Huntington Ingalls Industries Retiree Medical Plan
Summary Plan Description (SPD)
Huntington Ingalls Industries Retiree Medical Plan SPD

A Guide to Your Huntington Ingalls Industries Retiree Medical Plan

This guide is the summary plan description (SPD) for the Huntington Ingalls Industries Retiree Medical Plan (also referred to as the “Retiree Medical Plan” or “Plan”). If you have questions not answered in this guide, contact the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222 (Outside the U.S. 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. You can also find retiree benefits information on HII Benefits Connect at http://hiibenefits.com.

The Plan was established by the spin-off to Huntington Ingalls Industries, Inc. (referred to as the “Company”) of a portion of the Northrop Grumman Retiree Medical Plan (referred to as the “Northrop Grumman Plan”) in connection with the spin-off of the Company from Northrop Grumman Corporation (referred to as the “Company Spin-off”). The Plan is effective as of the date of the Company Spin-off. In accordance with the Employee Matters Agreement entered into by the Company and Northrop Grumman Corporation in connection with the Company Spin-off (referred to as the “Employee Matters Agreement”), the Plan provides benefits to eligible former employees of the Northrop Grumman shipbuilding business who are identified in the Employee Matters Agreement as “HII Retirees” and to Company employees who retire and qualify for benefits after the date of the Company Spin-off. The Retiree Medical Plan is a component plan under the Huntington Ingalls Industries, Inc. Retiree Welfare Benefits Plan. The Company reserves the right to amend, modify or terminate any and all parts of the Plan at any time and for any reason.

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

Huntington Ingalls Industries (also referred to as the “Company” in this guide) refers to Huntington Ingalls Industries, Inc. and its affiliates that participate in the Plan.
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PLAN HIGHLIGHTS

Initial Plan Year Automatic Enrollment

If you were covered under the Northrop Grumman Plan on the day before the Company Spin-off and were identified under the Employee Matters Agreement as an HII Retiree (generally, a former employee who retired from the shipbuilding business), you are automatically enrolled in the Retiree Medical Plan on the date of the Company Spin-off and do not need to take any action. You and any eligible family members who were enrolled in the Northrop Grumman Plan on that date will be automatically enrolled in the Retiree Medical Plan in the same medical plan option and with the same required contribution as you had under the Northrop Grumman Plan. If the medical plan option is not available, you will be automatically enrolled in the PPO and Prescription Drug plan options or, if Medicare eligible, the Medigap-type and Prescription Drug Plan options.

New Participants Must Enroll for Retiree Medical Benefits

If you are not automatically enrolled as described above, to receive retiree medical benefits for you and your family, you must actively enroll yourself and your dependents in a medical plan option under the Huntington Ingalls Industries Retiree Medical Plan. You are not automatically covered under the Huntington Ingalls Industries Retiree Medical Plan, even if you satisfy the eligibility requirements. Generally, you and Huntington Ingalls Industries share the cost for coverage, but in some cases, you are required to pay the full cost.
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ELIGIBILITY AND COST OF COVERAGE

Retiree Eligibility

The Huntington Ingalls Industries Retiree Medical Plan provides benefits for eligible retirees of Huntington Ingalls Industries, Inc. and related companies that participate in the Plan. This includes individuals who were covered under the Northrop Grumman Plan on the day before the Company Spin-off and who were identified as HII Retirees under the Employee Matters Agreement. Special rules apply to eligible retirees who previously worked for or retired from certain companies ("heritage companies") that were acquired by Northrop Grumman Corporation (or a related employer) prior to the Company Spin-off.

The heritage company eligibility rules described below are generally designed to be consistent with the retiree medical eligibility provisions of the plans in effect at the heritage company at the time it was acquired. However, the eligibility provisions set forth below are final and control in the event that there is any discrepancy with the eligibility provisions of a heritage company plan. The Huntington Ingalls Industries Employee Welfare Benefits Committee, in its sole discretion, may (but is not required to) refer to and interpret the terms of any heritage company plan in order to resolve any question regarding eligibility under the Huntington Ingalls Industries Retiree Medical Plan.

You will be eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan if you satisfy one of the following requirements:

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

Your years of qualifying service will be determined in accordance with the Huntington Ingalls Industries pension plan in which you are a participant at the time of retirement and include your years of qualifying service with Northrop Grumman Corporation prior to the Company Spin-off.

You are responsible for paying the full cost of coverage unless you are eligible for coverage as a member of an eligible heritage company group (described below) for which Huntington Ingalls Industries contributes toward the cost of coverage. Specific information regarding your cost for coverage and the amount (if any) contributed by Huntington Ingalls Industries is provided to you at the time of your retirement and on a periodic basis.
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thereafter. As noted previously, Huntington Ingalls Industries reserves the right to amend, modify, or terminate the plan at any time and for any reason. This right includes, but is not limited to, the right to change or eliminate the Company’s contribution toward the cost of retiree medical coverage.

Aerojet Heritage

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

Avondale May 2003 Special Retirement Incentive Program

- You terminated employment by May 31, 2003, under the Special Retirement Incentive Program, and
- Your age + years of service equaled 80 points.

Once you or your spouse becomes eligible for Medicare, the Medicare-eligible individual ceases to be eligible for Huntington Ingalls Industries-subsidized coverage and is eligible for the Medicare medical options with no company subsidy. However, the Medicare-eligible individual will be eligible for a Huntington Ingalls Industries stipend payment provided that the individual either remains covered under the Huntington Ingalls Industries Retiree Medical Plan or purchases individual Medicare supplement coverage for himself or herself.

Effective January 1, 2005, the Avondale EPO for Incentive Retirees was frozen. If you and your eligible dependents are still enrolled in that plan option, you can remain covered under that plan option until you or a covered dependent becomes eligible for Medicare and enrolls in the Huntington Ingalls Industries Retiree Medical Plan. At that time, all covered family members must move to a Huntington Ingalls Industries Retiree Medical Plan option.

Avondale November 2004 Special Retirement Incentive Program

- You terminated employment between July 1, 2004, and November 1, 2004, under the Special Retirement Incentive Program.

Once you or your spouse becomes eligible for Medicare, the Medicare-eligible individual ceases to be eligible for Huntington Ingalls Industries-subsidized coverage and is eligible for medical options with no subsidy. However, the Medicare-eligible individual will be

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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eligible for a Huntington Ingalls Industries stipend payment provided that the individual either remains covered under the Huntington Ingalls Industries Retiree Medical Plan or purchases individual Medicare supplement coverage for himself or herself.

Under the Avondale November 2004 Special Retirement Incentive Program, there is a cost to cover dependent child(ren).

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

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

Note: Electronic Systems retirees can “age into” a subsidized benefit, which means that if an individual retires with sufficient years of service, but has not attained the specified age, he or she may enroll in the plans and pay the full cost of coverage or defer benefits upon retirement. Once the retiree has attained the appropriate age, he or she is eligible for the subsidized benefit. For example, if an individual terminates employment at age 55 with 30 years of service, he or she will be eligible for the subsidized benefit at age 58. Please note: To be eligible for the “age into” benefit, you (the employee) must be at least age 55 at the time of termination.

Frozen or closed groups of Electronic Systems employees that were transferred to the IT sector on June 30, 2002, also retain eligibility for Electronic Systems heritage retiree benefits.
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Grumman
- You were hired prior to January 1, 1993, and you were in a Grumman heritage entity on or before June 30, 2003, and at termination, you meet one of the following requirements:
  - Your age plus years of service total 75 or more
  - You are age 50 or older with a minimum of 20 years of service
  - You are age 60 or older with at least one year of service.

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

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

Ingalls Grandfathered Retirees (frozen group)
- You are an exempt non-represented employee who was hired prior to June 1, 1996, and
- You were born prior to August 1, 1926.

Ingalls Early Retirees (frozen group)
- You are an exempt non-represented employee who was hired prior to June 11, 1990, and
- You terminate employment prior to July 1, 2004, and
- You attained at least age 59 upon retirement.

Ingalls May 2003 Special Retirement Incentive Program
- You terminate employment by May 31, 2003, under the Special Retirement Incentive Program, and
- You attained age 55 with a minimum of five years of service

Once you or your spouse becomes eligible for Medicare, the Medicare-eligible individual ceases to be eligible for Huntington Ingalls Industries-subsidized coverage and is eligible
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for medical options with no subsidy. However, the Medicare-eligible individual will be eligible for a Huntington Ingalls Industries stipend payment provided that the individual either remains covered under the Huntington Ingalls Industries Retiree Medical Plan or purchases individual Medicare supplement coverage for himself or herself.

Effective January 1, 2005, the Ingalls May 2003 incentive medical plan was frozen. If you and your eligible dependents are still enrolled in that plan option, you can remain covered under that plan option until you or a covered dependent becomes eligible for Medicare and enrolls in the Huntington Ingalls Industries Retiree Medical Plan. At that time, all covered family members must move to a Huntington Ingalls Industries Retiree Medical Plan plan option.

Ingalls November 2004 Special Retirement Incentive Program

- Your employment terminated between July 1, 2004, and November 1, 2004, under the Special Retirement Incentive Program, and
- You are at least age 60 with 20 years of service, or
- You are older than age 60 with a minimum of 80 points.

Once you or your spouse becomes eligible for Medicare, the Medicare-eligible individual ceases to be eligible for Huntington Ingalls Industries-subsidized coverage and is eligible for medical options with no subsidy. However, the Medicare-eligible individual will be eligible for a Huntington Ingalls Industries stipend payment provided that the individual either remains covered under the Huntington Ingalls Industries Retiree Medical Plan or purchases individual Medicare supplement coverage for himself or herself. If the retiree does not remain covered under the Huntington Ingalls Industries Retiree Medical Plan after attaining Medicare eligibility, the pre-Medicare spouse and/or dependent will no longer be eligible for coverage under the Huntington Ingalls Industries Retiree Medical Plan.

Under the Ingalls November 2004 Special Retirement Incentive Program, there is a cost to cover dependent child(ren).

Logicon

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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Navigation Systems
- You were employed by Navigation Systems prior to July 1, 2003, and in the Navigations System heritage on or before June 30, 2003, and
- You are at least age 55 with five years of service when you terminate employment.

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

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

Newport News Grandfathered Salaried
- You terminated employment prior to January 1, 1987, under the rules of the Newport News plan in effect at the time.

Surviving spouses may continue coverage under the Huntington Ingalls Industries Retiree Medical Plan until they remarry. COBRA continuation coverage may also be available for surviving spouses. See the “COBRA” section later in this document.

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

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- You are age 65 or older, regardless of your years of service.

Norden Non-Represented

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

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

Northrop

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

Rolling Meadows

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

Once you or your spouse becomes eligible for Medicare, the Medicare-eligible individual ceases to be eligible for Huntington Ingalls Industries-subsidized coverage and is eligible for medical options with no subsidy. However, the Medicare-eligible individual will be eligible for a Huntington Ingalls Industries stipend payment provided that the individual either remains covered under the Huntington Ingalls Industries Retiree Medical Plan or purchases individual Medicare supplement coverage for him or herself. If the retiree does not remain covered under the Huntington Ingalls Industries Retiree Medical Plan after attaining Medicare eligibility, the pre-Medicare spouse and/or dependent will no longer be eligible for coverage under the Huntington Ingalls Industries Retiree Medical Plan.

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TRW Heritage (including Mission Systems and Space Technology)

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

Sterling

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

Transferees to AMSEC LLC

- Employees of Northrop Grumman Corporation whose employment transferred to AMSEC LLC at the time of its formation in 1999 (certain former Newport News Salaried employees) or whose employment transferred to AMSEC LLC on or after July 13, 2007 at the request of Northrop Grumman Corporation are eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan with a Huntington Ingalls Industries contribution (if applicable) toward the cost of coverage in accordance with the heritage company group rules that apply to the heritage group from which the employee transferred. Northrop Grumman Corporation employees whose employment transferred to AMSEC LLC after its formation in 1999 (whether at the request of Northrop Grumman Corporation or otherwise) or whose employment transferred to AMSEC LLC on or after July 13, 2007 other than at the request of Northrop Grumman Corporation do not retain eligibility for any heritage company group rules regarding participation or Huntington Ingalls Industries contributions toward the cost of coverage while employed at AMSEC, but may qualify under the Huntington Ingalls Industries Retiree Medical Plan’s normal age and service rules to purchase coverage under the Plan by paying the full cost of coverage. Years of service with AMSEC will be counted for purposes of the years of service requirement. Employees who transfer out of AMSEC LLC prior to employment termination will regain any subsidy eligibility accrued prior to moving to AMSEC LLC.

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Multi-Heritage Subsidy Eligibility

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

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

Rehire Rules

If you are eligible for a heritage company subsidy under the Huntington Ingalls Industries Retiree Medical Plan (as described above) and you leave the Company during active employment and are later rehired, your eligibility for your heritage subsidy under the Huntington Ingalls Industries Retiree Medical Plan upon your return will be determined by your vesting service under the Huntington Ingalls Industries Pension Program.

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

Breaks in Service

A break in service is a period during which you complete less than 501 hours of service in a calendar year. If you experience five consecutive break-in-service years before you are vested, you will forfeit your eligibility for the Huntington Ingalls Industries Retiree Medical Plan, and if applicable, your heritage company subsidy under the Huntington Ingalls Industries Retiree Medical Plan.

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If you are not vested under the Huntington Ingalls Industries Pension Program before you leave the company, and you are rehired before you experience five consecutive break-in-service years, your vesting service will carry over and you will retain your eligibility for your heritage company subsidy under the Huntington Ingalls Industries Retiree Medical Plan.

For information about absences that may not cause you to incur a break in service, please refer to the Huntington Ingalls Industries Pension Program Summary Plan Description, available at HII Benefits Connect (http://hiibenefits.com) or by calling the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.

Vesting Service

For the Huntington Ingalls Industries Retiree Medical Plan, vesting service is used to determine eligibility for retiree medical benefits and a heritage subsidy only. It does not mean you have earned a non-forfeitable right to any particular benefit.

For the Retiree Medical Plan, vesting service includes employment with any member of the Company’s controlled group of corporations, subject to legal limitations and includes service with the Northrop Grumman Corporation controlled group of corporations that was counted as vesting service under the Northrop Grumman Plan on the day prior to the Company Spin-off. If you need help determining if your business unit is part of the Company, call the HIBC.

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

For example, let’s assume:

- Date of hire: September 1, 2011
- Vesting hours as of December 31, 2011: 600
- Vesting hours in 2012: 1,900

In this example, the participant does not have 1,000 or more hours of vesting service in 2011, so he or she does not earn a year of vesting service for that year. In 2012, the participant has 1,900 vesting hours, so he or she does earn one year of vesting service for 2012.
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If You Transfer

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

Discontinued Operations

If you terminate employment at age 55 or older with at least ten years of service, or at age 65 or older with at least five years of service, from an entity classified by Huntington Ingalls Industries as a discontinued operation for purposes of the Retiree Medical Plan, you will be eligible to participate in the Retiree Medical Plan by paying the full cost of coverage.

You are not eligible for the benefits under the Huntington Ingalls Industries Retiree Medical Plan if any of the following apply:

- You are covered as a dependent of an active Huntington Ingalls Industries employee. (You may join the plan upon termination of coverage in the active plan.)
- You are a retiree who dropped coverage under the Northrop Grumman Plan prior to January 1, 2005.
- You terminated employment with the Northrop Grumman Corporation controlled group of corporations prior to January 1, 2005, and are a deferred vested participant under the pension plan in which you participate.
- You are rehired by Huntington Ingalls Industries and become eligible for active employee benefits. You may reenroll in the Huntington Ingalls Industries Retiree Medical Plan if you terminate employment in the future, in the same heritage under which you originally enrolled.

Dependent Eligibility

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

By enrolling any person in the Retiree Medical Plan, you state, represent, and agree to all of the following:

- You understand the eligibility requirements set forth below
- The person you enroll meets the eligibility requirements set forth below

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- If the person ceases to meet the eligibility requirements you will immediately notify Huntington Ingalls Industries.
- You understand that Huntington Ingalls Industries reserves the right to require you, as a condition of eligibility and at any time, to submit proof of eligibility of any person you enroll and you agree to provide the required proof within the time specified by Huntington Ingalls Industries.
- You understand that meeting the eligibility requirements and providing required proof of eligibility are material conditions of enrollment and continued coverage under the Retiree Medical Plan.
- You understand that enrolling a person who does not meet the eligibility requirements, failing to notify Huntington Ingalls Industries immediately if a person ceases to meet the eligibility requirements, or refusing or failing to provide required proof of eligibility constitutes fraud or an intentional misrepresentation of material fact and is prohibited by the Retiree Medical Plan.
- If a person does not meet the eligibility requirements at the time of enrollment, Huntington Ingalls Industries will cancel that person's coverage as of the date of enrollment.
- If a person ceases to meet the eligibility requirements at a time after enrollment, Huntington Ingalls Industries will cancel that person's coverage as of the date that person ceased to meet the eligibility requirements.
- If you refuse or fail to provide required proof of eligibility for a person, Huntington Ingalls Industries will cancel that person's coverage as of the date of enrollment or such other date as Huntington Ingalls Industries determines, in its sole discretion, to be appropriate.

If you enroll a person who does not meet the eligibility requirements, or if you fail to notify Huntington Ingalls Industries immediately if a person ceases to meet the eligibility requirements, or if you refuse or fail to provide required proof of eligibility for a person, you may be financially and legally responsible for all health care expenses incurred during the period of ineligibility and you may be subject to disciplinary action and criminal charges.

Eligible dependents include the following:

1. Your Spouse

   (a) The spouse of an eligible retiree at the time of the employee's termination or retirement. The spouse does not need to have been covered under the active medical plan in order to be eligible for participation in the Retiree Medical Plan.

   (b) This includes your common-law spouse only if common-law status is recognized in your state of legal residency. You may be required to submit a Declaration of Informal Marriage or an affidavit to Huntington Ingalls Industries to confirm eligibility. This does not include your divorced spouse, even if the separation agreement or divorce decree states that your coverage must be provided. If the court orders you to provide coverage for your divorced spouse,
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you must arrange coverage on your own or through COBRA, as described in the “General Plan Administration: COBRA” section.

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

II. Your Domestic Partner

(a) The same sex or opposite sex domestic partner of an eligible retiree. (If the domestic partner is certified as a domestic partner of the employee, he or she may be added at the heritage spouse rate; otherwise, he or she will be added at full cost.) A domestic partner is an individual of the same sex or opposite sex who is your life partner and not your legal spouse. The domestic partner must meet all of the following requirements:

- Be at least 18 years of age and not related to you by blood
- Not be married to anyone else and not be the domestic partner of anyone else
- Live with you in the same permanent residence in an exclusive, emotionally committed, and financially responsible relationship similar to marriage for at least the last six months
- Be your sole domestic partner and intend to remain so indefinitely.

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

III. Your biological son or daughter, adopted son or daughter, stepson or stepdaughter, or foster child who is under the age of 26

(a) Adopted child: A person is treated as your adopted son or daughter if:

(1) you have legally adopted the person; OR
(2) the person is lawfully placed with you for legal adoption.

(b) Foster child: A foster child is a person who is placed with you:

(1) by an authorized placement agency; OR
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(2) by judgment, decree, or other order of a court of competent jurisdiction.

(c) Stepchild: A stepchild is the biological child or adopted child of your spouse but not of you. If you and your spouse divorce, your former stepchild is not eligible for coverage under this provision.

IV. Your unmarried and disabled biological son or daughter, adopted son or daughter, stepson or stepdaughter, or foster child of any age if:

(a) the disability occurred before age 26; AND

(b) one of the following is true:

(1) The person shares the same principal place of abode as you for more than half of the taxable year and the person has not provided over one-half of his or her own support for the taxable year; OR

(2) You provide over one-half of the person’s support in the taxable year and the person is not claimed as a tax dependent by another taxpayer for the taxable year.

Note: You might be required to submit an affidavit or other documents as required by Huntington Ingalls Industries to confirm a disability. The Plan considers a person to be disabled only if all of the following are true:

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

V. Your unmarried brother or sister, or unmarried child of your biological or adopted son or daughter, if all of the following are true:

(a) The person is younger than you;

(b) The person is under age 19;

(c) You provide over one-half of the person’s support in the taxable year;

(d) The person lives with you for more than half of the taxable year. The person is considered to have lived with you during periods of time in which the person is temporarily absent to attend school;

(e) You claim the person as a dependent on your federal income tax.
VI. Your unmarried brother or sister, or unmarried child of your biological or adopted son or daughter if all of the following are true:

(a) The person is younger than you;

(b) The person is at least age 19 but under age 25;

(c) The person is a full-time student;

(d) You provide over one-half of the person’s support in the taxable year;

(e) The person lives with you for more than half of the taxable year. The person is considered to have lived with you during periods of time in which the person is temporarily absent to attend school.

(f) You claim the person as a dependent on your federal income tax

Note:

− A person is considered a full-time student if he or she is enrolled in at least nine credit hours of a regular curriculum that leads to a diploma, certificate, or degree at an accredited high school, technical school, college, or university. If the institution does not utilize credit hours or is not on a traditional two semester system, then the schedule that the school considers full-time may be used. On-the-job training courses, a correspondence school, or a school offering courses only through the Internet do not count as a school.

− A temporary reduction in credit hours after the semester starts does not result in a change in status, unless your child no longer is enrolled in a qualified program, as outlined above.

− A person is considered a full-time student during semester breaks if he or she was enrolled the prior semester, unless the person secures a full-time permanent job, gets married, or does not enroll when school resumes. If the person who qualified for full-time student eligibility is no longer eligible due to graduation, his or her coverage in the Retiree Medical Plan will end on the first day of the first semester in which he/she is no longer enrolled for school. However, coverage will end on the date the student reaches age 25, regardless of full-time student status.

− You might be required to submit an affidavit or other document as required by Huntington Ingalls Industries to confirm full-time student status.

− If the full-time student becomes seriously ill or injured, and is put on approved medical leave or reduced hours from college, university or other post-secondary education institution by his or her physician, coverage under the medical plan option in which he or she is enrolled will continue for up to 12 months while the student is on medical leave or reduced hours, without a reduction in coverage, but...
INTRODUCTION

not beyond the time at which the student would otherwise lose coverage under the terms of the Plan.

VII. Your unmarried and disabled brother or sister, or unmarried and disabled child of your biological or adopted son or daughter of any age if all of the following are true:

(a) the disability occurred (1) before the age of 19 or (2) while the person was at least age 19 but under age 25 and a full-time student;
(b) You claim the person as a dependent on your federal income tax AND
(c) one of the following is true:

(1) You provide over one-half of the person's support in the taxable year and the person is not claimed as a tax dependent by another taxpayer for the taxable year; OR

(2) The person:

(i) shares the same principal place of abode as you for more than half of the taxable year; AND

(ii) the person has not provided over one-half of his or her own support for the taxable year.

VIII. Your unmarried and disabled brother-in-law or sister-in-law if all of the following are true:

(a) the disability occurred (1) before the age of 19 or (2) while the person was at least age 19 but under age 25 and a full-time student;
(b) you claim the person as a dependent on your federal income tax;
(c) the person shares the same principal place of abode as you for more than half the taxable year;
(d) you provide over one-half of the person's support in the taxable year and the person is not claimed as a tax dependent by another taxpayer for the taxable year.

IX. Children who must be covered under a Qualified Medical Child Support Order.

A child of an eligible Domestic Partner who satisfies one of the above eligibility categories is eligible for coverage provided that the child resides with the retiree and the retiree is the child’s primary source of support.

Dependent children listed in bullets III and IV are considered Category 1 children. Dependent children listed in bullets V, VI, VII, and VIII and considered Category 2 children. See chart “When Coverage Ends” for the treatment of each category.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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Split Coverage

If you and your eligible family members are not yet eligible for Medicare, or you are all eligible for Medicare, you must be covered under the same medical plan option in the Huntington Ingalls Industries Retiree Medical Plan. However, if you are eligible for Medicare and your eligible dependent(s) are not, or if your eligible dependent is eligible for Medicare and you are not, you do not need to be covered under the same medical plan option — you can choose different plan options even if they are administered by different carriers.

For example, if you are eligible for Medicare and you choose coverage under the Anthem Blue Cross Medigap-type plan option, your covered family members not eligible for Medicare can choose any pre-Medicare plan option available to them under the Huntington Ingalls Industries Retiree Medical Plan.

Once the pre-Medicare participant becomes Medicare eligible, he/she will be moved to the option in which the retiree is enrolled or the Medicare version of that plan.

Note: Dependents may not enroll in coverage unless the retiree is also enrolled. For example, a dependent cannot enroll in the Prescription Drug Program unless the retiree either a.) elects to enroll in the Prescription Drug Program or b.) is enrolled in a medical plan option that includes prescription drug coverage such as an EPO plan option.

Layoff Provision

Employees who are laid off and meet the following requirements, are eligible for coverage under the Huntington Ingalls Industries Retiree Medical Plan:

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

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

Disability Provision

Employees who meet the following requirements are eligible for benefits under the Huntington Ingalls Industries Retiree Medical Plan:

- Have a disability that began on or after July 1, 2003, and for which the long-term disability (LTD) carrier approved the payment of LTD benefits. (The applicable
INTRODUCTION

Have a minimum of 10 years of service regardless of age.

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

Retirees are eligible to continue participation in the Retiree Medical Plan as long as their disability is approved by the LTD carrier. If the individual is no longer considered to be disabled, coverage under the Retiree Medical Plan will end. If the retiree ceases to be eligible for LTD benefits due to a maximum age limit for LTD benefits, he or she may continue coverage as a retiree under the terms applicable to his or her heritage group.

Qualified Medical Child Support Order

A qualified medical child support order (QMCSO) is an order or judgment from a state court or administrative agency that satisfies certain requirements as to content and form. 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 notifies you and each affected child (or the child’s representative) about the procedures that determine the validity of the order and how it will be implemented.

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

If You and Your Spouse Both Are Retired from Huntington Ingalls Industries

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

- Your spouse may be covered as your dependent under the Huntington Ingalls Industries Retiree Medical Plan, or vice versa, or
INTRODUCTION

- You can be covered under your Retiree Medical Plan option and your spouse can be covered under his or her own Retiree Medical Plan option.

Questions about Eligibility

If you have questions about eligibility for coverage under the Huntington Ingalls Industries Retiree Medical Plan, please call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.
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HOW THE PLAN WORKS

Retiree medical plan options vary based on Medicare eligibility. Retiree life insurance benefits vary by heritage and eligibility. The following benefits are available under the Huntington Ingalls Industries Retiree Medical Plan, as applicable:

- Medical
- Prescription drug
- Mental health benefits
- Retiree life (see the “Life Insurance” section).

Cost for Coverage

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

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

You are responsible for paying the difference between the actual cost for coverage and Huntington Ingalls Industries’ contribution to your coverage (if any).

Huntington Ingalls Industries’ contributions and your costs may change from year to year. Your enrollment materials will provide additional information about your cost for coverage under each option.

As noted above, unless you qualify for a Huntington Ingalls Industries contribution toward the cost of coverage due to your classification as a member of a heritage group, you will be required to pay 100% of the cost for Retiree Medical Plan coverage.
When Coverage Ends

Coverage in the Huntington Ingalls Industries Retiree Medical Plan ends on the date indicated for you and/or your covered dependents on the occurrence of any of the following events:

<table>
<thead>
<tr>
<th>Event</th>
<th>Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of the retiree</td>
<td>■ Coverage for surviving dependents ends at the end of the month of the retiree’s death (Coverage for dependents may continue as described in the “Survivor Options” section or the “COBRA” section)</td>
</tr>
<tr>
<td>Category 1 child reaches age 26</td>
<td>■ Coverage for the child terminates on the date the child turns 26 (coverage may be continued as described in the “COBRA” section).</td>
</tr>
<tr>
<td>Category 2 child reaches age 19 and does not qualify for full-time student eligibility*</td>
<td>■ Coverage for the child terminates on the last day of the month in which the dependent’s 19th birthday occurs (coverage may be continued as described in the “COBRA” section).</td>
</tr>
<tr>
<td>Category 2 child who qualifies for full-time student status turns age 25*</td>
<td>■ Coverage for the child terminates on the date your dependent turns 25 (coverage may be continued as described in the “COBRA” section)</td>
</tr>
<tr>
<td>Category 2 child under-age-25 no longer qualifies due to marriage or a full-time job that offers benefits coverage*</td>
<td>■ Coverage for the child ends on the date of the event (coverage may be continued as described in the “COBRA” section)</td>
</tr>
<tr>
<td>Category 2 Child loses full-time student status due to a reduction in class hours or graduation and is between age 19 and age 25*</td>
<td>■ Coverage for the child ends on the first day of the semester in which he or she is no longer enrolled. (coverage may be continued as described in the “COBRA” section)</td>
</tr>
<tr>
<td>Category 2 child loses full-time student status because, due to serious illness or injury, he or she is put on approved medical leave from college or a reduced schedule by his or her physician*</td>
<td>■ Coverage for the child ends 12 months after date of event (or earlier if the child reaches age 25, recovers, or otherwise becomes ineligible for coverage) (coverage may be continued as described in the “COBRA” section)</td>
</tr>
<tr>
<td>Retiree requests cancellation of coverage under the plan</td>
<td>■ Coverage for the retiree and all covered dependents ends on the first of the month following the request</td>
</tr>
<tr>
<td>Retiree fails to pay the required premium</td>
<td>■ Coverage for the retiree and all covered dependents ends if you fail to make a timely payment. Payments are due on the first day of each month, and, if your payment is not received within 30 days after the first</td>
</tr>
</tbody>
</table>

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
## Event  
**Retiree returns to active employment and is eligible for active benefits**

- Coverage for the retiree and all covered dependents ends under the Huntington Ingalls Industries Retiree Medical Plan on the date benefits become effective under the Huntington Ingalls Industries Health Plan

## Event  
**Retiree fails to submit required documentation requested as a result of a quarterly random audit**

- Retroactive to the date the dependent was added

## Event  
**Retiree fails to confirm a Category 2 dependent’s full-time student status during the annual student verification process**

- October 1 of the year of the verification process (coverage may be continued as described in the COBRA section)
- Coverage for the dependent may be reinstated at the next Retiree Annual Enrollment or on the date the required documentation is provided to the HIBC

## Event  
**Your spouse/domestic partner loses eligibility due to a divorce or the end of a domestic partnership**

- On the effective date of the divorce or end of the domestic partnership

---

*These termination events apply to dependent eligibility categories that require full-time student status. Not all eligible child categories require full-time status. Please see “Dependent Eligibility” section for definitions of Category 1 and Category 2 dependent children.*

### Note:
Certain states may require continuation of coverage for dependent children beyond the dates specified above. The special continuation of coverage rules apply only if you are covered under a coverage option that provides benefits through an insurance contract. As of March 31, 2011, HII does not offer any insured medical options through the HIRMP. Please contact the Huntington Ingalls Benefits Center (HIBC) for additional information.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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Note: Huntington Ingalls Industries reserves the right to request proof of relationship for Category 1 dependents and dependency, residency, and full-time student eligibility for Category 2 dependents. Failure to comply with this provision timely will result in loss of coverage for the dependent and may result in financial repercussions for the retiree (you may incur costs for all services rendered during that time period.).

ENROLLING IN YOUR RETIREE MEDICAL PLAN OPTION

Initial Plan Year Automatic Enrollment

As noted above, if you were covered under the Northrop Grumman Plan on the day before the Company Spin-off and were identified under the Employee Matters Agreement as an HII Retiree (generally, a former employee who retired from the shipbuilding business), you are automatically enrolled in the Retiree Medical Plan on the date of the Company Spin-off and do not need to take any action. You and any eligible family members who were enrolled in the Northrop Grumman Plan on that date will be automatically enrolled in the Retiree Medical Plan in the same medical plan option and with the same required contribution as you had under the Northrop Grumman Plan. If the medical plan option is not available, you will automatically be enrolled in the PPO and Prescription Drug Plan options, or if Medicare eligible, the Medigap-type and Prescription Drug Plan options.

When You Can Enroll

You may select or change your medical plan option:

- When you terminate employment
- During the annual rate change event (enrollment period)
- If you experience a qualifying life event

Note: The Anthem CDHP has restrictions on when you can enroll. Please contact the Huntington Ingalls Benefits Center (HIBC) for additional information.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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Eligibility Date

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

<table>
<thead>
<tr>
<th>Type of Termination</th>
<th>Eligibility Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retirement, Quit, Discharge</td>
<td>The first of the month coincident with or next following the employee's date of termination provided the employee meets the qualifications on the date of separation from active service.</td>
</tr>
<tr>
<td>Total and permanent disability (see requirements in the “Disability Provision” section)</td>
<td>The first of the month following two years of disability.</td>
</tr>
<tr>
<td>Employee no longer covered as a dependent in the active plan</td>
<td>The first of the month following the date he or she is no longer covered as a dependent in the active plan.</td>
</tr>
<tr>
<td>Layoff at age 53 or older with 10 years of service</td>
<td>No earlier than the first of the month following the employee's 55th birthday. (Coverage may be deferred past age 55.)</td>
</tr>
<tr>
<td>Layoff prior to age 53 with 75 points</td>
<td>No earlier than the first of the month following the employee's 55th birthday. (Coverage may be deferred past age 55.)</td>
</tr>
<tr>
<td>Death of a retiree (survived by a dependent)</td>
<td>Coverage for the covered dependent(s) continues uninterrupted as long as payments continue to be made as described in the “Survivor Options” section of the “COBRA” section.</td>
</tr>
<tr>
<td>Death of an active employee who was eligible for retirement at the time of death (survived by a dependent)</td>
<td>Coverage for covered dependent(s) generally continues for one year after the death of the employee through the Huntington Ingalls Industries Health Plan. Then, the covered dependent(s) becomes eligible for coverage under the Retiree Medical Plan the first of the month following the end of any available extension of coverage under the active plan.</td>
</tr>
</tbody>
</table>

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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<table>
<thead>
<tr>
<th>Type of Termination</th>
<th>Eligibility Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deferred coverage at employment termination</td>
<td>The first of the month following an election to participate.</td>
</tr>
</tbody>
</table>
| Suspended Coverage After January 1, 2005   | - During any Annual Enrollment with coverage effective on January 1.  
- The first of the month coincident or next following a qualifying life event. |

If You Defer or Suspend Medical Coverage

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

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

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

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

The above rules also apply to surviving spouses and dependents.

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

When You Can Enroll Your Dependents

You can add existing eligible dependents to your retiree medical plan when you first enroll in the plan or during the annual enrollment period. You can enroll your existing dependents during the plan year only when you experience a qualifying life event such as marriage or loss of other coverage, that allows enrollment in the plan. The change must

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
be reported within 31 days after the event or you will have to wait until the next annual enrollment period to add your dependents.

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

The 31-day rule above is a special enrollment rule under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under the Huntington Ingalls Industries Retiree Medical Plan, if you do not enroll your eligible dependents within 31 days, you will not be able to enroll them until the next annual enrollment period or until you experience a qualifying life event.

To enroll your dependent, you must complete all required enrollment steps. If your dependent is age 45 or older or eligible for Medicare, you are required to provide his or her Social Security Number.

Initial Enrollment

If you want to participate in the Retiree Medical Plan, you must make an election by calling the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222. You will receive the materials necessary to make your election, including an explanation of the medical plan options available to you, your cost for each option, and enrollment instructions.

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

Enrolling During Annual Enrollment

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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Generally, if you do not make changes, your current coverage (if available) will carry over to the following benefit plan year, at the new year’s rates. In the event that your current coverage is not available and you fail to elect an available option, your coverage will default to the Anthem Blue Cross Preferred PPO or Anthem Blue Cross Medigap-type option, depending on your and your covered dependent’s Medicare status, and the Prescription Drug Program. If you are a retiree living outside the U.S., you and your covered dependents are offered enrollment only in the Aetna Global option.

Qualifying Life Events

A qualifying life event is a change in your personal situation that results in the gain or loss of eligibility for a Huntington Ingalls Industries Retiree Medical Plan option, your spouse’s employer’s plan, or your dependent’s employer’s plan. Qualifying life events include the following:

- Change in marital status, including marriage, divorce, annulment, and death of spouse
- Change in number of dependents, including birth, adoption, placement for adoption, and death of dependent
- Change in employment status (termination or commencement of employment) for your spouse or your dependent
- Change in work schedule, including a reduction or increase in hours of employment for your spouse or your dependent, a switch between part-time and full-time status, a strike or lockout, and beginning or returning from an unpaid leave of absence
- Inability of your dependent to meet the Plan’s coverage requirements due to a change in age, student status, or similar circumstances
- Change in residence for you, or change in residence or worksite for your spouse or your dependent, that results in a loss of coverage
- Enrollment by you, your spouse, or a dependent in Medicare or Medicaid
- Significant gain or loss in coverage (e.g., your spouse loses coverage in his or her employer’s plan)
- A court judgment, decree, or order requiring coverage for your dependent child(ren)
- 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. You have 31 days from the date of the qualifying life event to make your benefit changes by calling the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.
you do not make your changes within 31 days, you must wait until the next annual enrollment period, unless a dependent is no longer eligible. In that case, coverage for the dependent will be discontinued retroactive to the date eligibility was lost, regardless of when the loss of eligibility was reported. For events reported after 31 days, no premiums will be refunded.
Having access to quality health care is important to everyone. It gives you peace of mind to know that you have the coverage you need.

Huntington Ingalls Industries offers a variety of medical plan options, so you can choose coverage that best fits your and your family’s needs. Each plan option provides access to quality care and protection from the high cost of medical services and supplies.

**OVERVIEW**

**Medical Plan Options**

The medical plan options available to you and your family depend on your Medicare status and your geographic location as shown in the following table:

<table>
<thead>
<tr>
<th>Available nationwide</th>
<th>Not Medicare-eligible</th>
<th>Medicare-eligible</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>■ Anthem Blue Cross Preferred PPO</td>
<td>■ Anthem Blue Cross Medigap-type option)</td>
</tr>
<tr>
<td></td>
<td>■ Anthem Blue Cross EPO</td>
<td>■ Anthem CDHP</td>
</tr>
<tr>
<td></td>
<td>■ Anthem CDHP</td>
<td>■ Prescription Drug Program</td>
</tr>
<tr>
<td></td>
<td>■ TRICARE Supplement</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Prescription Drug Program</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

Your Contribution for Coverage

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

The amount of your contribution depends on your Huntington Ingalls Industries heritage, your Medicare status, the plan you choose, and whom you choose to cover (your “coverage category”). For cost information, please call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.
PREFERRED PROVIDER ORGANIZATION (PPO) MEDICAL PLAN OPTION

Offered nationwide, the PPO medical plan option allows you to visit any licensed provider for your health care, but you save money when you access care through PPO network providers. The PPO is available to retirees and dependents who are not eligible for Medicare.

Anthem Blue Cross administers the PPO medical plan option and the BlueCard PPO network of physicians, hospitals, and other health care providers. To locate a network provider or find out if your current provider is in the PPO network, access the Provider Finder Directory on the Anthem Web site. You also can call Anthem Blue Cross at the phone number listed on your medical ID card.

The PPO network is a group of physicians, hospitals, and other health care providers who 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 option:

- Prescription drug coverage is not included and may be elected separately under the Prescription Drug Program.

For additional information about the PPO medical plan option, refer to the “PPO Medical Plan Option” section of the SPD.

EXCLUSIVE PROVIDER ORGANIZATION (EPO) MEDICAL PLAN OPTIONS

Offered nationwide, the EPO medical plan option, administered by Anthem Blue Cross, offers you access to providers in Anthem’s BlueCard PPO network. Before you enroll in the EPO, search the provider directory for doctors in your area, and make sure you choose a doctor who is located near your home, or within the area you are willing to travel, and who is accepting new patients. The EPO is available to retirees and dependents who are not eligible for Medicare.

Similar to an HMO, the EPO provides care through a network of participating physicians and hospitals. The EPO option pays no benefits if you use a physician, hospital, or other provider that is not in the BlueCard PPO network—except in an emergency situation.

The EPO generally pay 100% of your eligible expenses after you pay a copayment or coinsurance, if applicable. You pay no deductibles, and there are no claim forms.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
If you enroll in the EPO plan option, you will receive mental health and substance abuse coverage through the EPO and prescription drug coverage through Express Scripts.

For additional information about the EPO plan option, refer to the “EPO Medical Plan Option” section of the SPD.

**ANTHEM CONSUMER DRIVEN HEALTH PLAN (CDHP) MEDICAL PLAN OPTION**

The Anthem CDHP medical plan option is offered nationwide (excluding Hawaii). It is a consumer-driven health program that puts you in charge of how your health care dollars are spent. Here is an overview of how the Anthem CDHP plan option works:

- Each benefit plan year, Huntington Ingalls Industries credits a specified dollar amount to a Health Reimbursement Account (HRA)* for you and your enrolled dependents. If you had an HRA balance under the Northrop Grumman Plan on the day before the Company Spin-off, that balance will be credited to your HRA under the Huntington Ingalls Industries Retiree Medical Plan on the date of the Company Spin-off. Any claims paid on or after the Company Spin-off will be charged against your HRA balance.

- The funds credited to the HRA are used to pay for covered medical expenses. As long as there is enough money credited to your account, you pay nothing for covered services or prescription drugs — no copays, coinsurance or deductibles.

- Unused funds credited to your HRA roll over to the next benefit plan year, and can be used to reduce your future out-of-pocket medical costs.

- If you use all of the annual HRA credit, you are responsible for paying a limited out-of-pocket amount — called the Bridge.* The Bridge is paid as you incur additional eligible expenses. However, if you have HRA funds rolled over from previous years, these funds can be used to fully or partially satisfy the Bridge.

- After you pay the Bridge, the plan pays a majority of the cost of services, and you pay a percentage of the cost (called coinsurance) up to an annual coinsurance maximum.

- After you reach the annual out-of-pocket maximum, the plan pays 100% of your eligible expenses for the remainder of the benefit plan year.

Prescription drugs in the Anthem CDHP are covered the same way as any other medical expenses under the plan. There is no preferred drug list (or formulary) with the Anthem CDHP and no separate out-of-pocket maximum (once you reach your annual maximum, prescriptions are covered at 100% of the discounted price when you use a network pharmacy). In addition, the Anthem CDHP offers a mail-order service, which is available for you to order maintenance medications at a lower cost.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
MEDICAL

If you are rehired as an active employee, any balance remaining in your HRA can be transferred to your HRA under the active Anthem CDHP plan option. You must enroll in the Anthem CDHP plan option under the Huntington Ingalls Industries Health Plan for your HRA balance to transfer.

For additional information about the Anthem Blue Cross CDHP option, refer to the “Anthem Blue Cross CDHP Medical Plan Option” SPD.

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

TRICARE SUPPLEMENT PLAN OPTION

The TRICARE Supplement Plan option is not part of the Huntington Ingalls Industries Retiree Medical Plan. However, you may enroll in coverage and pay the full, unsubsidized cost. Huntington Ingalls Industries will collect your premiums and submit to Associates & Society Insurance, the insurance carrier, on your behalf.

The TRICARE Supplement Plan is available to you and your eligible dependents if you are:

- Active in or retired from military service or married to a military active or retiree
- Eligible for and enrolled in TRICARE Standard (formerly called CHAMPUS), Extra, or Prime, and
- Under age 65 and not Medicare-eligible.

Your dependent child(ren) must be under age 21, or under age 23 if a full-time student, to be eligible for the TRICARE Supplement Plan option. TRICARE does not provide domestic partner coverage. The TRICARE Supplement Plan option provides additional benefits to your TRICARE Standard, Extra, or Prime coverage, including the reimbursement of the following:

- Certain copayments and cost shares
- A portion or all of your annual deductible, depending on your TRICARE plan (Standard, Extra, or Prime).

For more information about the TRICARE Supplement Plan option, call the Huntington Ingalls Industries Benefits Center (HIBC) at 1-877-216-3222.

Association & Society Insurance, not Huntington Ingalls Industries, is responsible for the payment of all benefits covered under the insurance contract and has the sole authority, discretion and responsibility to interpret and apply the terms of the contract.
Huntington Ingalls Industries Retiree Medical Plan SPD

**MEDICAL**

Note: Once the retiree attains age 65 or becomes Medicare eligible, coverage for the spouse and dependent children also ends, unless the retiree elects to enroll in another Huntington Ingalls Industries Retiree Medical Plan medical plan option. Continuation of TRICARE can be arranged directly with Association & Society Insurance.

**MEDIGAP-TYPE PLAN OPTION (MEDICARE-ELIGIBLE)**

If you are Medicare-eligible, regardless of your age, one of your medical plan choices is the Medigap-type plan option, which helps you pay some of the medical costs that Medicare Parts A and B do not cover, such as the coinsurance for physicians’ services and hospitalization. *Please note:* The Medigap-type plan option covers Medicare-approved amounts. If your provider does not accept Medicare assignment, you may have to pay an extra fee charged by the provider.

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

For a summary of the Medigap-type benefits provided by Huntington Ingalls Industries, refer to the “Medigap-type Medical Plan Option” SPD or call the Huntington Ingalls Industries Benefits Center (HIBC) at 1-877-216-3222. For information on Medicare and Medigap plans in general, go to [www.medicare.gov](http://www.medicare.gov).

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program plan option is available to retirees and their eligible dependents, regardless of Medicare eligibility. This plan option, administered by Express Scripts, enables you and your eligible dependents to receive coverage for prescription drugs. Note: You do not need to enroll in Medicare Rx (Medicare Part D) to be eligible for this plan option. If you enroll in Medicare Rx (Medicare Part D), you will not be able to enroll in the Prescription Drug Program plan option.

If you are enrolled in the PPO or Medigap-type option, you must separately enroll in the Prescription Drug Program plan option to receive prescription drug coverage. You cannot simultaneously enroll in the Prescription Drug Program and the EPO, HMO, or Anthem CDHP plan option as prescription drug coverage is included with the medical coverage in these options.

For more information about the Prescription Drug Program plan option, go to the “Prescription Drug Program Plan Option” section of the SPD or call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.

IF YOU OR YOUR DEPENDENT BECOMES ELIGIBLE FOR MEDICARE

If you or your dependent becomes eligible for Medicare, regardless of your age, your coverage will be affected as described below. As noted previously, the Medicare-eligible individual must enroll in Medicare Parts A and B on a timely basis so that Medicare Part A and B coverage is effective as of the earliest date that it could be effective under Medicare rules. In general, you become eligible for Medicare the first day of the month in which you attain age 65 or the first day of the month following receipt of 24 months of Social Security Disability payments.

- **PPO Option:** If you are enrolled in the Anthem Blue Cross PPO, you may choose to enroll in the Medigap-type option and separately elect prescription drug coverage. If no election is made, the Medicare-eligible person’s default coverage will be the Anthem Blue Cross Medigap-type option. If they are currently enrolled in the Prescription Drug Program, prescription drug coverage will continue.

- **EPO Option:** If you are enrolled in the Anthem Blue Cross EPO, you may choose to enroll in a Medigap-type option and separately elect prescription drug coverage or enroll in the CDHP. If no election is made, the Medicare-eligible person’s default coverage will be the Anthem Blue Cross Medigap-type option AND the Prescription Drug Program.

- **Anthem CDHP:** If you are enrolled in the Anthem CDHP, you may remain with the same plan. No election will be required. The Anthem CDHP will begin coordinating benefit payments with Medicare.

- **TRICARE Supplement:** (a) If you become eligible for Medicare and fail to actively enroll in another available option, your and your dependents’ medical coverage will be terminated the first of the month in which you become eligible for Medicare. (b)
If your covered spouse or dependent becomes eligible for Medicare and you fail to make an active election to move to another available option, your Medicare-eligible spouse or dependent will be terminated from coverage. Your and your non-Medicare eligible dependents’ coverage will continue.

- **Prescription Drug Program Option:** There will be no change to your coverage.

## BENEFIT MAXIMUMS

### Overview

The Plan will not impose a lifetime dollar limit on essential benefits. The Plan lifetime dollar limit is the total amount the self-insured medical plan options (PPO, EPO, Prescription Drug Program, Anthem CDHP, and Medigap-type options) pay for all benefits for each enrolled participant.

However, the plan options may have lifetime and benefit plan year maximums on specific services. For more information about maximums in the PPO, EPO, and Anthem CDHP plan options, refer to those sections of this SPD.

### Retirement Health Care Security Fund

Electronic Systems Sector employees are no longer allowed to contribute to the Retirement Health Care Security Fund (RHCSF). The plan is closed. Plan participants elected to receive a full refund of their account balance including interest or used their account balance to purchase protection for caps on Company contributions for retiree medical coverage. If the participant elected to receive a refund, he/she will be subject to the caps on the employer contribution for pre-Medicare coverage. If the participant elected to purchase protection, he/she will not be subject to caps on the employer contributions for pre-Medicare coverage.

### THIRD-PARTY REIMBURSEMENT (RIGHT OF SUBROGATION)

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

- Reimburse the plan for the full amount of benefit payments made on your behalf in connection with the injury or illness for which you make a recovery

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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.

**ADDITIONAL INFORMATION ABOUT YOUR MEDICAL BENEFITS**

**Important Notice About the Women’s Health and Cancer Rights Act**

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

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
Huntington Ingalls Industries Retiree Medical Plan SPD

MEDICAL

- Prostheses and treatment for physical complications for all stages of a mastectomy, including lymphedemias (swelling associated with the removal of lymph nodes).

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

If you would like more information about the Women’s Health and Cancer Rights Act, call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.

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

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

Under the non-duplication of benefits provision, the Huntington Ingalls Industries Retiree Medical Plan options consider the benefit payments you receive from another group plan. When the Huntington Ingalls Industries Retiree Medical Plan is the secondary payer, the Huntington Ingalls Industries Retiree 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 Retiree Medical Plan option.

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

Exception: Anthem CDHP plan option. If you are eligible for Medicare, the Anthem CDHP plan will apply a coordination of benefits provision to coordinate payments with Medicare. Under the coordination of benefits provision, the Anthem CDHP plan considers the benefit payments you receive from Medicare. When the Huntington Ingalls Industries Retiree Medical Plan is the secondary payer, the Anthem Blue Cross CDHP plan pays up to the maximum benefit that otherwise would be payable under the CDHP. This means that the CDHP plan payment will be equal to the total allowed charge minus the benefit paid by Medicare, subject to CDHP plan Bridge and other plan design provisions. This provision ensures that payments from Medicare, plus any payments from the Huntington Ingalls Industries Anthem CDHP plan option, do not exceed the total allowed charge.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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 Retiree Medical Plan is always secondary to any automobile insurance coverage, including, but not limited to, no-fault coverage and uninsured motorist coverage, and to any medical payment provision under homeowner’s or renter’s insurance.

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

These are some general guidelines:

<table>
<thead>
<tr>
<th></th>
<th>Huntington Ingalls Industries Retiree Medical Plan option pays…</th>
<th>Your spouse’s active medical plan option pays…</th>
<th>Medicare pays…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are…</strong></td>
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</tr>
<tr>
<td>Not Medicare eligible</td>
<td>Second</td>
<td>First</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medicare-eligible</td>
<td>Third</td>
<td>First</td>
<td>Second</td>
</tr>
<tr>
<td><strong>If your spouse is…</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Medicare eligible</td>
<td>Second</td>
<td>First</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medicare-eligible</td>
<td>Second</td>
<td>First</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>If your child is…</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not Medicare eligible</td>
<td>Second</td>
<td>First</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Medicare-eligible</td>
<td>Second</td>
<td>First</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
If you are divorced, legally separated, or not married to your child’s parent and your child is enrolled in both a Huntington Ingalls Industries Retiree Medical Plan option and the other parent’s employer’s plan, the plans pay in this order:

- First, the plan of the parent awarded financial responsibility for the child’s medical expenses by a court decree
- Then, the plan of the parent with custody of the child
- Then, the plan of the stepparent whose spouse has custody of the child
- Then, the plan of the parent who does not have custody of the child.

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

To ensure proper payment of claims under the non-duplication of benefits provision, Huntington Ingalls Industries may ask you to confirm your other coverage, if any. Your claims administrator will send you a coordination of benefits (COB) questionnaire, usually after your claims administrator receives the first claim for your enrolled spouse or children.

The COB questionnaire requests information about any other insurance under which you, your spouse or your children are covered. Claims administrators vary on their process for processing the claim associated with the questionnaire. In some cases, until your claims administrator receives your completed questionnaire (which can be completed in writing or over the telephone with the claims administrator), the claim that triggered the questionnaire is “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.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
Coordination with Medicare for Retirees

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

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

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

End-Stage Renal Disease

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

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

If you enroll in the medical PPO plan option, your dependents can visit a physician in the PPO network anywhere in the nation and receive reimbursement at the higher in-network benefit level. If your dependents go to an out-of-network provider, reimbursement will be made at the out-of-network level.

In general, if you participate in an EPO, your dependent must use EPO network providers for all care. In an EPO, out-of-network care is not covered, except in an emergency. Contact your medical plan carrier for more information on how to access care.

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

Under federal law, the Huntington Ingalls Industries Retiree Medical Plan may not restrict benefits for the mother or newborn child to less than:

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

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

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

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
LIFE INSURANCE

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

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

LIFE INSURANCE

Eligibility and Coverage Amounts

Certain heritage retirees who terminated employment on or before December 31, 2005, are eligible for life insurance coverage as shown below. Life insurance will not be offered to retirees on or after January 1, 2006, except as noted in this section.

Electronic Systems (Westinghouse Heritage) Basic Life:

<table>
<thead>
<tr>
<th>Group</th>
<th>Coverage Amount</th>
</tr>
</thead>
</table>
| Grandfathered: employees and retirees who were continuously covered since December 31, 1991, and retire with 10 or more years of service | Coverage amount is $50,000, offered at no cost to the retiree  
Coverage amount remains in full until the retiree reaches age 62. At age 62, the amount will reduce 5% every month until 1/3 of the original benefit is reached ($16,667).  
Coverage will continue for current retirees. |
| Non-Grandfathered: employees and retirees who were not continuously covered since December 31, 1991, and retire with 10 or more years of service prior to December 1, 2005. Eligible individuals must be receiving retiree benefits under the | $7,500  
Coverage amount remains in full until death.  
Employees who retire on or after December 1, 2005, are not eligible for |
LIFE INSURANCE

Huntington Ingalls Industries Retiree Medical Plan prior to January 1, 2006.

Newport News Salaried:

<table>
<thead>
<tr>
<th>Group</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grandfathered salaried group eligible to retire prior to January 1, 1995 (but didn’t necessarily retire).</td>
<td>Retirement eligibility: age 55 with at least 10 years of service</td>
</tr>
<tr>
<td></td>
<td>If eligible to retire between May 1, 1976, and January 1, 1995 – 25% of Active Basic Life (1.5 times salary)</td>
</tr>
<tr>
<td></td>
<td>If eligible to retire between May 1, 1976, and January 1, 1995, but did not retire until after January 1, 2004 – 25% of Active Basic Life (one times salary)</td>
</tr>
<tr>
<td>Salaried group eligible to retire on and after January 1, 1995, who retired prior to January 1, 2006. Eligible individuals must be receiving retiree benefits under the Huntington Ingalls Industries Retiree Medical Plan prior to January 1, 2006, to be eligible for retiree life insurance.</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

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

Retirees who are covered under the Newport News Retiree Life plan on December 31, 2006, may continue coverage. Employees who retire on or after January 1, 2007, are not eligible for retiree life, unless they are part of the grandfathered group.
TRW Heritage (including Mission Systems and Space Technology):

<table>
<thead>
<tr>
<th>Group</th>
<th>Coverage Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Retirees between January 1, 1998, and December 1, 2005</td>
<td>▪ $7,500</td>
</tr>
<tr>
<td>▪ Retirees between October 1, 1989, and December 31, 1997</td>
<td>▪ MS, ST: $7,500</td>
</tr>
<tr>
<td></td>
<td>▪ Old BSC: $5,000</td>
</tr>
<tr>
<td>▪ Retirees prior to October 1, 1989</td>
<td>(varies by location)</td>
</tr>
</tbody>
</table>

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

With the exception of the grandfathered groups listed above, employees who retire on or after January 1, 2007, will not be eligible for life insurance coverage.

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

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

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

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

Beneficiary Designation

Your beneficiary is the person or persons you choose to receive life insurance benefits when you die. You also may choose your estate or living trust as the beneficiary of your life insurance benefits. If the beneficiary is under age 18, the insurance company may require that benefits be paid to a legal guardian on behalf of the minor. If you do not name a beneficiary, your benefits are distributed to your estate according to the laws of your state, or as described below.

You must designate your beneficiary online through Your Benefits Resources via HII Benefits Connect. If you do not have internet access, please call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222. Designations submitted on a paper form are not valid.

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

- To the beneficiary or beneficiaries you have designated online through Your Benefits Resources or by calling the HIBC
- To your surviving spouse, if you have not designated a beneficiary online or by calling the HIBC or there is no surviving beneficiary at the time of your death
- To your estate, if you do not have a surviving spouse and have not designated a beneficiary online or by calling the HIBC.

Steps to Report a Death

To receive benefits under the life insurance plan, your beneficiary must report your death. In order for your beneficiary to initiate the payment of life insurance benefits, he or she must call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222 to report the death. The Huntington Ingalls Benefits Center (HIBC) notifies the insurance company, gathers the necessary information, and provides your beneficiary with information about the payment of life insurance benefits.

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

Assignment of Coverage

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law.
GENERAL PLAN ADMINISTRATION

This section contains information on the administration of the Plans, as well as your rights as a participant. You probably do not need this information on a day-to-day basis; however, it is important for you to understand your rights and the procedures you need to follow in certain situations.

Huntington Ingalls Industries is responsible for the general administration of the plan, and will be the fiduciary to the extent not otherwise specified in this SPD, the plan document or in an insurance contract. Huntington Ingalls Industries 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 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 will be liable in any manner for any determination made in good faith.

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

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

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

A Note About Fraud

If you make a claim that you know contains or is based on false, incomplete, or misleading information, with the intention of obtaining benefits that you are not entitled to, the Huntington Ingalls Industries Retiree Medical Plan may terminate your eligibility for benefits, or may demand that you repay benefits or offset future benefits, and you may be subject to prosecution under state and federal law.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
GENERAL PLAN ADMINISTRATION

Power and Authority of the HMO

Benefits may be provided under a group insurance contract entered into between Huntington Ingalls Industries and an HMO. With respect to fully insured benefits, claims for benefits are sent to the HMO. The HMO is responsible for paying claims — not Huntington Ingalls Industries.

The HMO is also responsible for the following:

- Determining eligibility for, and the amount of, any benefits payable under the Plan.
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan.

The HMO also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the benefits provided through the HMO.

Claim procedures are set forth in the next section.

If you have any questions about this information, call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222 or contact the nearest regional office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), an agency of the U.S. Department of Labor.

Liability of Insurer

For benefits that are provided on an insured basis (not self-insured by Huntington Ingalls Industries), the insurance carrier or health maintenance organization (HMO) through which coverage is provided is solely responsible for the payment of benefits and has the sole authority, discretion and responsibility to interpret the terms of the insurance or HMO coverage contract, including eligibility for benefits. Huntington Ingalls Industries does not guarantee the payment of any benefit described in an insurance or HMO coverage contract, and you must look solely to the insurance carrier or HMO for the payment of benefits.

BENEFIT AND ADMINISTRATIVE CLAIMS

Types of Claims

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

How to File a Claim

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

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

To request a claim form, call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222 or by call 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 15 months after the benefit plan year ends. For example, assume you incur a claim in April 2011. Since the benefits plan year ends on December 31, 2011, you have until March 31, 2013 to submit your claim for reimbursement. The medical plan option does not pay claims that are submitted after the 15-month deadline.

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

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

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

- Medical urgent claims: Medical care is “urgent” if a longer time could seriously jeopardize the participant’s life, health, or ability to regain maximum function. Also, care may be urgent if, in a doctor’s opinion, it would subject the participant to severe pain if care or treatment were not provided. If you require care that is classified as being urgent, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 24 hours. You have 48 hours after that time to supply any additional information. Until you supply this information, the time limits that apply for the review are suspended (or “toggled”).

- Medical concurrent care decisions: These are decisions involving an ongoing course of treatment over a period of time or a number of treatments. If you or your dependent is undergoing a course of treatment, or is nearing the end of a prescribed number of treatments, you may request extended treatment or benefits. If the course of treatment involves urgent care and you request at least 24 hours before the expiration of the authorized treatments, the claims administrator will respond to your claim within 24 hours. If you reach the end of a pre-approved course of treatment before requesting additional benefits, the normal, “urgent”, “pre-service” or “post-service” time limits will apply, as described below.

- Medical pre-service determinations: A “pre-service” determination requires the receipt of approval of those benefits in advance of obtaining the medical care. If you request a review for pre-service benefits, but do not submit enough information.
for the claims administrator to make a determination, the claims administrator will notify you within 15 days. You have 45 days after that to supply any additional information. Until you supply this information, the time limits that apply to the claims administrator are tolled.

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

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

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

If Your Benefit or Administrative Claim Is Denied

If your Benefit or Administrative Claim is denied (either in whole or in part), the claims administrator will send you a written explanation of why the claim was denied. In the case of an urgent claim, this can include oral notification, as long as you are provided with a written notice within three days.

This explanation will contain the following information to the extent required by law:

- If a medical 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 specific Plan provisions on which the denial is based
- 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.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.

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

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

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

- You may call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- You may write directly to the claims administrator. Be sure to explain why you think your claim should be paid and provide all relevant details.
- If your claim is denied by the Level 1 appeals review committee and it is not an “urgent” claim or Administrative Claim, ask the claims administrator to submit your claim to the claims appropriate Level 2 appeals review committee as indicated in the chart entitled “Claims and Appeal Contact Information.”

In deciding appeals, the claims administrator acts as or for the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the plan and to make factual determinations as to whether you are entitled to benefits.

**Appealing a Denied Administrative Claim**

If your Administrative Claim is denied, you have the right to make an appeal by writing to the claims administrator. Be sure to explain why you think your Administrative Claim should be approved and provide all relevant details. There is only one level of appeal for Administrative Claims. See the chart entitled “Claims and Appeal Contact Information” for the contact information of the claims administrator. The claims administrator identified in the following chart acts as the appropriate named fiduciary for purposes of deciding appeals and has discretionary authority to interpret the plan and to make factual determinations.
Timing of Your Appeal

If you make a Benefit or Administrative Claim and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can initiate a lawsuit to enforce your rights under ERISA (see “Employee Retirement Income Security Act of 1974” for details). In the case of medical 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 life insurance Benefit Claims and Administrative Claims, you have 65 days from the time that you receive a claim denial from the claims administrator to file an appeal. Following are the timeframes that apply when you file an appeal.

<table>
<thead>
<tr>
<th>Type of Claim</th>
<th>Time to Appeal from Date Claim Is Denied</th>
<th>Time for Decision on Appeal</th>
<th>Extensions for Claims Administrator, If Necessary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical: Urgent claims</td>
<td>180 days</td>
<td>72 hours</td>
<td>None</td>
</tr>
<tr>
<td>Medical: Pre-Service claims</td>
<td>180 days for each level of appeal</td>
<td>Two levels of appeal: 15 days from the receipt of the appeal for each level</td>
<td>None</td>
</tr>
<tr>
<td>Medical: Post-Service claims</td>
<td>180 days for each level of appeal</td>
<td>Two levels of appeal: 30 days from the receipt of the appeal for each level</td>
<td>None</td>
</tr>
<tr>
<td>Life Insurance</td>
<td>65 days</td>
<td>One level of appeal: 60 days</td>
<td>60 days</td>
</tr>
<tr>
<td>Administrative</td>
<td>65 days</td>
<td>One level of appeal: 60 days</td>
<td>60 days</td>
</tr>
</tbody>
</table>

**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 claims administrator. Your decision as to whether to file a voluntary level 2 appeal...
of an urgent claim denial will have no effect on any of your other rights under the plan, and the same rules and procedures apply to a voluntary level 2 appeal of an urgent claim denial as for all other level 2 appeals.

### Pre-Service 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.

### Life Insurance Claims

There is one level of appeal. If your initial claim for benefits is denied, you may appeal that denial within 60 days after you receive the claim denial and you will be notified of the decision on your appeal within 60 days, with a 60-day extension permitted, if necessary. If your claim is wholly or partially denied after your appeal, you may request a final review of your claim within 60 days after you receive the notification that your appeal has been denied. The insurance company will provide its final decision in writing within 60 days after receipt of your request for final review.

### Administrative Claims

There is one level of appeal:

- You may file an appeal with the claims administrator within 65 days after you receive the claim denial. Your appeal must be considered within 60 days, with a 60-day extension permitted, if necessary.
GENERAL PLAN ADMINISTRATION

Claims and Appeals Contact Information

<table>
<thead>
<tr>
<th>Claims Administrator</th>
<th>Claims</th>
<th>Level 1 Appeals</th>
<th>Level 2 Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem Blue Cross PPO, EPO and Medigap-type Medical Plan Options</strong></td>
<td>All Claims must be submitted to your local Anthem Blue Cross Plan. Please contact customer service with questions.</td>
<td>Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365</td>
<td>Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365</td>
</tr>
<tr>
<td><strong>Anthem CDHP</strong></td>
<td><em>Medical Claims</em> must be submitted to your local Anthem Blue Cross Plan. Please contact customer service with questions. <em>Pharmacy Claims</em>: Anthem Prescription Drug Plan P.O. Box 145433 Cincinatti, OH 45250-5433</td>
<td>Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365</td>
<td>Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365</td>
</tr>
<tr>
<td><strong>Express Scripts (includes prescription drug coverage under EPO and Prescription Drug Program)</strong></td>
<td>Express Scripts, Inc. Attn: Claims Department P.O. Box 66773 St. Louis, MO 63166-6773</td>
<td>Express Scripts, Inc., Attn: Pharmacy Appeals Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439</td>
<td>Express Scripts, Inc., Attn: Pharmacy Appeals Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439</td>
</tr>
<tr>
<td><strong>MetLife (Life Insurance)</strong></td>
<td>MetLife Group Life Claims Oneida County Industrial Park 5950 Airport Road Oriskany, Ny 13424</td>
<td>MetLife Group Life Claims Oneida County Industrial Park 5950 Airport Road Oriskany, Ny 13424</td>
<td>MetLife Group Life Claims Oneida County Industrial Park 5950 Airport Road Oriskany, Ny 13424</td>
</tr>
<tr>
<td><strong>Administrative Claims</strong></td>
<td>Huntington Ingalls Benefits Center P.O. Box 563912 Charlotte, NC 28256-3912</td>
<td>Employee Welfare Benefits Committee Huntington Ingalls Industries Corporation P.O. Box 563912 Charlotte, NC 28256-3912</td>
<td>N/A</td>
</tr>
</tbody>
</table>

For all other claims administrators, refer to your medical plan ID card for contact information.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
GENERAL PLAN ADMINISTRATION

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 benefit claims:

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

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

- The specific reasons for the denial
- Reference to the plan provisions on which the decision was based

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
Huntington Ingalls Industries Retiree Medical Plan SPD

GENERAL PLAN ADMINISTRATION

- If a medical 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 denial code and its corresponding meaning, as well as a description of the standard, if any, that was used in denying the appeal, including a discussing of the decision
- 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 claims administrator 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, 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.

Limits on Legal Actions

If your Benefit or Administrative Claim is denied on the final level of appeal, you generally may file a lawsuit under ERISA regarding your claim, provided that you comply with the deadlines for filing a lawsuit described in this section. If you wish to file a lawsuit, you must do so by the earlier of the date that is 12 months after the date your claim was denied on
appeal or the date that is 12 months from the date a cause of action accrued. A cause of action “accrues” when you know or should know that the claims administrator or Huntington Ingalls Industries as plan sponsor has clearly denied or otherwise repudiated your claim.

- **Example 1:** If your claim for payment of a medical expense (other than an urgent claim) is denied after a second level of appeal, the 12-month period begins on the date of the denial of the second level of appeal.
- **Example 2:** If your urgent claim is denied, and you file suit after the first level of appeal, the 12-month period begins on the date of the denial of the first level appeal. If you file a voluntary level 2 appeal of an urgent claim denial, the 12-month period begins on the date of the denial of the level 2 appeal.

**EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)**

**What Is ERISA?**

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs employee benefit plans.

**What ERISA Means to You**

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

ERISA does not require any company to offer an employee benefit plan and generally does not specify the benefits you should receive. However, if a plan is offered, ERISA provides you with certain rights as a participant, and requires that employers who offer covered employee benefit plans follow certain standards related to the plan’s operation.

**What ERISA Does**

You and your beneficiaries have basic rights and protections under ERISA, which:

- Requires the plan administrator to provide you with information about the plans, including important information about the plans’ features and how they are funded. In certain circumstances, the plan administrator may request a small fee to cover copying costs.
- Requires that fiduciaries of your benefit plans operate the plans prudently and in the interest of all plan participants.
- Gives you the right to sue for benefits or for breaches of fiduciary duty.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
What Is a Fiduciary?

A fiduciary is a person or organization whose duty is to operate your benefit plans prudently and in the interest of all plan participants and beneficiaries. Fiduciaries may include employees who make certain discretionary decisions about the management or administration of a benefit plan, or employees who make decisions about funding plan benefits. They also may include outside investment advisors, trustees, and certain others.

Your ERISA Rights

As a plan participant under ERISA, you have the right to:

- Examine all plan documents without charge at the plan administrator's office or at other specified locations. This includes plan documents, trust agreements, insurance contracts and collective bargaining agreements. Copies of all documents filed on behalf of the plan with the U.S. Department of Labor, such as annual reports, are also available for you to review at the plan administrator's office.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated SPD. The plan administrator may charge a reasonable fee for the copies.

- Receive a summary of the plan's annual financial reports. You do not have to ask for your copy of the summary; the plan administrator sends you a Summary Annual Report (SAR) each year.

- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the "COBRA" section and the documents governing the plan for rules about your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties on the plan fiduciaries — the people responsible for operating the plan. At Huntington Ingalls Industries, plan fiduciaries may include employees who make certain discretionary decisions about the management or administration of the plan.

Fiduciaries have a duty to operate the plan prudently and in the sole interest of plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and/or required to reimburse the plan for losses that they have caused.

No one, including Huntington Ingalls Industries or any person, may discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.
Enforcing Your ERISA Rights

Under ERISA, there are several steps you can take to enforce your rights. For instance, if you request plan materials and you do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent for a reason beyond the control of the plan administrator, or the plan administrator otherwise had a reasonable basis for not providing them.

If you have a claim for benefits that is denied or ignored — in whole or in part — and you have satisfied all of the plan’s appeals procedures, then you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision (or lack thereof) concerning the qualified status of a medical child support order, you may file a suit in federal court. If a fiduciary misuses the plan’s assets, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court.

In addition to deciding what damages, if any, should be awarded, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay them. If you lose, the court may order you to pay these costs and fees (for example, your claim is frivolous).

Questions?

If you have any questions about your rights under ERISA or about this statement outlining your rights, you should contact the nearest regional office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. You also may contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administrator (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

What Is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets standards for employee benefit plans — specifically related to your ability to obtain new coverage, the opportunity to select or change coverage after certain qualifying life events, and health information privacy. Please note that although the Huntington Ingalls Industries Retiree Medical Plan is required to comply with the HIPAA health information privacy rules described below, it is not required to comply with the HIPAA rules relating to obtaining new coverage or changing coverage. Huntington Ingalls Industries has chosen to operate the

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
GENERAL PLAN ADMINISTRATION

Plan in accordance with those rules, as described below in "Obtaining New Medical Coverage Under HIPAA" and "Special Enrollment Periods Provided Under HIPAA," but is not required by HIPAA to do so.

Obtaining New Medical Coverage Under HIPAA

HIPAA can help you and your family obtain new medical coverage if your coverage ends under the Huntington Ingalls Industries medical plans. For example, if you take a new job with another company, you most likely will request coverage under your new employer’s health care plan.

Specifically, HIPAA limits your new employer’s health plan’s ability to exclude you from coverage due to a preexisting condition.

By using preexisting condition exclusions, a health care plan could avoid covering expenses for medical conditions that existed prior to a person’s participation in that plan. Because of these exclusions, employees with preexisting conditions had difficulty changing jobs, since such a change generally resulted in a change in health care plans.

Under HIPAA, health plans are required to cover the preexisting conditions of a new member immediately upon enrollment — as long as the new member provides proof that:

- He or she previously was enrolled in another health plan for 12 months or more, and
- That coverage had not ended more than 63 days before the new coverage began.

HIPAA requires health plans to provide individuals whose coverage terminates under the plan with proof of their medical coverage — called a Certificate of Creditable Coverage. Therefore, when you or your dependents stop participating in a Huntington Ingalls Industries health care plan, Huntington Ingalls Industries must provide you with a Certificate of Creditable Coverage. The certificate is sent to you within 45 days of the date Huntington Ingalls Industries is notified of your termination.

You can present your Certificate of Creditable Coverage to a new health care plan to prove that you previously had coverage. This can reduce the length of time preexisting conditions affect your new coverage. Your Certificate of Creditable Coverage states:

- The date the certificate was issued
- The name of the Huntington Ingalls Industries Retiree Medical Plan option you or your dependents were covered under
- The period of time you or your dependents were enrolled in the medical plan option
- The name, address, and telephone number of the issuer of the certificate
- Whom to contact for further information.

Certificates of Creditable Coverage are issued to you:

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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- Automatically, when your coverage under the plan ends — whether or not you elect COBRA
- Automatically, when your COBRA coverage ends, if you elected COBRA coverage
- On request within 24 months of the date your coverage ends.

If you need to request a Certificate of Creditable Coverage, or if you are interested in more information about HIPAA, call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.

Special Enrollment Periods Provided Under HIPAA

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

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

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

If you enroll in retiree coverage and you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new 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.

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

In the case of both of the last two special enrollment events, coverage will be effective as of the date specified in regulations or other guidance issued by the Internal Revenue Service or U.S. Department of Labor.

HIPAA Privacy Rights

Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Huntington Ingalls Industries Retiree Medical Plan — whether received in writing, in an electronic medium, or as an oral communication. The privacy rights under Title II of HIPAA are effective April 14, 2003.

Permitted Uses and Disclosures of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules.

The Huntington Ingalls Industries Retiree Medical Plan or its health insurer or HMO may disclose your health information without your written authorization to Huntington Ingalls Industries for plan administration purposes. Huntington Ingalls Industries may need your health information to administer benefits under the Plan. Huntington Ingalls Industries agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Personnel within the following areas of responsibility are the only Huntington Ingalls Industries employees who will have access to your health information for plan administration functions:

- Huntington Ingalls Industries Corporation HIPAA Privacy Official
- Corporate Benefits Director
- Corporate Benefits Manager, Executives and Gulf Coast Operations
- Benefits Manager, Newport News Operations
- Benefits Analyst, Health and Welfare Programs

Here’s how additional information may be shared between the Huntington Ingalls Industries Retiree Medical Plan and Huntington Ingalls Industries, as allowed under the HIPAA rules:

- The Huntington Ingalls Industries Retiree Medical Plan, or its Insurer or HMO, may disclose "summary health information" to Huntington Ingalls Industries if requested, for purposes of obtaining premium bids to provide coverage under the plan, or for modifying, amending, or terminating the plan. Summary health information is

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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information that summarizes participants’ claims information, but from which names (and other identifying information) have been removed.

- The Huntington Ingalls Industries Retiree Medical Plan, or its Insurer or HMO, may disclose to Huntington Ingalls Industries information on whether an individual is participating in the plan, or has enrolled or disenrolled in an insurance option or HMO offered by the plan.

In addition, you should know that Huntington Ingalls Industries cannot and will not use health information obtained from the plan for any employment-related actions. However, health information collected by Huntington Ingalls Industries from other sources, for example under the Family and Medical Leave Act, Americans with Disabilities Act, disability income programs, or workers’ compensation is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.

Information describing your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the opportunity to agree or object to these disclosures (although exceptions may be made: for example if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

Except as described in the Huntington Ingalls Industries Health Plan Privacy Notice (“Privacy Notice”) and plan document, other uses and disclosures will be made only with your written authorization. You may revoke your authorization as allowed under the HIPAA rules. However, you cannot revoke your authorization if the plan has taken action relying on it.

Default Procedure

It is the plan’s procedure, upon request for assistance, to disclose your health information to your spouse or your domestic partner (if applicable), and his or her health information to you, and to disclose the health information of your over-age enrolled dependent (for example, your child who is over age 21) to you or your spouse or your domestic partner (if applicable), unless the person whose health information would otherwise be disclosed chooses to opt out of this default procedure. You may request the plan not share your health information with your spouse or your domestic partner (if applicable) by opting out of this default procedure. To opt out, you must contact the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222. Your spouse, domestic partner (if applicable) and/or your over-age enrolled dependent may also opt out of this procedure by contacting the Huntington Ingalls Benefits Center (HIBC). Once an individual has opted out of this default, the plan generally will not disclose any of his or her health information to family members, unless some other part of the HIPAA regulations permits or requires it (for

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example, that individual becomes incapacitated). Any individual may change his or her opt-out election at any time by contacting the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.

Your Rights Under HIPAA

You have the following rights with respect to your health information the Huntington Ingalls Industries Retiree Medical Plan maintains. These rights are subject to certain limitations, as discussed below.

■ Right to request restrictions on certain uses and disclosures of your health information and the plan’s right to refuse:

— You have the right to ask the plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. In addition, you have the right to ask the plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the plan must be in writing.

— The plan is not required to agree to a requested restriction. However, if the plan does agree, a restriction may later be terminated by your written request, by agreement between you and the plan (including an oral agreement), or unilaterally by the plan for health information created or received after you’re notified that the plan has removed the restrictions. The plan may also disclose health information about you if you need emergency treatment, even if the plan has agreed to a restriction.

■ Right to receive confidential communications of your health information:

— If you think that disclosure of your health information by the usual means could endanger you in some way, the plan will accommodate reasonable requests to allow you to receive communications of health information from the plan by alternative means or at alternative locations.

— If you want to exercise this right, your request to the plan must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you.

■ Right to inspect and copy your health information:

— With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “Designated Record Set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies

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of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the plan may deny your right to access, although in certain circumstances you may request a review of the denial.

— If you want to exercise this right, your request to the plan must be in writing.

■ Right to amend your health information that is inaccurate or incomplete:

— With certain exceptions, you have a right to request that the plan amend your health information in a Designated Record Set. The plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

— If you want to exercise this right, your request to the plan must be in writing, and you must include a statement to support the requested amendment.

■ Right to receive an accounting of disclosures of your health information:

— You have the right to a list of certain disclosures the plan has made of your health information. This is often referred to as an “accounting of disclosures.” You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Privacy Notice.

— If you want to exercise this right, your request to the plan must be in writing.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Health and Human Services and or with the plan. You will not be retaliated against if you file a complaint. To file a complaint with respect to a violation of your privacy rights, please contact the Privacy Official or its designee.

COBRA CONTINUATION OF COVERAGE

What Is COBRA?

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, your enrolled family members are eligible to pay for continued group health care (medical and prescription drug) coverage if they lose their coverage under certain circumstances, known as COBRA qualifying events. Under the Retiree Medical Plan, the qualifying events are your (the retiree’s) death, your divorce from your spouse, or your dependent child’s loss of eligible dependent child status. In addition, you and your enrolled family members are eligible to pay for continued coverage if coverage under the plan is

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substantially eliminated in the event that Huntington Ingalls Industries files for bankruptcy protection under Title 11 of the United States Code.

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

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

If you elect COBRA continuation:

- Initially, you and your dependents will keep the same type of plan coverage you were enrolled in before the qualifying event (for example, PPO, EPO, or HMO).
- You may keep the same coverage category you had before the qualifying event or choose a different category. For example, if your spouse and all of your dependents were enrolled under the Huntington Ingalls Industries medical plan, you could choose to enroll all, some or none under COBRA.
- Coverage is effective on the date of the event that qualified you for COBRA coverage, unless you waive COBRA coverage and subsequently revoke your waiver within the 60-day election period. In that case, your coverage begins on the date you revoke your waiver.
- You may change plan coverage and coverage category (including adding eligible dependents) during the annual rate change event or if you have a qualifying 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.

COBRA-like coverage is also available for eligible domestic partners. For details, call the Huntington Ingalls Benefits Center (HIBC) at 1-877-216-3222.

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
COBRA Continuation Period

<table>
<thead>
<tr>
<th>Qualifying Event</th>
<th>Maximum Continuation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retiree</td>
</tr>
<tr>
<td>You die</td>
<td>N/A</td>
</tr>
<tr>
<td>You and your spouse legally separate or divorce</td>
<td>N/A</td>
</tr>
<tr>
<td>Your child no longer qualifies as a dependent</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Newly Eligible Child

If you, the Huntington Ingalls Industries retiree, elect continuation coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Huntington Ingalls Industries-sponsored group health plan and the requirement of the federal law, these qualified beneficiaries can be added to COBRA coverage by contacting the Huntington Ingalls Industries Benefits Center. This notice must be provided within 30 days of birth, adoption, placement for adoption, or appointment as a legal guardian. The notice must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the Huntington Ingalls Benefits Center in a timely fashion regarding your newly acquired child, you will not be offered the option to elect COBRA coverage for that child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries, but may be added to the employee's continuation coverage, if enrolled in a timely fashion, subject to the plan's rules for adding a new dependent.

Cost for COBRA

COBRA participants pay monthly premiums for their coverage based on the full group rate per enrolled person set at the beginning of the benefit plan year, plus 2% for administrative costs. Your spouse or child who is a qualified beneficiary making a separate election is charged the same rate as if you were electing retiree-only coverage.

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

Notification

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
Qualified beneficiaries are notified by mail of their COBRA election rights when they lose health coverage with Huntington Ingalls Industries as a result of your death or Medicare entitlement. If your spouse is a qualified beneficiary, notice to your spouse is considered notice to all qualified beneficiaries who reside with your spouse.

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

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

Questions About COBRA

If you have any questions about COBRA coverage or the application of the law, please contact your local human resources representative or contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s Web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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In order to protect your and your family’s rights, you should keep your local human resources representative informed of any changes in your or your family members’ addresses. You should also keep a copy, for your records, of any notices you send.

SURVIVOR OPTIONS

In the event of the retiree’s death, the covered spouse and dependent children may elect to either continue medical coverage under the plan or suspend coverage to a later date.

— If coverage is continued, the spouse will be covered as the participant under the plan with any children covered as his or her dependents. Any required contributions will be based on the dependent cost, not the retiree cost. Any required contributions will be deducted from the survivor’s pension check if sufficient, or the survivor will be direct-billed.

— If coverage is suspended, the surviving spouse and dependent children may reelect coverage during the next retiree annual enrollment or if he or she experiences a qualifying life event.

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

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

FUTURE OF THE PLANS

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

Amendments to or termination of a plan may apply to active, inactive or former employees. A plan change may transfer plan assets to another plan, or split a plan into two or more parts. The plan administrator notifies you if an amendment or termination substantially affects your benefits.

Any amendment, termination, or other action by Huntington Ingalls Industries with respect to the plan shall be duly authorized by the Employee Welfare Benefits Committee or a committee or persons authorized to take such action.

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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.

If a plan is terminated, retired employees and beneficiaries who are receiving coverage or benefits under the plan stop their participation and receive no additional benefits. Claims for expenses incurred before the termination date, however, are honored.

After all benefits are paid and legal requirements are met, the plan assets will become the sole property of Huntington Ingalls Industries, to the extent permitted by law.
**GENERAL PLAN ADMINISTRATION**

**ADMINISTRATIVE INFORMATION**

**General Plan Facts**

<table>
<thead>
<tr>
<th><strong>Employer/Plan Sponsor</strong></th>
<th>Huntington Ingalls Industries, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Employer Identification Number (EIN)</strong></td>
<td>90-0607005</td>
</tr>
<tr>
<td><strong>Type of Plan</strong></td>
<td>Welfare benefit plan</td>
</tr>
<tr>
<td><strong>Type of Administration</strong></td>
<td>Insured and self-insured</td>
</tr>
<tr>
<td><strong>Plan Administrator</strong></td>
<td>Employee Welfare Benefits Committee Huntington Ingalls Industries, Inc. P.O. Box 563912 Charlotte, NC 28256-3912</td>
</tr>
<tr>
<td><strong>Agent for Service of Legal Process</strong></td>
<td>Huntington Ingalls Industries, Inc. c/o Corporate Secretary Huntington Ingalls Industries, Inc. Service of process may also be made to the plan administrator.</td>
</tr>
<tr>
<td><strong>Benefit Plan Year</strong></td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td><strong>Plan Number</strong></td>
<td>The Huntington Ingalls Industries Retiree Medical Plan is a component plan of the Huntington Ingalls Industries, Inc. Retiree Welfare Benefits Plan, which is plan number 502. This summary plan description is considered part of the written instrument for the Plan for purposes of section 402(a)(1) of ERISA.</td>
</tr>
</tbody>
</table>

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
## Specific Plan Facts

<table>
<thead>
<tr>
<th>Medical Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured by:</strong> Huntington Ingalls Industries self-insures the PPO, EPO, Anthem CDHP, and Medigap-type medical plan options. All other medical plan options are fully insured under contracts with insurers. Insurers are listed below.</td>
</tr>
<tr>
<td><strong>Claims administered by:</strong> Refer to the claims administrators and addresses provided in the chart under “Claims and Appeals Contact Information” in the “Benefit Claims” section. For all other plan options, refer to your medical ID card for claims administration details.</td>
</tr>
<tr>
<td><strong>Sources of contributions:</strong> Depending on the benefits selected by the participant and the participant’s heritage status, the cost of benefits will either be covered by contributions from Huntington Ingalls Industries or will be shared by Huntington Ingalls Industries and the participant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Prescription Drug Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Insured by:</strong> Huntington Ingalls Industries self-insures the Prescription Drug benefits in the EPO and Anthem CDHP medical plan options and the Prescription Drug Program. Prescription Drug benefits under all other medical plan options are provided under contracts between the medical plan and prescription drug providers</td>
</tr>
</tbody>
</table>
| **Claims administered by:** For Prescription Drug benefits in the Prescription Drug Program option and EPO option, claims are administered by:  
Express Scripts, Inc. *(initial claim determinations)*  
Attn: Claims Department  
P.O. Box 66773  
St. Louis, MO 63166-6773  

| Express Scripts, Inc. *(appeals determinations)*  
Attn: Pharmacy Appeals  
6625 West 78th Street  
Mail Route BL0390  
Bloomington, MN 55439  

For all other plan options, refer to the claims administrators and addresses provided in the chart under “Claims and Appeals Contact Information” in the “Benefit Claims” section.
**GENERAL PLAN ADMINISTRATION**

<table>
<thead>
<tr>
<th>Contact Information</th>
<th>Contact Information in the &quot;Benefit Claims&quot; section of the Huntington Ingalls Industries Retiree Medical Plan Summary Plan Description (SPD), or refer to your medical ID card for claims administration details.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funded by¹</td>
<td>Huntington Ingalls Industries and participant contributions</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Insured by: | MetLife  
One Madison Avenue  
New York, NY 10010 |
| Claims administered by: | MetLife  
Group Life Claims  
Oneida County Industrial Park  
5950 Airport Road  
Oriskany, NY 15424 |
| Funded by¹ | Huntington Ingalls Industries and retiree contributions |

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

³ In the Anthem CDHP plan option, mental health and substance abuse coverage and prescription drug coverage are provided through the Anthem CDHP. In the EPO, prescription drug coverage is provided through Express Scripts. Refer to the claims administrators and addresses provided in the chart under “Claims and Appeals Contact Information” in the “Benefit Claims” section.
GENERAL PLAN ADMINISTRATION

CARRIER CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Plan Option/Carrier</th>
<th>Phone</th>
<th>Web Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem CDHP</td>
<td>1-800-223-0056</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
</tr>
<tr>
<td>Anthem Blue Cross PPO</td>
<td>1-800-223-0056</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
</tr>
<tr>
<td>Anthem Blue Cross EPO</td>
<td>1-800-223-0056</td>
<td><a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
</tr>
<tr>
<td>Express Scripts, Inc.</td>
<td>1-877-498-4161</td>
<td><a href="http://www.express-scripts.com">www.express-scripts.com</a></td>
</tr>
<tr>
<td>Kaiser/Senior Advantage HMO</td>
<td>1-800-443-0815 (Medicare)</td>
<td><a href="http://www.kaiserpermanente.org/california">www.kaiserpermanente.org/california</a></td>
</tr>
<tr>
<td></td>
<td>1-800-464-4000 (Non-Medicare)</td>
<td></td>
</tr>
<tr>
<td>MetLife — life insurance</td>
<td>Call the HIBC at 1-877-216-3222</td>
<td>N/A</td>
</tr>
<tr>
<td>TRICARE Supplement</td>
<td>1-800-638-2610, ext. 255</td>
<td><a href="http://www.corporatetricaresupp.com">www.corporatetricaresupp.com</a></td>
</tr>
</tbody>
</table>

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
GLOSSARY

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

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

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

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

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

Annual restoration — The amount the self-insured medical plan options (PPO, EPO, and Anthem CDHP restore to your lifetime maximum benefit each benefit plan year.

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

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

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

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

Benefit plan options — The various options available to you and your family within the Huntington Ingalls Industries Retiree Medical Plan.

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

**Benefits Services** — The Huntington Ingalls Industries benefits department at several office locations.

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

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

**Bridge** — If you use all the money in your Anthem CDHP, you are responsible for paying additional covered medical expenses up to a specified amount out of your pocket. This is called the Bridge, and it is similar to the deductible in traditional plans.

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

**Case management** — A process in which a registered nurse and case management team is assigned to an individual patient to assess, coordinate, monitor, and evaluate the options and services required to meet the patient’s health care needs. Case managers access all available resources to promote quality and cost-effective outcomes.

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

**Claim** — Any charge for services submitted for payment to the claims administrator either by you or a service provider.

**Claims administrator** — The outside firm with which Huntington Ingalls Industries contracts to administer benefits under the guidelines of the plan and generally accepted insurance practices. The claims administrator may collect premiums, pay claims, and/or provide administration services. For claims that are Administrative Claims, the claims administrator is the Huntington Ingalls Benefits Center or the Huntington Ingalls Industries Employee Welfare Benefits Committee.

**Coinsurance** — Your percentage share of the cost of eligible expenses. For example, in the PPO plan options, the coinsurance arrangement is 90%/10%, in which case the Plan pays 90% of the usual, reasonable, and customary (URC) expenses and you pay 10%. You pay coinsurance after you meet the individual or family deductible.
Collective bargaining agreement — A contract between a union and an employer covering benefits, wages, and working conditions.

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

Consolidated Omnibus Budget Reconciliation Act (COBRA) — A federal law that requires employers to offer continued health insurance coverage to employees and retirees and their dependents when their eligibility for group health insurance coverage ends, such as at termination of employment, divorce, or death.

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

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

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

Coverage categories — The number of family members, such as you only or you and family, that you enroll in the benefit plans. Coverage categories vary under the Huntington Ingalls Industries benefit plans.

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

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

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

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

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

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

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
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**Employer contribution** — The amount Huntington Ingalls Industries contributes toward the premium cost of your benefits.

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

**Exclusive provider organization (EPO)** — A medical plan that offers its members a wide range of medical services from a specific group of medical providers.

**Experimental** — A procedure, service or supply that does not conform to accepted medical practice, is not approved by the appropriate governing body, such as the Food and Drug Administration (FDA), or has not completed scientific testing or whose effectiveness has not been established. Typically, experimental procedures, services or supplies are not covered under the medical plan option.

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

**Family deductible** — A deductible that is satisfied by the combined expenses of all enrolled family members.

**Fiduciaries** — The people or entities responsible for operating a plan. At Huntington Ingalls Industries, plan fiduciaries may include employees who make certain discretionary decisions about the management or administration of the plans.

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

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

**Group rates** — The discounted insurance rates offered to an employer (such as Huntington Ingalls Industries), union, trust, association, or organization.

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

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
Health Reimbursement Account (HRA) — In the Anthem CDHP option, Huntington Ingalls Industries puts a specified dollar amount into a Health Reimbursement Account (HRA) for you and your eligible dependents each year. The funds in your HRA are used to pay for 100% of the cost of any covered medical expenses. Any unused funds in your HRA roll over from benefit plan year to benefit plan year when you reenroll in the Anthem CDHP option, and can be used to reduce your future out-of-pocket cost.

Home health care — Care provided in your home by an agency licensed by the state in which you live. Benefits may be approved for individuals who are homebound for medical reasons, physically unable to obtain necessary medical care as an outpatient, or under the care of a physician.

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

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

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

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

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

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

Investigational — See Experimental.

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

Lifetime maximum — The maximum amount payable during your lifetime under all Huntington Ingalls Industries self-insured medical plan options, including prescription drugs and mental health, for active and retired employees.

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

Generally applicable to eligible non-represented retired employees and eligible retired employees of certain represented business units.
GLOSSARY

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

Maximum allowed amount — As determined by the claims administrator, is the maximum amount of reimbursement the carrier will allow for all for services and supplies. The services must meet the definition of covered services, to the extent such services and supplies are covered under the plan and not excluded, must be Medically Necessary and must have been provided in accordance with all applicable preauthorization, utilization management and other requirements set forth in the plan.

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

Medically necessary — In general, services or supplies that meet the medical necessity criteria of the claims administrator.

Medicare — A federally administered, nationwide health insurance program that covers the cost of health care for individuals who are eligible for Social Security benefits.

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

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

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

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

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

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

**Huntington Ingalls Benefits Center (HIBC)** — A telephone center staffed with trained benefits service representatives who can provide answers to your benefit questions or direct you to other resources. You can reach the HIBC at 1-877-216-3222 Monday through Friday from 9:00 a.m. to 6:00 p.m. Eastern time. The HIBC is closed on major holidays.

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

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

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

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

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

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

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

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

**Payment limits** — The maximum number of treatments or services or maximum amount of benefits that you or your enrolled dependents can receive each benefit plan year. This is the same as a benefit plan year maximum.
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Personalized identification number (PIN) — A number assigned to an employee or retiree that allows the employee or retiree access to personalized benefit information through Huntington Ingalls Industries’s information resources, such as the Huntington Ingalls Benefits Center (HIBC), Hill Benefits Connect.

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

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

Pre-certification — The advance review and approval of proposed hospital stays and specific health care services.

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

Preferred provider organization (PPO) — A group of health care providers who enter into a contract with Huntington Ingalls Industries’s medical PPO plan to provide services to participants at a specified, discounted fee. Similar to a network.

Premium — The cost of your benefit plans. The health plans have one premium rate for you only and another, separate premium rate or rates for you with dependents. Premiums may change periodically. Your share of the premium is called your contribution.

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

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

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

Provider (medical) — A hospital, skilled nursing facility, ambulatory surgical facility, physician, practitioner, laboratory, or other individual or organization that is licensed to provide medical or surgical services, supplies and/or accommodations.
Qualified medical child support order (QMCSO) — An order or judgment from a state court or administrative agency that directs the plan administrator to cover a child for benefits under the plan. Applies to medical benefits.

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

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

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

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

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

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

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

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

Traditional Health Coverage component — The Traditional Health Coverage component in the Anthem CDHP option begins after you use your annual HRA allocation and pay the Bridge. Under the Traditional Health Coverage component, the plan pays the majority of the cost of covered services, and you pay a percentage of the cost (coinsurance) up to the out-of-pocket maximum.

Usual, reasonable, and customary (URC) fee — The “going rate” for medical services in your geographic area, as determined by the claims administrator. The medical plans pay benefits up to the URC fee. Expenses that exceed URC limits do not apply to out-of-
pocket maximums. You pay 100% of expenses over the URC fee. When you receive care from a network provider, expenses never exceed the URC limit.