Eligible Dependents

You may establish a Dependent Care FSA account if you incur care expenses that are necessary for your eligible dependents so you can work. If you are married, the expenses must be necessary so that both you and your spouse can work, unless your spouse is incapable of self-care, or so that your spouse can attend school on a full-time basis. Your eligible dependents include:

- Your dependent child who is under the age of thirteen (13) that you are entitled to receive an income tax deduction for under the Code
- Your dependent child or spouse who is physically or mentally unable to care for himself or herself and who has the same principal place of abode as you for more than one-half of the plan year

- Your dependent, as generally defined by IRS rules per section 152 of the Internal Revenue Code, who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the Participant for more than one-half of the plan year

Eligible Expenses

Federal tax law allows you to use the Dependent Care FSA for charges relating to care for an eligible dependent that are incurred to enable you, and your spouse, if you are married, to be gainfully employed or to look for work.

Eligible dependent care expenses can include:

- Babysitting (work-related, in your home or someone else's home)
- Before or after school programs
- Elder care
- Expenses for household services related to care of an eligible dependent
- Payroll taxes related to eligible care
- Nursery schools and day care centers that meet local regulations and provide care for more than six non-resident people and receive fees for services provided
- Summer day camps
- Transportation to and from eligible care

To be eligible, expenses must have been incurred during the plan year (or applicable grace period) and while you were covered under the plan. An expense is considered incurred when the care or service is provided — not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

The Dependent Care FSA account cannot be used to pay for the care of someone who lives in a nursing home or other residential facility.

When filing your tax return, you will need to provide the taxpayer ID number or Social Security number of the caregiver.

Paying for Eligible Expenses

When you incur an eligible expense, you pay the provider and submit a claim form along with your receipts. Claim forms are available through the Smart Choice Service Center. For the Dependent Care FSA, you will be reimbursed up to the amount of your current account balance. You will be reimbursed through direct deposit with tax-free dollars from your account.

To submit a claim from your Smart Choice online account, visit www.hiibenefits.com, click on "Worklife Log On" (or through the mobile app), go to the Reimbursements Account page.

- Select the "Get Reimbursed" tab in the Your Accounts section of home page (or "Get Reimbursed" from the drop down menu if using the Take Action tab).

- Create Claim Step 1: Choose Account Type: Dependent Care, type of expense, date of service, and requested amount
- Create Claim Step 2: Enter Service Provider and dependent name. Then elect "Pay Me Directly" or "Pay My Provider" (requires account number for this option)
- Create Claim Step 3: Send receipts — Choose from Upload, Fax/Mail, or Send Later
- Create Claim Step 4: Review Claim Information — Hit submit at the bottom of page
- Create Claim Step 5: Print cover sheet or upload documents.

Along with the claim form, you will need to provide documentation to verify that the expense is eligible, such as an itemized receipt. Your documentation must include:

- Name of service provider or retailer
- Date of service or purchase
- Description of service
- Purchase amount for each product or service
- Total purchase amount.

Your claim should be processed within one to two business days after it is received and verified. Payments are sent shortly thereafter.

How the Pay My Provider Option Works

To arrange to pay your dependent care providers directly from your FSA for your eligible expenses, log into your Smart Choice account online or through the mobile app. If this is your first time logging into your account, be sure to register for your account.

Once you've logged in to your Smart Choice online account:

- Select the "Get Reimbursed" tab in the Your Accounts section of home page (or "Get Reimbursed" from the drop down menu if using the Take Action tab).
    - Create Claim Step 1: Choose Account Type: Dependent Care. Choose service begin and end date and requested amount
    - Create Claim Step 2: Enter service provider and dependent name. Pay My Provider (requires an account number for this option along with address, city, state, ZIP)
    - Create Claim Step 3: Send supporting documents.
        - This allows for the service provider signature (this can be done via mobile app where the provider can enter their signature on phone) this limits the need for receipts or they can choose the Send receipts option.
    - Create Claim Step 4: Review Claim Information — Hit submit at bottom
    - Create Claim Step 5: Print cover sheet which is a dependent certification form.

Additional Rules

Deadline for Filing

You will be reimbursed for expenses incurred during the plan year (July 1 through June 30) or applicable grace period (2 months and 15 days after the end of each plan year), but you have until the end of the calendar year to submit your request for reimbursement of these expenses.

If you terminate employment or otherwise become ineligible to participate in the Dependent Care FSA, you will be reimbursed for dependent care expenses incurred up to the date on which you became ineligible to participate, but only up to the amount you had deposited in your account as of your date of termination or other cause of ineligibility, less any prior reimbursements. You have until the end of the calendar year to submit your request for reimbursement of such expenses.

Use It or Lose It

In exchange for the tax benefits, the Internal Revenue Service (IRS) has strict rules governing the operation of FSA(s). One of these is the "use it or lose it" rule, which states that any money remaining in your account(s) after submitting all claims for the plan year and grace period is forfeited. Keep in mind that you have until the end of the calendar year (December 31 — the "run out" period) to submit claims for dependent care expenses incurred during the previous plan year and/or applicable grace period.

Forfeited amounts may be used to pay reasonable administrative costs of the plan. Because of these IRS rules, it is important that you carefully estimate the amount of eligible expenses you are likely to incur in a given year.

Remember - A run out period and grace period are two separate and distinct things. A run out period is a period following the end of the plan year during which expenses incurred during the previous plan year may be submitted for reimbursement. A grace period is a period following the end of the plan year during which expenses incurred may be reimbursed with contributions from the prior year.

In order to take advantage of the grace period, you must be a participant in the Plan with Dependent Care FSA coverage that is in effect on the last day of the plan year to which the grace period relates (i.e., June 30).

Example: For the July 1, 2022 — June 30, 2023 plan year, you may submit claims for eligible dependent care expenses incurred during the plan year *and* during the grace period (i.e., July 1, 2023 — September 15, 2023). You have until December 31, 2023 to submit claims incurred during these periods; after December 31, 2023, you will forfeit any balance remaining after subtracting all timely claims for eligible dependent care expenses incurred during the plan year and/or grace period.

Eligible dependent care expenses incurred during a grace period and approved for reimbursement will be paid first from available amounts that were remaining at the end of the preceding plan year and then from any amounts that are available to reimburse expenses incurred during the current plan year.

- Example: Assume that you have $50 remaining in your Dependent Care FSA at the end of the 2022-2023 plan year. On July 15, 2023, you incur an eligible dependent care expense of $150 and properly submit a claim for such expense. Your $50 balance from the 2022-2023 plan year is applied to reduce the outstanding balance of the expense to $100, and $100 is deducted from your current plan year balance to pay the rest of the expense.

Loss of Time Benefits

Huntington Ingalls provides you with a level of financial protection against a substantial economic loss should you become unable to work due to a disability. Loss of time benefits are designed to provide assurance that you will continue to have income during certain periods of illness or injury when you cannot work.

In the event that you are unable to work due to a disability, the Plan offers benefits that provide you with a source of income during that time.

If you become disabled due to an occupational illness or injury, you may be entitled to benefits from Workers' Compensation. For more information, contact the HII Benefits Center at 1-877-216-3222.

Loss of time benefits can help protect you from financial loss if you have a non-work related illness or injury (including pregnancy) that keeps you from performing your job.

More Information

- *Administrative Information* section — Contains information about your rights under the disability plans, including information about the claims appeals process.

Loss of Time Benefits at a Glance

- You are eligible for loss of time benefits that provide a weekly benefit equal to $345 in the event that you are unable to work due to illness or injury.
- The plan provides a weekly benefit beginning on the first day of an accidental injury, or on the 8th day of sickness (including pregnancy) for up to 26 weeks.

Eligibility and Participation

Loss of time benefits are provided by Huntington Ingalls to eligible employees.

Eligibility

You are eligible for loss of time benefits for yourself on the first day of the month following the date you complete 30 days of continuous service if you are then a regular full-time employee of the Company in a collective bargaining unit covered by the agreement. The loss of time benefit is administered by Prudential.

Enrollment

All eligible employees are automatically enrolled for loss of time benefits.

Process for Requesting Leave

In the event that you become disabled and are eligible for benefits, please contact your business unit's Leave of Absence administrator who can assist you on how to file a claim with the disability administrator. In addition, you must notify your supervisor. You should provide 30 days advance notice of the need to take leave when the need is foreseeable, when a 30-day notice is not possible, you should provide notice as soon as practicable.

How the Plan Works

You are eligible for loss of time benefits that provide a weekly benefit in the event that you are unable to work due to illness or injury. Benefits begin on:

- the first day of an accidental injury, or
- on the 8th day of sickness (including pregnancy), or if earlier the first day of hospital confinement. Benefits will continue up to the maximum disability period:
- Injury — 26 weeks
- Sickness or Pregnancy — 26 weeks. Limited to 13 weeks per lifetime for disability resulting from alcoholism, drug addiction, other chemical dependency, or other mental or nervous disorders related to the use of alcohol or any drug not prescribed by a physician.

The weekly rates payable under the plan are determined based on the rates in effect on the date the disability occurs. As of July 1, 2021, you are eligible for loss of time benefits that provide a weekly benefit equal to $345 in the event that you are unable to work due to illness or injury.

* *Loss of Time Benefit Limitations*

The loss of time benefit for any and all periods of disability resulting from alcoholism, drug addiction, other chemical dependency, or other mental or nervous disorders related to the use of alcohol or any drug not prescribed by a doctor, shall not exceed an aggregate maximum of 13 weeks during the lifetime of the participant.

Loss of time benefits shall end on the date your employment terminates from the Company.

Loss of time benefits are limited to 26 weeks for any 12 consecutive months for the same or related disability. Successive periods due to entirely unrelated causes must be separated by return to active, full-time work for at least one day to be considered separate disabilities.

When You Are Considered Disabled

For purposes of the loss of time benefit, you are considered disabled if, while this coverage is in force, you have a covered accidental bodily injury or sickness and you are:

- Wholly and continuously disabled, preventing you from engaging in your occupation; and
- Under the regular care and attendance of a legally qualified physician and/or surgeon, podiatrist, or osteopath.

More Information
For more details about loss of time benefits, please refer to summary of coverage in the Appendix".

Life and Accident Insurance

HII offers protection benefits for you and your family to provide important financial support if you or a covered family member dies or is seriously injured in an accident. By offering Company-paid life and AD&D benefits, the Company provides you and your family with valuable financial coverage.

You automatically receive the following basic benefits at no cost to you

- Basic life insurance
- Basic accidental death and dismemberment (AD&D) insurance

More Information

You will find information about your life and AD&D insurance benefits throughout this handbook:

- Administrative Information section – Contains information about your rights under the survivor benefit plans, including information about the claims appeals process.

Life and AD&D Insurance at a Glance

The HII life and accidental death & dismemberment (AD&D) insurance plans provide income protection in the case of an accident or death.

Survivor Benefit Plan	Enrollment	Cost Sharing	Coverage
Basic Life Insurance	Automatic	The Company pays the full cost	$50,000
Basic Accidental Death & Dismemberment Insurance	Automatic	The Company pays the full cost	$50,000

Eligibility and Enrollment

You are eligible for Life and AD&D Insurance on the first day following the completion of 30 days of continuous service if you are then a regular full-time employee of the Company in a collective bargaining unit covered by the agreement and are actively at work on that day. If you are not actively at work on the day your insurance would otherwise begin, coverage will begin on the first day you return to full-time work.

Enrollment

All eligible employees are automatically enrolled for basic life and AD&D Insurance. The Company pays the full cost of this coverage.

Basic Life Insurance

Huntington Ingalls Industries, Inc. provides you with basic life insurance equal to $50,000. You are automatically covered by this insurance; you do not have to enroll in the plan. Huntington Ingalls Industries, Inc. pays the full cost of basic life insurance for you.

If you die, the plan pays benefits to the beneficiary or beneficiaries you choose. If you have not named a beneficiary, the benefit will be paid to your current spouse, if living, or to your estate.

Basic AD&D Insurance

Huntington Ingalls Industries, Inc. provides you with basic accidental death and dismemberment (AD&D) insurance equal to $50,000. You are automatically covered by this insurance; you do not have to enroll in the plan. Huntington Ingalls Industries, Inc. pays the full cost of basic AD&D insurance for you.

If you die, the plan pays benefits to the beneficiary or beneficiaries you choose. If you lose a limb or your sight, speech, or hearing or become paralyzed as a result of a covered accident, the plan pays a portion of your AD&D benefits.

Naming a Beneficiary

It is very important that you designate a beneficiary when you first become eligible for coverage. By doing so, there should be no question regarding the individual(s) to whom you want your benefits paid.

You may name anyone you wish as your beneficiary except the Company or any of its affiliates. You also may choose more than one person to be your beneficiary. If you name more than one person, you must indicate the percentage of benefit you would like each named beneficiary to receive. If you do not do this, benefits will be distributed equally among all of your named beneficiaries.

You may change your beneficiary at any time. Changes in your beneficiary designation must be made on Worklife at www.hiibenefits.com or by calling the HII Benefits Center at 1-877-216-3222.

Cost of Coverage

Huntington Ingalls provides basic life and AD&D insurance to you at no cost.

When Coverage Begins

If you meet the eligibility requirements, coverage becomes effective on the first day following the completion of 30 days of continuous service, provided you are actively at work that day. If you are not actively at work on the day your insurance would otherwise begin, coverage will begin on the first day you return to full-time work.

Leaves of Absence

- If you are on an approved leave of absence, continuation of coverage will depend on the type of leave as follows:
- If you are on a furlough or temporary layoff, and if any required contribution is paid, you will be covered to the end of the month, plus one month following the date your temporary layoff begins.
- If you are on a medical leave of absence, and if any required contribution is paid, you will be covered to the end of one year following the date your leave of absence begins.
- If you are on a personal or educational leave of absence, and if any required contribution is paid, you will be covered to the end of the month following the date your leave of absence begins.
- If you are on a military/mobilization leave of absence, coverage terminates on the date your leave of absence begins.
- If you are on a family leave of absence, and if any required contribution is paid, you will be covered to the end of the month, plus four months following the date your leave of absence

begins.

Assigning Your Benefits

Your life and AD&D insurance may be assigned only as a gift assignment. Any rights, benefits or privileges that you have as an employee may be assigned. This includes any right you have to choose a beneficiary or to convert to another contract of insurance. Prudential will not decide if an assignment does what it is intended to do. Prudential will not be held to know that one has been made unless it or a copy is filed with Prudential through the contract holder.

This applies only to insurance for which you have the right to choose a beneficiary, when that right has been assigned. If an assigned amount of insurance becomes payable on account of your death and, on the date of that death, there is no beneficiary chosen by the assignee, it will be payable to:

- The assignee, if living; or
- The estate of the assignee, if the assignee is not living.

When Coverage Ends

Coverage normally will continue as long as you remain eligible and pay any required premiums. However, coverage will end on the earliest of the following:

- The last day of the month in which your employment ends
- The day on which the plans are terminated

Converting Your Coverage

If your coverage ends because your employment with Huntington Ingalls Industries, Inc. ends or the coverage is terminated, you may elect to convert the terminating coverage to an individual policy of your own. You must apply for the coverage within 31 days of the date coverage ends (or within 15 days of the date you are notified if later). Evidence of insurability is not required.

Conversion allows you to convert all or $10,000 of coverage to an individual policy (subject to conversion amount limitations). Amounts you convert are no longer part of your Huntington Ingalls Industries, Inc. coverage, and you are solely responsible for keeping the individual policy(ies) active. You pay the insurance company directly. Your cost is based on the insurance company's standard individual rates, which may differ from the rates you currently pay.

Converted coverage becomes effective the first day after the 31-day conversion period ends. If you elect to convert your life insurance, you may add an AD&D Benefit Rider to your policy.

For more information or to request a conversion or portable policy, contact Lincoln Financial at 1-888-787-2129.

Filing a Claim

To receive benefits under any of the life insurance plans, you or your beneficiary must report the death of the enrolled person. Here are some simple steps to follow to initiate the payment of life insurance benefits:

1. Call the HII Benefits Center at 1-877-216-3222 to report the death. The HII Benefits Center notifies the insurance company, gathers the necessary information, and provides you or your beneficiary with information about the payment of life insurance benefits.

2. You will be asked to provide certified copies of the death certificate, birth certificate, and marriage certificate of the deceased. These must be certified; photocopied certificates are not valid. You may also be required to provide other information, as requested by the insurance carrier.

Additional Benefits

As an employee of Huntington Ingalls, you also have access to a variety of other benefits.

More Information

You will find information about these benefits throughout this SPD:

- *Administrative Information* — Contains information about your rights under these benefits, including information about the claims appeals process.

HII Employee Reach Out (HERO) – formerly EAP

The HII Employee Reach Out (HERO) is a free, professional, and confidential counseling and referral program that is available to you and your family/household members who are eligible to enroll in the Plan. HERO is separate from the mental health and substance abuse program described under the medical plan options.

For more information about HERO and Work/Life Services administered by Anthem, access the Anthem HERO Provider Link at www.hiibenefits.com.

Eligibility

Employees and family/household members can use HERO services, even if they are not enrolled in a Huntington Ingalls Industries, Inc. medical plan option.

How the Plan Works

HERO provides eight free counseling sessions for each participating individual per issue per year, including marriage, family and bereavement counseling. HERO also provides telephonic assistance to include information on a variety of behavioral health topics, community resources and referrals. Assistance required beyond your HERO benefit is coordinated with the mental health benefits under your medical plan option, if applicable. HERO services do not include inpatient treatment for mental health or chemical dependency or other intensive or specialty services designed to treat acute and chronic mental illness or chemical dependency diagnoses.

Work/Life Services are additional benefits provided under HERO, and includes 24/7 confidential assistance in balancing work and life commitments. Work/Life services offers information, resources and referrals for many everyday issues included but not limited to ongoing or emergency child and elder care, help for care givers, school and college information, assistance for children with special needs, adoption resources, housing options, assistance with relocation, resources to assist in preparing for retirement and pet care. The program can also help you locate community resources for financial counseling or debt management.

For more information about HERO administered by Anthem, access the HERO Provider Link at www.hiibenefits.com.

Administrative Information

This section provides important information about your legal rights as they apply to the following Huntington Ingalls benefits:

- Health care benefits (including medical and prescription drug)
- Flexible Spending Accounts
- Loss of time benefits
- Life and AD&D insurance
- Additional benefits

The Plan will comply, to the extent applicable, with the requirements of all applicable state and federal laws, including but not limited to USERRA, COBRA, HIPAA, Health Information Technology for Economic and Clinical Health Act, Newborns' and Mothers' Health Protection Act of 1996, Women's Health and Cancer Rights Act of 1998, Family and Medical Leave Act of 1993, Mental Health Parity Act of 1996, Mental Health Parity and Addiction Equity Act of 2008, Michelle's Law, Genetic Information Nondiscrimination Act of 2008, Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, the Consolidated Appropriations Act of 2021 ("CAA"), including the No Surprises Act, and the American Rescue Plan Act of 2021.

No Surprises Act

Recent legislation known as the "No Surprises Act" requires group health plans to abide by certain federal standards to resolve surprise medical bills. More specifically, the law's provisions relating to surprise medical bills generally bar surprise "balance" billing and limit "out-of-network" (i.e., Nonpreferred Provider) cost-sharing in three specific instances: (1) emergency services rendered by Nonpreferred Providers or Nonpreferred Provider facilities, (2) non-emergency services provided by Nonpreferred Providers at Preferred Provider facilities (subject to certain exceptions where notice and consent requirements are satisfied – see "Important Note – Non-emergency Services Provided by a Nonpreferred Provider at a Preferred Provider Facility" below), and (3) air ambulance services. In these situations, the rules generally prevent balance billing of covered persons (or holding covered persons liable) for any amounts exceeding Preferred Provider "in-network" charges.

In addition, the No Surprises Act implemented new requirements with respect to the processing of certain group health plan claims (e.g., external review requirements and advanced explanation of benefits requirements). If you have any questions regarding whether and/or how the No Surprises Act impacts your group health plan benefits, you may contact the applicable carrier/third-party administrator for additional information (see "Contacts").

Important Note – Non-emergency Services Provided by a Nonpreferred Provider at a Preferred Provider Facility

Pursuant to the No Surprises Act, when non-emergency services are furnished by a Nonpreferred Provider at a Preferred Provider facility, and the Nonpreferred Provider does not satisfy the applicable notice and consent criteria for those benefits, the Plan cannot

impose a cost-sharing requirement for those items or services that is greater than the cost-sharing requirement that would apply had the benefits been furnished by a Preferred Provider. However, a Nonpreferred Provider may balance bill (i.e., charge additional "out-of-network" amounts) a covered person for an item or service, other than an emergency service, furnished if the provider (or a Preferred Provider facility acting on behalf of the Nonpreferred Provider) satisfies the applicable notice and consent criteria, summarized as follows:

- **Timing of Notice**. If the appointment for non-emergency items or services is made at least 72 hours before the scheduled date, the Nonpreferred Provider or Preferred Provider facility must provide the covered person (or their authorized representative) a written notice, not later than 72 hours before the date on which the covered person is furnished the items or services. If the appointment is made within 72 hours before the scheduled date, the notice must be provided on the date the appointment is made.
- **Content and Availability of Notice**. The notice must: (i) be in paper or electronic form, as selected by the covered person, (ii) contain the following information: (1) notification that the health care provider is a Nonpreferred Provider with respect to the Plan; (2) notification of the good faith estimated amount that the Nonpreferred Provider may charge the covered person for the items and services involved, including a notification that the provision of the estimate or consent to be treated does not constitute a contract with respect to the estimated charges; (3) a list of any Preferred Providers at the facility who are able to furnish the items and services involved and notification that the covered person may be referred, at their option, to such a Preferred Provider; and (4) information about whether prior authorization or other care management limitations may be required in advance of receiving such items or services at the facility; (iii) clearly state that consent to receive the items and services from the Nonpreferred Provider is optional and that the covered person may instead seek care from a Preferred Provider for the Plan, in which case the covered person's cost-sharing responsibility would not exceed the responsibility that would apply for such an item or service that is furnished by a Preferred Provider; and (iv) be available in the 15 most common languages in the geographic region of the applicable facility.
- **Consent.** The consent must be signed by the covered person before the items or services are furnished. The consent must acknowledge (in clear and understandable language) that the covered person: has been provided the written notice; has been informed that payment of the charge may not accrue toward meeting any limitation that the Plan places on cost-sharing, including an explanation that such payment may not apply to an "in-network" (i.e., Preferred Provider) deductible applied under the Plan; and has been provided the opportunity to receive the written notice in the form selected by the covered person. The consent also must document the date on which the covered person received the written notice and the date on which the covered person signed the consent. This consent operates only to provide consent to the receipt of the information provided. It does not constitute a contractual agreement to any estimated charge or amount included in the information.

NonPreferred Providers (or Preferred Provider facilities acting on behalf of a Nonpreferred Provider) are responsible for satisfying applicable notice and consent requirements. If you have any questions regarding the notice and consent requirements applicable to non-emergency items or services furnished by a Nonpreferred Provider at a Preferred Provider facility, please contact the appropriate carrier/third-party administrator (see "Contacts").

Administrative Details

The following provides important Plan information about your Ingalls Operations Hourly Health and Disability Plan benefits.

General Plan Facts

Employer/Plan Sponsor	Huntington Ingalls Industries, Inc. 4101 Washington Avenue Newport News, VA 23607
Employer Identification Number (EIN)	90-0607005
Type of Plan	Welfare benefit plan
Type of Administration	Insured and self-insured
Plan Administrator	Employee Welfare Benefits Committee Huntington Ingalls Industries, Inc. 4101 Washington Avenue Newport News, VA 23607
Agent for Service of Legal Process	Huntington Ingalls Industries, Inc. c/o Corporate Secretary Huntington Ingalls Industries, Inc. 4101 Washington Avenue Newport News, VA 23607 Service of process may also be made to the Plan Administrator.
Benefit Plan Year	July 1 to June 30; for annual reporting purposes (Form 5500), the Plan year is the calendar year
Plan Name and Number	The Ingalls Operations Hourly Health and Disability Plan is a component plan under the Huntington Ingalls Industries, Inc. Group Benefits Plan; plan number 501

Specific Plan Facts

Medical Plan	
Insured by:	Huntington Ingalls Industries, Inc. self-insures the PPO medical plan option
Claims administered by:	Anthem P.O. Box 54159 Los Angeles, CA 90054
Sources of contributions:	Depending on the benefits selected by the employee, the cost of benefits will either be covered by contributions from Huntington Ingalls Industries, Inc. or shared by Huntington Ingalls Industries, Inc. and the participant.

Prescription Drug Plan in the Medical Plan Options	
Insured by:	Huntington Ingalls Industries, Inc. self-insures the prescription drug benefits in the PPO medical plan
Claims administered by:	For prescription drug benefits in the PPO, claims are administered by: CVS/caremark P.O. Box 659541 San Antonio, TX 78265-9541
Funded by:	Huntington Ingalls Industries, Inc. and participant contributions

Basic Life and Accidental Death and Dismemberment Insurance	
Insured by:	Lincoln Financial 100 Liberty Way Mail Stop 02-5 Dover, NH 03821
Claims administered by:	Lincoln Financial 100 Liberty Way Mail Stop 02-5 Dover, NH 03821
Funded by:	Huntington Ingalls Industries, Inc.

Health Care and Dependent Care Flexible Spending Account Plans	
Insured by:	Huntington Ingalls Industries, Inc. self-insures the Health Care and Dependent Care Flexible Spending Account plans
Claims administered by:	Smart Choice Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407 877-216-3222
Funded by:	Participant contributions

Future of the Plans

Huntington Ingalls Industries, Inc. 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. This right includes, but is not limited to, the amendment of any plan or plan provision in response to the occurrence of a natural disaster, emergency, pandemic or similar catastrophic event, to the extent permitted or mandated by law.

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 will notify you if an amendment or termination substantially affects your benefits.

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 Huntington Ingalls Industries, Inc.

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, if any, will become the sole property of Huntington Ingalls Industries, Inc., to the extent permitted by law.

Plan Administration

Huntington Ingalls Industries, Inc. is responsible for the general administration of the Plan, and will be the named fiduciary to the extent not otherwise specified in this SPD, another component "Group Benefits Plan" document or in an insurance contract. Huntington Ingalls Industries, Inc. 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 Huntington Ingalls Industries, Inc. will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan

Administrator nor Huntington Ingalls Industries, Inc. will be liable in any manner for any determination made in good faith.

Huntington Ingalls Industries, Inc. may designate other organizations or persons to carry out specific fiduciary responsibilities for Huntington Ingalls Industries, Inc. in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping.
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan, and
- The responsibility to act as claims administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator has not been delegated such authority.

Huntington Ingalls Industries, Inc. will administer the Plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated.

Liability of Insurer

For benefits that are provided on an insured basis (not self-insured by Huntington Ingalls Industries, Inc.), the insurance carrier 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 coverage contract, including eligibility for benefits. Huntington Ingalls Industries, Inc. does not guarantee the payment of any benefit described in an insurance coverage contract, and you must look solely to the insurance carrier for the payment of benefits.

Claims Procedures

The following provides important information about the claims procedures for the benefits offered by Huntington Ingalls Industries, Inc.

Claims and Appeals for Fully-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component plans that are provided under insurance contracts, the respective insurer is the named fiduciary and claims administrator under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract. To obtain benefits from the insurer, you must follow that insurer's claims procedures. Refer to the applicable Benefit Booklet listed in the Appendix for more information.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative

appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain component benefit options you may also have the right to obtain external review (that is, review outside of the Plan). Refer to the applicable Benefit Booklet listed in the Appendix for more information about the claims process for insured benefits.

Claims and Appeals for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the self-funded component plan options provided through the Company's general assets (as well as for purposes of determining eligibility to participate in the Plan), the Plan Administrator is the named fiduciary and claims administrator under the Plan (unless a different claims administrator has been designated for that benefit), with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must submit a claim to the Plan Administrator (or, if applicable, to the claims administrator for that benefit) in accordance with the claims procedure for that component benefit option, as set forth in the applicable Benefit Booklet listed in the Appendix.

General Requirements

Except to the extent otherwise provided by the applicable claims administrator, or as provided under a particular Benefit Booklet, claims and appeals for benefits provided under the Plan will be subject to the timing and notice requirements set forth below.

Types of Claims

A claim that relates to the payment of a specific benefit under the Plan is called a "Benefit Claim." For example, when you receive medical care and the provider submits a claim to the Plan to be paid for the service, that is considered a Benefit Claim. Claims that are not a claim for a specific benefit under the Plan are called "Administrative Claims." For example, you believe that you are being charged too much for the benefit coverage you have elected and file a claim. Because your claim is not for the payment of a specific benefit under the Plan, your claim is treated as an Administrative Claim.

How to File a Claim

Benefit Claims. When you receive medical (including prescription drugs or mental health and/or chemical dependency care), dental, or vision care from an in-network provider, your provider should automatically file a claim for you.

If you receive care or treatment from an out-of-network provider (if applicable), you will usually need to pay the provider directly at the time you receive care and then file a claim with the claims administrator for reimbursement of your eligible expenses. Your claim must include the appropriate paperwork and receipts. If you receive reimbursement from another source, such as your spouse's plan, your claim must include the explanation of benefits from that plan. Be sure to keep a copy of everything for your records.

Most claim forms can be obtained at the *Forms* link at www.hiibenefits.com. You can also request claim forms by calling the HII Benefits Center at 1-877-216-3222 or by calling the claims administrator directly at the number provided on your ID card.

You must submit medical claims that you incur during the benefit plan year within 12 months after the benefit plan year ends (please note, if you are enrolled in the PPO plan option administered by Anthem, 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 in October 2021. Since the benefit plan year ends on June 30, 2022, you have until June 30, 2023 to submit your claim for reimbursement (if you are in a medical plan administered by Anthem, you have until September 30, 2023 to submit your medical claim for reimbursement). The medical plan options do not pay claims that are submitted after the 12-month (for medical plans administered by Anthem, 15-month) deadline.

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

Administrative Claims. Administrative Claims must be submitted to the claims administrator within 65 days from the date you know or should have known that there is an issue, dispute, problem or other claim with respect to the Plan. If a claim involves a Plan change or amendment, you are considered to know about your claim when the change or amendment is first communicated to participants in the Plan, and the 65-day period for filing a claim begins on the date the change is first communicated, whether or not the change or amendment has become effective by that date.

If you do not file a Benefit Claim or an Administrative Claim by the applicable deadline and in the proper manner, your claim will expire and be automatically denied if it is subsequently filed. You will not be able to proceed with a lawsuit based on that claim.

Timeframes for Determinations

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

Type of Claim	Initial Deadline for Claims Review	Time for You to Provide Additional Information	Extensions for Claims Review, if Necessary
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
Disability	45 days	45 days	Up to Two 30-day Extensions
Life, AD&D Insurance	90 days	45 days	90 days
Administrative	90 days	45 days	90 days

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

- 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 "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.

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:

- If a medical (not including FSA) claim, the date of the service, name of the health care provider, claim amount, diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning
- The specific reason for the denial
- References to the specific Plan provisions on which the denial is based
- If a medical (not including FSA) claim, the denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the claim
- A description of additional material or information that you may need to perfect the claim and an

explanation of why such material or information is necessary

- A description of the Plan's review procedures (including any 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.

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 rule, guideline, or protocol, free of charge upon request
- If the denial is based on an exclusion applicable to medical necessity or experimental treatment or similar exclusion, the denial must 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 (Except Disability)

If your Benefit Claim is denied, you have the right to make an appeal:

- You may call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- If you cannot correct the problem by phone, or if you choose not to call the claims administrator, you have the right to file a level 1 appeal by writing directly to the claims administrator. Be sure to explain why you think your claim should be paid and provide all relevant details.
- If your claim is denied by the level 1 appeals review committee, and it is not an urgent claim or Administrative Claim, ask the claims administrator to submit your claim to the appropriate level 2 appeals review committee.
- In deciding appeals, the claims administrator acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations as to whether you are entitled to benefits.

Appealing a Denied Claim for Disability Benefits

Prudential Insurance Company of America ("Prudential") is the decision-maker for both disability claims and appeals, with fully delegated authority for such decisions. You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made not later than 45 days following receipt of the written request for review. If Prudential determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Prudential will notify you in writing if an additional 45-day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45 day extension of the appeal period will begin after you

have provided that information. If you fail to deliver the requested information within the time specified, Prudential may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. Prudential will provide you with any new or additional evidence/rationale reviewed in connection with your appeal before the 45-day period expires (or 90-day period, in the event of an extension), and you will be given a reasonable opportunity to respond to such new evidence/rationale.

The review will be conducted by Prudential will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Prudential will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of your claim, Prudential will provide you with the names of each support expert, regardless of whether the advice was relied upon.

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

- The specific reason(s) for the determination (including an explanation for the basis for disagreeing with or not following: (i) the views of the health care professionals who treated you or the vocational professionals who evaluated you; (ii) the views of medical/vocational experts whose advice was obtained on behalf of the plan in connection with the determination; and/or (iii) a Social Security Administration disability determination);
- A reference to the specific Plan provision(s) on which the determination is based;
- If the determination is based on a medical necessity or experimental or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination (or a statement that such explanation will be provided free of charge upon request);
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- A statement describing your right to bring a lawsuit under ERISA; and
- The statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

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

Appealing a Denied Administrative Claim

If your Administrative Claim is denied, you have the right to make an appeal by writing to the claims administrator. Be sure to explain why you think your Administrative Claim should be approved and

provide all relevant details. There is only one level of appeal for Administrative Claims. See the "Claims and Appeals Contact Information" for the contact information of the claims administrator. The claims administrator identified in the chart acts as the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the Plan and to make factual determinations.

Timing of Your Appeal

If you make a Benefit or Administrative Claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see "Administrative Information" for details).

In the case of medical, health care flexible spending account (FSA), and disability benefit claims, you have 180 days from the time that you receive a claim denial from the claims administrator to file an appeal. In the case of administrative claims and all other benefits, you have 65 days from the time that you receive a claim denial from the claims administrator to file an appeal. Below are the timeframes that apply when you file an appeal.

Type of Claim	Time to Appeal From Date Claim Is Denied	Time for Decision on Appeal	Extensions for Claims Administrator, If Necessary
Medical: Urgent claims	180 days	72 hours	None
Medical: Pre-Service claims	180 days for each level of appeal	Two levels of appeal: 15 days from the receipt of the appeal for each level	None
Medical: Post-Service claims	180 days for each level of appeal	Two levels of appeal: 30 days from the receipt of the appeal for each level	None
Life, AD&D	65 days	One level of appeal: 60 days	60 days
Disability	180 days	45 days	45 days
Administrative	65 days	One level of appeal: 60 days from the receipt of the appeal	60 days

- Urgent Medical Claims. There is only one level of appeal that is required for urgent claims. You may file an urgent claim appeal with the claims administrator within 180 days if your initial claim for benefits is denied. Your appeal must be considered within 72 hours, with no extensions. You may file a lawsuit under ERISA if your appeal of an urgent claim is denied. However, if you wish, you may file a voluntary level 2 appeal of an urgent claim denial with the claims administrator within 180 days, and your appeal will be considered within 72 hours, with no extensions. For urgent claims, the level 2 appeal is voluntary — it is your choice to request it or not — and you are not required to file a voluntary level 2 appeal in order to file a lawsuit. If you would like additional information to help you decide whether to file a voluntary level 2 appeal of an urgent claim denial, please call the claim administrator. Your decision as to whether to file a voluntary level 2 appeal of an urgent claim denial will have no effect on any of your other rights under the Plan, and the same rules and procedures apply to a voluntary level 2 appeal of an urgent claim denial

as for all other level 2 appeals.

- Pre-Service Medical 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 Medical 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 30 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 30 days, with no extensions.
- Disability Claims. There is one level of appeal. If your initial claim for disability benefits was denied, you may appeal that denial within 180 days after you receive the claim denial. Your appeal must be considered within 45 days, with a 45-day extension permitted if necessary.
- Administrative Claims**.** There is only one level of appeal for administrative claims. 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 and Level 2 Appeals
Anthem PPO Medical Plan	All Claims must be submitted to your local plan. Please contact customer service with questions.	Anthem PO Box 4310 Los Angeles, CA 90060-0007
CVS/caremark (Prescription Drugs)	CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136	CVS/caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Fax: 1-866-443-1172
Prudential Insurance Company of America (Loss of Time Benefits)	Prudential Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176	Prudential Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176
Prudential Insurance Company of America (Life & AD&D insurance)	Lincoln Financial 100 Liberty Way Mail Stop 02-5 Dover, NH 03821	Lincoln Financial 100 Liberty Way Mail Stop 02-5 Dover, NH 03821
Smart Choice (Flexible Spending Account Administrator)	Smart Choice Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407	Smart Choice Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407
COBRA	HII Benefits Center COBRA Administration	Employee Welfare Benefits Committee Huntington Ingalls Industries, Inc.

Claims Administrator	Claims	Level 1 and Level 2 Appeals
	P.O. Box 563912 Charlotte, NC 28256-3912	P.O. Box 563912 Charlotte, NC 28256-3912
Administrative Claims	HII Benefits Center P.O. Box 661095 Dallas, TX 75266-1095	Employee Welfare Benefits Committee Huntington Ingalls Industries, Inc. P.O. Box 661095 Dallas, TX 75266-1095
Family Health Center/Wellness Solutions	QuadMed W227 N6103 Sussex Road Sussex, WI 53089	QuadMed W227 N6103 Sussex Road Sussex, WI 53089

Additional Information About the Appeals Process

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, health care flexible spending account (FSA), and disability benefit claims:

- The decision on the appeal will be made by a person or persons at the claim administrator who is not the person who made the initial claim decision and who is not a subordinate of that person
- The decision will be made in a manner designed to ensure the independence and impartiality of the persons involved in making the decision
- In making the decision on the appeal, the claims administrator will give no deference to the initial claim decision
- If the determination is based in whole or in part on a medical judgment, the claims administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional will not be the same individual who was consulted (if one was consulted) with regard to the initial claim decision and will not be a subordinate of that person
- If the claims administrator considers, relies upon or generates new or additional evidence in the process of considering your claim, such evidence will be provided to you as soon as possible in advance of the date by which the claims administrator is required to provide notice of its final decision on appeal
- If the claims administrator intends to issue an adverse final decision on appeal (deny your appeal in whole or part) based on a new or additional rationale, the claims administrator will provide you with the rationale as soon as possible in advance of the date by which the claims administrator is required to provide notice of its final decision on appeal

If benefits are still denied on appeal, the notice that you receive will provide, to the extent required by law:

- The specific reasons for the denial
- Reference to the Plan provisions on which the decision was based
- If a medical (excluding FSA) claim, the date of the service, name of the health care provider, claim amount, diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning
- If a medical (excluding FSA) 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 discussion of the decision
- If a medical (excluding FSA) 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.)

Depending on the type of claim, the notice that you receive from the final review level will also contain the following information:

- 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 or similar exclusion, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge.

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.

Your ERISA Rights

In 1974, the President of the United States signed into law the Employee Retirement Income Security Act (ERISA). ERISA sets out certain rights to which you are automatically entitled as a participant in the employee benefits program.

The Company will continue its long-established compliance with all legal requirements concerning full disclosure of your rights as a benefit Plan participant. Since we are sincerely interested in communicating these rights, we want you to know that you are entitled to certain rights and protections under ERISA.

Under ERISA, all Plan participants are entitled to receive information about your Plan and benefits. You are entitled to:

Receive Information About Your Plan Benefits

- Examine, without charge, at the Plan Administrator's office and other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report

Continue Group Health Plan Coverage

If there is a loss of coverage under the Plan as a result of a qualifying event, you or your dependents may have to pay for such coverage. Review the rules governing your COBRA continuation rights.

You should be provided a certificate of creditable coverage (HIPAA certificate), free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan and when your COBRA continuation coverage ceases.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and don't 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 because of a reason beyond the control of the Plan Administrator.

If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor. You also may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you have sued to pay these costs and fees. If your suit is not successful, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory. You also may contact:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 866-444-3272.

Your HIPAA Privacy Rights

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulate how an employer group health plan:

- Permits special enrollment periods and prohibits discrimination based on health status.
- Maintains the privacy of your health information.

HIPAA requires Huntington Ingalls Industries, Inc. to provide you with a notice of the Plan's legal duties and privacy practices with respect to your protected health information (PHI). The Plan creates, receives, uses, maintains and discloses health information about you and your covered dependents in the course of providing these benefits: medical and the employee assistance program. The privacy notice describes how the Plan may use or disclose your health information, and under what circumstances it may share this information without your authorization (generally, to carry out treatment, payment or health care operations).

Huntington Ingalls Industries, Inc. distributes the notice via mail or in electronic form. You should retain this notice with your personal records. To receive a copy of the Plan's Privacy Notice, please contact the HII Benefits Center at 1-877-216-3222.

Special Enrollment Rights

In accordance with the terms of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), if you are declining group health plan coverage for yourself or your eligible dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself and/or your eligible dependents in the Plans if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself, your spouse and/or your new eligible dependent children by processing enrollment within 31 days of the event. Otherwise, if you decline group health plan coverage when you first are eligible, restrictions may apply if you wish to enroll at a later time.

If you experience a special enrollment event or a Qualified Life Event, you must contact the HII Benefits Center at 1-877-216-3222 within 31 days in order to make a change to your election.

If you request a change due to a Qualified Life Event within the 31 day timeframe, coverage will be effective the date of the event.

To request special enrollment or obtain more information, contact the HII Benefits Center at 1-877-216-3222.

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

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers 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 in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing 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. For information on precertification, contact the Plan Administrator.

Contacts

For questions not answered in this SPD, or to learn more about a provider network, etc., we have provided contact information for all the carriers/third-party administrators for your reference. Please use these resources as an added tool to get the most out of your benefits.

You can also contact the HII Benefits Center at 1-877-216-3222.

Plan Name	Address	Phone	Website
General			
HII Benefits Center		1-877-216-3222	
Medical Plan			
Anthem PPO Medical Plan Options	Medical Claims: Anthem P.O. Box 4310 Los Angeles, CA 90060-0007	1-844-465-7237	www.Anthem.com/CA
Prescription Drug Program	CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136	1-844-287-1289	http://www.caremark.com/ www.cvscaremarkspecialtyrx.com
Flexible Spending Account Plans			
Health Care Flexible Spending Account ***Dependent Care Flexible Spending Account***	Smart Choice Claims and Appeals Management P.O. Box 1407 Lincolnshire, IL 60069-1407	1-877-216-3222	www.hiibenefits.com, click on Worklife
Disability, Life Insurance, AD&D			
Loss of Time Benefits	Prudential Group Life Claim Division P.O. Box 8517 Philadelphia, PA 19176	1-800-524-0542	-
Life Insurance Accidental Death & Dismemberment	Lincoln Financial 100 Liberty Way Mail Stop 02-5 Dover, NH 03821	1-888-787-2129	-
Additional Benefits			
HERO	Anthem	1-855-400-9185	Access the HERO Provider Link at www.hiibenefits.com.

Plan Name	Address	Phone	Website
Family Health Center/Wellness Solutions	QuadMed W227 N6103 Sussex Road Sussex, WI 53089	-	-

Appendix

This appendix is a complete list of all the Benefit Booklets — for each of the benefit plans that are incorporated by reference into this SPD. These supplemental documents along with the information contained in this document constitute the SPD for the Ingalls Operations Hourly Health and Disability Plan.

This table provides a list of each specific document and the file name, so you can access them directly at www.hiibenefits.com.

Plan Name	Document Title
Medical Plans	
Anthem Preferred PPO	Anthem Preferred PPO Plan Benefit Booklet
Disability	
Loss of Time Benefits	Prudential booklet
Life Insurance/AD&D	
Life and AD&D Insurance	Lincoln Financial booklet