Huntington Ingalls Industries, Inc. Retiree Welfare Benefits Plan – Huntington Ingalls Industries Retiree Medical Plan

Summary Plan Description (SPD)

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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"), which is a Component Plan of the Huntington Ingalls Industries, Inc. Retiree Welfare Benefits Plan (the "Welfare Benefits Plan"). If you have questions that are not answered in this SPD, contact the HII Benefits Center at 1-877-216-3222 (outside the U.S. at 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 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 Company reserves the right to amend, modify, or terminate any and all parts of the Welfare Benefits Plan, including this Plan, at any time and for any reason.

The self-insured medical benefits (PPO and Medigap-Type options) provided under the Plan are described in detail in separate Benefits Booklets prepared by Anthem, a third party administrator. The self-insured pharmacy benefits provided under the Plan are described in a separate Summary Plan Description prepared in consultation with CVS/Caremark, a third party administrator. Insured benefits provided under the Plan (if any) are described in detail in the coverage certificate or subscriber contract through which those benefits are provided. These separate documents 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.

Copies of the following documents can be accessed online at http://hiibenefits.com or by calling the HII Benefits Center at 1-877-216-3222:

- Anthem High PPO Benefits Booklet
- Anthem Medium PPO Benefits Booklet
- Anthem Low PPO Benefits Booklet
- Anthem Medigap-Type Benefits Booklet
- Prescription Drug Program Plan Option Summary Plan Description

If there are any differences between the information contained in this SPD and any separate document, those documents will always govern. If there are any differences between the information contained in this SPD and the Welfare Benefits Plan document, the Welfare Benefits Plan document will always govern.

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.

Important Coverage Changes Beginning July 1, 2023!

Beginning July 1, 2023:

- The CDHP medical plan option was eliminated
- High and Low PPO medical plan options were added
- Prescription drug benefits are now included under each PPO medical plan option (i.e., PPO participants no longer have to separately elect prescription drug coverage)

As a result of these changes, the following transition rules applied for the '23-24 coverage period unless an eligible retiree elected otherwise:

- Retirees enrolled in Anthem Medium PPO or CDHP medical coverage were enrolled in the Anthem Medium PPO with prescription drug benefits
- Medicare eligible participants due to disability that were enrolled in CDHP medical coverage were enrolled in Medigap-Type coverage and in Prescription Drug Program coverage
- Retirees enrolled in Prescription Drug Program only coverage were required to enroll in a PPO medical plan option or waive retiree coverage for the 2023-24 coverage period (subject to the Plan's election change rules)

Mission Technologies Rebranding

As you read through this SPD, please keep in mind that beginning in April 2022, the Technical Solutions Division became known as the Mission Technologies Division. References in this document to "Mission Technologies Participating Companies" shall mean "TSD Participating Companies" for periods prior to April 2022. This change is not intended to otherwise impact the Plan's eligibility rules and the Plan shall be administered and interpreted in accordance with this intent.

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INTRODUCTION

Plan Highlights

New Participants Must Enroll for Retiree Medical Benefits

If you were not automatically enrolled as of the date of the Company Spin-Off, as described below, to receive retiree medical benefits for you and your family, you must actively enroll yourself and your eligible dependents in a medical plan option under the Plan. You are *not* automatically covered under the Plan, even if you satisfy the eligibility requirements. Generally, you are required to pay the full cost of coverage, but, in some cases, you and Huntington Ingalls Industries share the cost of coverage.

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 were automatically enrolled in the Plan on the date of the Company Spin-off and did not need to take any action. You and any eligible family members who were enrolled in the Northrop Grumman Plan on that date were automatically enrolled in the 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 was not available, you were automatically enrolled in the PPO and Prescription Drug Program plan options or, if Medicare-eligible, the Medigap-Type and Prescription Drug Program plan options.

Eligibility and Cost of Coverage

Pre-65 Retiree Eligibility

The Plan provides benefits for *eligible* retirees of Huntington Ingalls Industries, Inc. and related companies that participate in the Plan (collectively, the "Participating Companies" and individually a "Participating Company"). 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 in the table below are final and control in the***

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

event that there is any discrepancy with the eligibility provisions of a heritage company plan. The Huntington Ingalls Industries Administrative Committee, in its sole discretion, may (but is not required to) refer to and interpret the terms of any heritage company plan in order to resolve any question regarding eligibility under the Plan.

You will be eligible to participate in the Plan if you satisfy the following requirements:

- You begin employment with (and/or transfer employment to) a Participating Company, *and*
  - You terminate from active service with a Participating Company or Mission Technologies Participating Company at age 55 or older with a minimum of 10 years of vesting service; *or*
  - You terminate from active service with a Participating Company or Mission Technologies Participating Company and meet the eligibility provisions of a heritage company group (described below) at the time of termination.

Note: If you terminate from active service with a Participating Company or Mission Technologies Participating Company at age 65 or older with a minimum of 5 years of vesting service, you are **not** eligible to participate in the Plan, but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See the "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" and "Dependent Eligibility" sections for details. If you enroll in a Medicare Supplement Plan through Via Benefits, your pre-65 eligible dependents may be enrolled in coverage under the Plan.

Your years of vesting service will include your years of vesting service with Northrop Grumman Corporation prior to the Company Spin-off. "Years of vesting service" may also be referred to as "years of service" throughout this SPD.

Your eligibility to participate in the Plan terminates when you become Medicare-eligible as a result of turning age 65; however, you may be able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See the "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" and "Dependent Eligibility" sections for details.

Important - 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 (as described in the tables 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 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.

Participating Companies

Immediately below is a list of the relevant Participating Companies in the Plan. If you are employed by an entity that is **not** on this list, you will generally **not** be able to participate in the Plan (certain exceptions apply – see "Mission Technologies Participating Companies" below for details). If you have questions regarding your eligibility for the Plan, you may contact the HII Benefits Center at 1-877-216-3222 (outside the U.S. at 408-916-9765).

- HII Services Corporation (Entity 520 – also known as HII Corporate)
- Huntington Ingalls Incorporated – Ingalls Non-Represented (Entity 146)
- Huntington Ingalls Incorporated – Newport News Shipbuilding and Dry Dock Company Non- Represented (Entity 265)
- HII Mechanical Inc. (Entity 272)

Note! As indicated above, you must begin employment with a Participating Company to be eligible to participate in the Plan (i.e., you will **not** be eligible to participate in the Plan if you begin employment with a Mission Technologies Participating Company or any other Huntington Ingalls Industries entity that is not specifically listed as a Participating Company in the Plan).

Potential Heritage Subsidy Options

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 regardless of whether through Via Benefits.

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 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 regardless of whether through Via Benefits.

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,

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

- 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.

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 follow 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.

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

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 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 regardless of whether through Via Benefits.

Effective January 1, 2005, the Ingalls May 2003 incentive medical plan was frozen. If you and your eligible dependents were enrolled in that plan option, you could have remained covered under that plan option until you or a covered dependent became eligible for Medicare and enrolled in the Huntington Ingalls Industries Retiree Medical Plan. At that time, all covered family members were required to move to a Huntington Ingalls Industries Retiree Medical 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

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

coverage for himself or herself regardless of whether through Via Benefits. 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 group on or before June 30, 2003, and you terminate employment at age 55 with a minimum of five years of service.

- If 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 65, regardless of your years of service, you are **not** eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan, but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details. If you enroll in a Medicare Supplement Plan, your pre-65 eligible dependents may be enrolled in coverage under the Retiree Medical Plan.

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.

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

- 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 is 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 "Survivor Options" and "COBRA Continuation of Coverage" sections for additional details.

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.

- If 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 age 65 or older, regardless of your years of service, you are **not** eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan, but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details. If you enroll in a Medicare Supplement Plan, your pre-65 eligible dependents may be enrolled in coverage under the Retiree Medical Plan.

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.

- If 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 age 65 or older, regardless of your years of service, you are **not** eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan,

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

but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details. If you enroll in a Medicare Supplement Plan, your pre-65 eligible dependents may be enrolled in coverage under the Retiree Medical Plan.

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.

- If 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 65 or older with a minimum of 5 years of service, you are **not** eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan, but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details. If you enroll in a Medicare Supplement Plan, your pre-65 eligible dependents may be enrolled in coverage under the Retiree Medical Plan.

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 regardless of whether through Via Benefits. 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.

TRW Heritage (including Mission Systems and Space Technology)

- You were hired prior to January 1, 2005, 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.

- If you were hired prior to January 1, 2005, you were in a TRW heritage entity on or before December 31, 2004, and you terminate employment at age 65 or older with a minimum of five years of service, you are **not** eligible to participate in the Huntington Ingalls Industries Retiree Medical Plan, but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details. If you enroll in a Medicare Supplement Plan, your pre-65 eligible dependents may be enrolled in coverage under the Retiree Medical Plan.

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 LLC, 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 LLC 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.

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 at the time you terminate employment and retire. ***Please note, however, that your heritage subsidy decision is irrevocable. You may not change to another heritage subsidy in the future.***

Heritage eligibility and subsidies 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 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 considered for purposes of determining heritage eligibility.

Special Grandfathering for Former HII San Diego Shipyard Inc. Employees

In connection with the transaction that occurred on February 1, 2021, certain employees of HII San Diego Shipyard Inc. transferred employment to a non-Huntington Ingalls Industries-related entity – Continental Maritime of San Diego ("CMSD" – the "Transferred CMSD Employees"). Pursuant to the terms of the transaction, Huntington Ingalls Industries has agreed to preserve service crediting for the Transferred CMSD Employees provided that such employees continue to be employed by CMSD (i.e., Transferred CMSD Employees will continue to accrue vesting service on and after February 1, 2021, while employed by CMSD).

More specifically, Transferred CMSD Employees will continue to be eligible to participate in the Plan provided such employees satisfy **one** of the following requirements:

- The Transferred CMSD Employee terminates from active service with a Participating Company, a Mission Technologies Participating Company *or* CMSD at age 55 or older with a minimum of 10

years of vesting service; The Transferred CMSD Employee terminates from active service with a Participating Company, a Mission Technologies Participating Company *or* CMSD at age 65 or older with a minimum of 5 years of vesting service; or

- The Transferred CMSD Employee terminates from active service with a Participating Company, a Mission Technologies Participating Company *and* meets the eligibility provisions of a heritage company group at the time of termination.
    - A Transferred CMSD Employee is considered a Newport News Salaried heritage company group employee (and therefore qualifies for the NNS heritage subsidy) if the employee satisfies the following requirements:
        - The Transferred CMSD Employee was hired prior to January 1, 2004, and was in the Newport News heritage company group on or before December 31, 2003, *and*
        - The Transferred CMSD Employee terminates employment with CMSD at age 55 or older with 10 or more years of vesting service that were accrued after such employee turned age 45.

If an eligible Transferred CMSD Employee elects coverage under the Plan, the employee will generally be responsible for paying the **full cost** of coverage *unless* such employee was in the Newport News Salaried heritage company group and qualifies for a subsidy.

Vesting Service

For purposes of the Plan, vesting service, as may be accounted for under a Huntington Ingalls Industries retirement plan, is used to determine *eligibility* for retiree medical benefits and a heritage subsidy, as applicable. Accruing any particular amount of vesting service for retirement plan purposes, does *not* mean that you have earned a non-forfeitable right to any particular benefit under the Plan.

Vesting service includes all years of service earned while employed by a Participating Company or Mission Technologies Participating Company. Years of service generally include employment with a Participating Company or a Mission Technologies Participating Company, and also 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 a Participating Company, call the HII Benefits Center.

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 a Participating Company or Mission Technologies Participating Company (including paid sick leave, vacation time, jury duty, and, in some cases, certain qualified leaves of absence, such as military leaves, and medical leaves up to two years

from the beginning of the leave).

For example, let's assume:

- Date of hire: September 1, 2020
- Vesting hours as of December 31, 2020: 600
- Vesting hours in 2021: 1,900

In this example, the participant does not have 1,000 or more hours of vesting service in 2020, so he or she does not earn a year of vesting service for that year. In 2021, the participant has 1,900 vesting hours, so he or she does earn one year of vesting service for 2021.

Mission Technologies Participating Companies

As indicated above, you will only be eligible to participate in the Plan if you commence employment with (or transfer employment to) a Participating Company. Notwithstanding this Plan requirement, you will continue to accrue vesting service if you transfer employment to a "Mission Technologies Participating Company." The Plan will credit vesting service with these Huntington Ingalls Industries-related entities; however, initial employment with a Mission Technologies Participating Company does **not** satisfy the Plan's eligibility requirements, and an employee who begins employment with a Mission Technologies Participating Company will generally **not** be eligible to participate in the Plan and will **not** receive credit for vesting service earned with the Mission Technologies Participating Company prior to the time at which the employee initially becomes employed with a Participating Company.

For example, let's assume:

- You are hired by HII Energy Inc. on January 1, 2021.
- You transfer employment to HII Services Corporation on January 1, 2022.
- You retire from employment with HII Services Corporation on March 1, 2033 at age 56.

In general, you will be eligible for coverage under the Plan because you terminated from active service with a Participating Company at age 55 or older with at least 10 years of vesting service. Your service with HII Energy Inc. (a Mission Technologies Participating Company), however, will **not** be counted for purposes of Plan eligibility.

Immediately below is a list of the relevant Mission Technologies Participating Companies. If you have questions regarding vesting service crediting, you may contact the HII Benefits Center at 1-877-216-3222 (outside the U.S. at 408-916-9765).

- HII Energy Inc. (Entity 492)
- HII Nuclear Inc. (Entity 515)
- HII Technical Solutions Corporation (Entity 525)

If You Are Rehired

If you are originally hired by a non-Participating Company, and are later rehired by a Participating Company, you will begin to accrue vesting service as of your rehire date with the Participating Company.

If you subsequently transfer employment to a non-Participating Company and/or terminate and are again rehired by a non-Participating Company, you will generally **not** be eligible to participate in the Plan.

Remember – to be eligible to participate in the Plan you must, among other requirements, terminate from active employment with a Participating Company and/or Mission Technologies Participating Company.

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 the subsidy. If your transfer(s) 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. ***Please note, however, that 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 vesting service with a Participating Company or Mission Technologies Participating Company that is classified by Huntington Ingalls Industries as a "discontinued operation" for purposes of the Plan, you will be eligible to participate in the Plan **by paying the full cost of coverage** (i.e., you will **not** receive a contribution (heritage subsidy or stipend) from Huntington Ingalls Industries towards the cost of coverage).

If you terminate employment at age 65 or older with at least five years of service with a Participating Company or Mission Technologies Participating Company that is classified by Huntington Ingalls Industries as a "discontinued operation" for purposes of the Plan, you are not eligible to participate in the Plan, but are able to enroll in coverage under a Medicare Supplement Plan through Via Benefits without Company subsidy. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details. If you enroll in a Medicare Supplement Plan, your pre-65 eligible dependents may be enrolled in coverage under the Plan.

Layoff Provision

Employees who are laid off and meet the following requirements, are eligible for coverage under the

Plan:

- Employees who are laid off from a Participating Company or Mission Technologies Participating Company at age 53 or older with a minimum of 10 years of vesting service. Benefits may not start earlier than age 55, but the participant may defer coverage at the time of the layoff and enroll in coverage under the Plan when they turn age 55.
- Employees who are laid off from a Participating Company or Mission Technologies Participating Company before age 53 and the sum of whose age and years of vesting service is 75 or more. Benefits may not start earlier than age 55, but the participant may defer coverage at the time of the layoff and enroll in coverage under the Plan when they turn age 55.

Laid off 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 Plan:

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

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

Ineligible Retirees

You are not eligible for the benefits under the Plan if any of the following apply:

- You are covered as a dependent of an active Huntington Ingalls Industries employee. **Note!** 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 a Huntington Ingalls Industries entity and become eligible for active employee benefits. You may re-enroll in the Plan if you terminate employment in the future, in the same heritage group under which you originally enrolled, as applicable.
- You become Medicare-eligible as a result of reaching age 65. See "Transition to Via Benefits for Age 65 Medicare-Eligible Retirees" for details.

Transition to Via Benefits for Age 65 Medicare-Eligible Retirees

Eligibility under the Plan terminates when you become Medicare-eligible as a result of turning age 65. Certain medical and prescription drug benefits will be available to Medicare-eligible retirees and dependents through Via Benefits. Via Benefits is a marketplace where Medicare-eligible individuals can select a Medicare Supplement Plan from an array of insurance providers that provide medical and prescription drug benefits to Medicare-eligible individuals and their dependents in exchange for insurance premiums. Any Medicare Supplement Plan that such retiree enters into through Via Benefits is solely with the insurer selected by the Medicare-eligible retiree. ***In other words, Huntington Ingalls Industries is not a party to such Medicare Supplement Plans.***

Prior to turning age 65, you will receive additional information regarding Via Benefits and the Medicare Supplement Plan options available. For more information, please contact the HII Benefits Center at 1-877-216-3222.

Dependent Eligibility

Unless otherwise noted, eligible dependents may be covered under the Plan only if the retiree is also covered under the Plan *or* a Medicare Supplement Plan through Via Benefits. If the retiree voluntarily drops coverage, then coverage for the spouse and/or dependents is also terminated.

Dependent eligibility under the Plan terminates when the dependent becomes Medicare-eligible as a result of turning age 65. Coverage will be available for dependents under Medicare Supplement Plans through Via Benefits, Any Medicare Supplement Plan that such individual enters into through Via Benefits is solely with the insurer selected by the Medicare-eligible individual. ***In other words, Huntington Ingalls Industries is not a party to such Medicare Supplement Plans.***

If the retiree reaches age 65 prior to his or her covered dependents and the retiree enrolls in a Medicare Supplement Plan through Via Benefits, his or her covered dependents may remain enrolled in the Plan until they become Medicare-eligible as a result of turning age 65.

Failure by the retiree to timely enroll in coverage under a Medicare Supplement Plan through Via Benefits will result in the termination of coverage under the Plan for any remaining covered dependents. If, after enrolling in a Medicare Supplement Plan through Via Benefits, the retiree's coverage under such Medicare Supplement Plan terminates for any reason, coverage for any remaining dependents under the Plan will also terminate.

Prior to turning age 65, covered dependents will receive additional information regarding Via Benefits and the Medicare Supplement Plan options available. For more information, please contact the HII Benefits Center at 1-877-216-3222.

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

- You understand the eligibility requirements set forth below.
- The person you enroll meets the eligibility requirements set forth below.
- If the person ceases to meet the eligibility requirements you will *immediately* notify 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 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 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.
- 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 will be financially and legally responsible for all health care expenses incurred during the period of ineligibility, and you may be subject to criminal charges.

Note: All retirees with dependent coverage must comply with the annual dependent verification request for information in order for your dependent to remain eligible under the Plan. Failure to comply with request for documentation will result in loss of coverage for the dependent.

Eligible dependents include the following persons:

I. Your Spouse

(a) A person who is the legal 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 Plan.

(b) This definition includes your common-law spouse only if common-law status is recognized in your state of legal residency. You will be required to submit a Declaration of Informal Marriage 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, you must arrange coverage on your own or through COBRA, as described in the "COBRA Continuation of Coverage" section.

(c) A spouse acquired after the employee's termination or retirement may be added at full, unsubsidized cost (i.e., no subsidy provided). (Exception: A new pre-Medicare spouse may be added at subsidized rates for individuals who 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, pursuant to applicable Plan procedures, he or she may be added at the heritage spouse rate if applicable; 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:

(1) Be at least 18 years of age and not related to you by blood;

(2) Not be married to anyone else and not be the domestic partner of anyone else;

(3) 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; and

(4) Be your sole domestic partner and intend to remain so indefinitely.

Domestic Partner Tax Note: For domestic partner benefits, the IRS treats Company contributions towards coverage (if 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 under the Plan. Therefore, you may want to consult your tax and legal advisors to determine the impact to 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

(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 age 26 or older 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 will 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); AND

(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); AND

(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 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; AND

(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. A child of your domestic partner is eligible if the child is unmarried, lives with you and your domestic partner in a parent/child relationship, and if one of the following is true:

(a) The child is under the age of 19; OR

(b) The child is at least age 19, but under age 25, and a full-time student.

X. Children who must be covered under a 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. You can obtain, without charge, a copy of the procedures from the plan administrator.

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.

Dependents listed in III and IV are considered Category 1 dependents. Dependents listed in V, VI, VII, VIII, IX, and X are considered Category 2 dependents. See chart "When Coverage Ends" for the treatment of each category.

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 Plan, you have two options for your medical coverage:

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

Questions about Eligibility

If you have questions about eligibility for coverage under the Plan, please call the HII Benefits Center at 1-877-216-3222.

How the Plan Works

The following benefits are available under the Plan, as applicable:

- Medical
- Prescription drug
- Mental health and substance abuse benefits

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 due to disability
- Your coverage category:
  - Retiree Only (or Spouse Only/Domestic Partner Only)
  - Retiree + spouse/domestic partner
  - Retiree (or spouse/domestic partner) + child(ren)
  - Retiree + family (i.e., 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 Plan coverage.

When Coverage Ends

Coverage under the Plan ends on the date indicated for you and/or your covered dependents on the occurrence of any of the following events:

Event	Termination Date
Retiree reaches age 65	▪ Coverage for the retiree terminates at the end of the month prior to becoming Medicare-eligible as a result of turning age 65 ▪ Coverage for the dependent terminates at the end of the month prior to the retiree becoming Medicare-Eligible as a result of turning age 65, if the retiree does not enroll in a Medicare Supplement Plan through Via Benefits
Dependent reaches age 65	▪ Coverage for the dependent terminates at the end of the month prior to becoming Medicare-eligible as a result of turning age 65
Retiree coverage under a Medicare Supplement Plan through Via Benefits terminates for any reason	▪ Coverage for dependents under the Plan terminates on the date the retiree's Medicare Supplement Plan coverage terminates
Death of the retiree prior to reaching age 65	▪ Coverage for surviving dependents ends at the end of the month of the retiree's death (surviving dependents may continue coverage as described in the "Survivor Options" section or the "COBRA Continuation of Coverage" section)
Category 1 child reaches age 26	▪ Coverage for the child terminates at the end of the month in which the child turns age 26 (coverage may be continued as described in the "COBRA Continuation of Coverage" section)
Category 2 dependent reaches age 19 and does not qualify for full-time student eligibility*	▪ Coverage for the dependent 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 Continuation of Coverage" section)
Category 2 dependent who qualifies for full-time student status turns age 25*	▪ Coverage for the dependent terminates on the date your dependent turns 25 (coverage may be continued as described in the "COBRA Continuation of Coverage" section)
Category 2 dependent under age 25 no longer qualifies due to marriage or a full- time job that offers benefits coverage*	▪ Coverage for the dependent ends on the date of the event (coverage may be continued as described in the "COBRA Continuation of Coverage" section)

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

Category 2 dependent loses full-time student status due to a reduction in class hours or graduation and is between age 19 and age 25*	▪ Coverage for the dependent 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 Continuation of Coverage" section)
Category 2 dependent 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*	▪ Coverage for the dependent ends 12 months after the date of event (or earlier if the dependent reaches age 25, recovers, or otherwise becomes ineligible for coverage (coverage may be continued as described in the "COBRA Continuation of Coverage" section)
Retiree requests cancellation of coverage under the Plan	▪ Coverage for the retiree and all covered dependents ends on the first of the month following the request
Retiree fails to pay the required premium under the Plan	▪ Coverage for the retiree and all covered dependents ends if you fail to make a timely payment. Payments are due on the first day of each month, and, if your payment is not received within 30 days after the first day of the month (the "grace period"), coverage will be suspended effective as of the last day of the period for which payment was made. For example, if payment for May coverage is due May 1, and you fail to make the applicable payment by May 30, your coverage will be suspended retroactive to April 30. If this occurs, you will be responsible for any claims incurred after the date on which your coverage ends. You will have the opportunity to re-enroll in the Plan during the next annual enrollment period, or if you experience a qualifying life event. Re-enrollment will not result in the payment of claims incurred between the end of the period for which payment was made and the date re-enrollment is effective.
Retiree returns to active employment and is eligible for active benefits	▪ Coverage for the retiree and all covered dependents ends under the Plan as of the date benefits become effective under the Huntington Ingalls Industries Health Plan
Retiree fails to respond to a dependent verification or does not submit appropriate documentation timely	▪ Coverage for the dependent ends as of the communicated deadline to submit appropriate documentation (as described in the "Dependent Eligibility" section).

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

Retiree fails to confirm a Category 2 dependent's full-time student status during the annual student verification process	▪ Coverage for dependents ends as of October 1 of the year of the verification process (coverage may be continued as described in the "COBRA Continuation of Coverage" section) ▪ Coverage for the dependent may be reinstated during the next annual enrollment period or on the date the required documentation is provided to the HII Benefits Center
Your spouse/domestic partner loses eligibility due to a divorce or the end of a domestic partnership	▪ Coverage for the spouse/domestic partner ends on the effective date of the divorce or end of the domestic partnership (coverage may be continued as described in the "COBRA Continuation of Coverage" section)

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

Enrolling in Your Retiree Medical Plan Option

When You Can Enroll

You may select or change your medical plan option:

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

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 were automatically enrolled in the Plan on the date of the Company Spin-off and did not need to take any action. You and any eligible family members who were enrolled in the Northrop Grumman Plan on that date were automatically enrolled in the 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 was not available, you were automatically enrolled in the PPO and Prescription Drug Program plan options, or if Medicare-eligible, the Medigap-Type and Prescription Drug Program plan options.

Eligibility Date

The eligibility date is the earliest date that a retiree (or surviving dependent) is eligible to participate in the 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.

Type of Termination	Eligibility Date
Retirement, Quit, Discharge	▪ The first of the month coincident with or next following the employee's date of termination provided the employee meets the qualifications on the date of separation from active service.
Total and permanent disability (see requirements in the "Disability Provision" section)	▪ The first of the month following two years of disability.
Employee no longer covered as a dependent in the active plan	▪ The first of the month following the date he or she is no longer covered as a dependent in the active plan.
Layoff at age 53 or older with 10 years of service	▪ No earlier than the first of the month following the employee's 55th birthday. (Coverage may be deferred past age 55.)
Layoff prior to age 53 with 75 points	▪ No earlier than the first of the month following the employee's 55th birthday. (Coverage may be deferred past age 55.)
Death of a covered retiree (survived by a covered dependent)	▪ Coverage for the covered dependent(s) continues uninterrupted prior to their reaching age 65 as long as payments continue to be made as described in the "Survivor Options" section or the "COBRA Continuation of Coverage" section.
Death of an active employee who was eligible for retirement at the time of death (survived by a covered dependent)	▪ 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 Plan the first of the month following the end of any available extension of coverage under the active plan.
Deferred coverage at employment termination	▪ The first of the month following an election to participate.

If You Defer or Suspend Medical Coverage

When you initially become eligible for coverage under the 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 Plan and enroll at a later date if you lose coverage under your spouse's plan.

After you enroll in the Plan, you may suspend coverage and re-enroll. 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 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 enroll in the Plan. Retirees described in this paragraph who enrolled in the Plan prior to January 1, 2005, but suspended coverage on or after January 1, 2005, are not allowed to re-enroll in the Plan.

When You Can Enroll Your Dependents

You can add existing eligible dependents to the 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 (e.g., a new marriage or loss of other medical coverage). The change must 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, eligible dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll your new dependent, provided that you request enrollment and complete all enrollment steps 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. See "Special Enrollment Periods Under HIPAA" for more information.

The 31-day rule above is a special enrollment rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that the plan administrator has applied to the Plan. Under the 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.

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

To enroll your eligible 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 Plan, you must make an election by calling the HII Benefits Center 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 the sections below. If you timely enroll a child born to you or your spouse, coverage for the child will become effective on his or her date of birth, even if the child is in a hospital.

> **Note!** You must complete all steps required to enroll the child within 31 days after the date of birth. Simply calling the HII Benefits Center or adding the child to your account ***will not*** complete the child's enrollment.

Enrolling During Annual Enrollment Period

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 July 1 through the following June 30. Before the annual enrollment period begins, Huntington Ingalls Industries sends you a packet with information about your medical plan options, the associated costs, and instructions on how you can enroll.

Generally, if you do not make changes, your current coverage (if available) will carry over to the following 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 (i) Anthem Medium PPO with pharmacy benefits, or (ii) Anthem Blue Cross Medigap-Type option and the Prescription Drug Program, depending on your and your covered dependent's Medicare status.

Tobacco Certification

If you are a tobacco user (that means you smoke cigarettes or use other tobacco products or e-cigarettes), a tobacco user surcharge will be added to your medical plan option contribution amount. More specifically, a tobacco surcharge will be added to your monthly premium contribution for medical coverage unless you satisfy one of the following conditions: (1) during the annual enrollment period (and prior to July 1st) you report that you have been tobacco-free for six months;

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

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

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

From January 1 to June 30, your monthly premium contribution will not include the tobacco surcharge since you reported your tobacco-free status before the end of the calendar year.

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

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 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 HII Benefits Center at 1-877-216-3222. If you do not make your changes within 31 days, you must wait until the next annual enrollment period, unless a dependent is no longer eligible. In that case, coverage for the dependent will be discontinued retroactive to the date eligibility was lost, regardless of when the loss of eligibility was reported. For events reported after 31 days, no premiums will be refunded.

Special Enrollment Periods Provided Under HIPAA

Please note that the Plan 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 Plan in accordance with those rules as described below in this section, but is not required by HIPAA to do so.

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

- Lose eligibility for coverage under another group health plan,
- Lose the employer contribution toward another group plan's coverage, or

- Exhaust COBRA coverage under another group health plan (your COBRA coverage ends, but not because you failed to make the premium payment).

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

If you enroll in retiree coverage and you have a new eligible 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 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 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.

MEDICAL

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:

	Not Medicare-eligible	Pre-65 Medicare-eligible
Available nationwide	▪ Anthem High PPO with Rx ▪ Anthem Medium PPO with Rx ▪ Anthem Low PPO with Rx ▪ TRICARE Supplement	▪ Anthem Blue Cross Medigap-Type plan option ▪ Prescription Drug Program

Note! The Plan was amended, effective July 1, 2023, to reflect that non-Medicare eligible retirees may elect coverage under Anthem's High, Medium or Low PPO options, with each PPO option including prescription drug benefits. Pre-65 Medicare eligible retirees may elect prescription drug benefits under the Prescription Drug Program regardless of whether he/she enrolls in the Medigap-Type plan option. Prescription drug benefits are described in the Prescription Drug Program Plan Option Summary Plan Description.

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 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 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. See the "If You Defer or Suspend Medical Coverage" section 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 Plan. **If you do enroll in a separate Medicare Part D plan, your prescription coverage under this Plan will be terminated**.

The prescription drug coverage under the 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 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 HII Benefits Center for your share of the cost for coverage.

The amount of your contribution depends on your Huntington Ingalls Industries heritage status (if any), your Medicare status, the plan option you choose, and whom you choose to cover (your "coverage category"). For cost information, please call the HII Benefits Center at 1-877-216-3222.

Anthem High, Medium and Low PPO Medical Plan Options

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

Anthem Blue Cross administers the PPO medical plan options 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.

Prescription Drug Benefits. You automatically receive prescription drug coverage when you enroll in an Anthem PPO plan option (see "Prescription Drug Program Plan Option").

TRICARE Supplement Plan Option

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

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

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

- 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, under age 23 if a full-time student, or under 26 if enrolled in the TRICARE Young Adult (YA) program, 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, including dependent eligibility, call Selman and Company at 1-800-638-2610 or call the HII Benefits Center at 1-877-216-3222.

Selman and Company, 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.

Note! Once the retiree attains age 65 and becomes Medicare-eligible, coverage for the spouse and dependent children also ends, unless the retiree elects to enroll in a Medicare Supplement Plan through Via Benefits and enrolls his pre-65 spouse and dependents in another Plan option. If the retiree becomes Medicare-eligible for any other reason than attaining age 65, coverage for the spouse and dependent children also ends, unless the retiree elects to enroll in another Plan option. Continuation of TRICARE can be arranged directly with Selman and Company.

Medigap-Type Medical Plan Option (Medicare-Eligible)

If you are Medicare-eligible and under age 65, 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. You may need to begin the enrollment process up to three months before the month in which you become eligible in order for your coverage to be effective on the first day of that month. You may be eligible for Medicare prior to turning age 65 if you become disabled 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 Medicare enrollment status. You should contact Medicare at 1-800-633-4227 (TTY users: 1-877-486-2048) or visit **www.medicare.gov** for details regarding Medicare eligibility and enrollment.

For a summary of the Medigap-Type benefits provided by Huntington Ingalls Industries, refer to the Medigap-Type Benefits Booklet. For information on Medicare and Medigap plans in general, go to **www.medicare.gov**.

Prescription Drug Program Plan Option

Automatic PPO Prescription Drug Coverage

Prescription drug coverage is provided automatically when you enroll in an Anthem PPO medical plan option; you will **not** make a separate election to obtain prescription drug coverage when you enroll in an Anthem PPO. Prescription drug benefits are administered by CVS/Caremark and are described in the Prescription Drug Program Plan Option Summary Plan Description.

Medicare-Eligible Prescription Drug Coverage

The Prescription Drug Program is available to retirees and their eligible dependents if they are Medicare-eligible prior to age 65. This plan option, administered by CVS/Caremark, enables you and your eligible dependents to receive coverage for prescription drugs. **You must separately enroll in the Prescription Drug Program** option to receive prescription drug coverage. You may enroll in the Prescription Drug Program even if you do not enroll in the Medigap-Type plan option.

> **Note!** You do not need to enroll in Medicare Rx (Medicare Part D) to be eligible for this Plan option. In fact, **if you enroll in Medicare Rx (Medicare Part D), you will not be able to enroll in the Prescription Drug Program Plan option**.

More Information

For more information about the Prescription Drug Program, refer to the Prescription Drug Program Plan Option Summary Plan Description.

If You or Your Dependent Become Eligible for Medicare Prior to Age 65

If you or your dependent becomes eligible for Medicare prior to attaining age 65, 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 prior to age 65 the first day of the month following receipt of 24 months of Social Security Disability payments.

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

- **TRICARE Supplement Option:** (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. You and your non-Medicare-eligible dependents' coverage will continue.

Benefit Maximums

Overview

The Plan will not impose a lifetime dollar limit on essential health benefits. The Plan lifetime dollar limit on non-essential health benefits is the total amount the self-insured medical plan options (High, Medium, and Low PPO options, Prescription Drug Program options, and Medigap-Type options) pay for all benefits for each enrolled participant.

Note, however, that the Plan options may have lifetime and benefit plan year maximums on specific services. For more information about maximums, refer to those sections of applicable Benefits Booklet or summary.

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 Plan option, you agree to:

- Reimburse the Plan for the full amount of benefit payments made on your behalf in connection with the injury or illness for which you make a recovery;
- Provide any documents that allow the Plan to recover the payments it made to you or to a medical professional; and
- 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% 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
- Prostheses and treatment for physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

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

If you would like more information about the Women's Health and Cancer Rights Act, call the HII Benefits Center at 1-877-216-3222.

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

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

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

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

benefits after the primary plan has paid.

This 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 this 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 of both plans for the coordination of benefit rules under the plans.

These are some general guidelines:

	Huntington Ingalls Industries Retiree Medical Plan option	Your spouse's active medical plan option	Medicare pays...
If you are...			
Not Medicare-eligible	First	Second	Not applicable
Medicare-eligible	Third	First	Second
If your spouse is...			
Not Medicare-eligible	Second	First	Not applicable
Medicare-eligible	Third	First	Not applicable
If your child is...			
Not Medicare-eligible	First, if your birthday falls earlier in the year than your spouse's birthday; second, if your birthday falls later in the year than your spouse's birthday	First, if your birthday falls earlier in the year than your spouse's birthday; second, if your birthday falls later in the year than your spouse's birthday	Not applicable
Medicare-eligible	Third	First	Second

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

Coordination with Medicare for Pre-65 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 the applicable 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 this 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 re-

enroll, 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 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 Medical Plan 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 disability at the time you become eligible for Medicare due to end-stage renal disease, your Plan option pays primary for the first 30 months you are enrolled in (or eligible to enroll in) Medicare. Thereafter, the Plan 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 disability, Medicare will remain the primary payer.

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

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

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

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

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

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

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

GENERAL PLAN ADMINISTRATION

This section contains information on the administration of the Plan, as well as your rights as a participant. 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 Welfare Benefit Plan document, another Plan document, or in an insurance contract. Huntington Ingalls Industries has the discretionary authority to construe and interpret the provisions of the Plan, 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; and/or
- 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 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.

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.

The following sets forth general claims and appeals procedures that comply with the Employee Retirement Income Security Act of 1974 (ERISA). You must, however, follow the specific claims procedures established by the Claims Administrator (i.e., Anthem or CVS/Caremark). Failure to do so could result in a delay or loss of Plan benefits.

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 HII Benefits Center 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 within 15 months from date of service. For example, assume you incur a claim in April 1, 2024. You have until June 30, 2025 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.

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

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

- **Medical urgent claims**: Medical care is "urgent" if a longer time could seriously jeopardize the participant's life, health, or ability to regain maximum function. Also, care may be urgent if, in a doctor's opinion, it would subject the participant to severe pain if care or treatment were not provided. If you require care that is classified as being urgent, but do not submit enough

information for the claims administrator to make a determination, the claims administrator will notify you within 24 hours. You have 48 hours after that time to supply any additional information. Until you supply this information, the time limits that apply for the review are suspended (or "tolled").

- **Medical concurrent care decisions**: These are decisions involving an ongoing course of treatment over a period of time or a number of treatments. If you or your dependent is undergoing a course of treatment, or is nearing the end of a prescribed number of treatments, you may request extended treatment or benefits. If the course of treatment involves urgent care and you request at least 24 hours before the expiration of the authorized treatments, the claims administrator will respond to your claim within 24 hours. If you reach the end of a pre-approved course of treatment before requesting additional benefits, the normal, "urgent," "pre-service," or "post-service" time limits will apply, as described below.
- **Medical pre-service determinations**: A "pre-service" determination requires the receipt of approval of those benefits in advance of obtaining the medical care. If you request a review for pre-service benefits, but do not submit enough information for the claims administrator to make a determination, the claims administrator will notify you within 15 days. You have 45 days after that to supply any additional information. Until you supply this information, the time limits that apply to the claims administrator are tolled.
- **Medical post-service claims**: A "post-service" determination is made for benefits after you have already received care or treatment. A "post-service" determination does not require advance approval of benefits.

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

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

If Your Benefit or Administrative Claim Is Denied

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

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

- 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; and
- A description of the Plan's review procedures (including any external review process) and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA following an adverse decision at the final level of appeal.

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

- If the denial is based on an internal rule, guideline, protocol, or standard, the denial will say so and state that you can obtain a copy of the 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; and
- 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. Following are the timeframes that apply when you file an appeal.

Type of Claim	Time to Appeal from Date Claim Is Denied	Time for Decision on Appeal	Extensions for Claims Administrator, If Necessary
Medical: Urgent claims	180 days	72 hours	None
Medical: Pre-Service claims	180 days for each level of appeal	Two levels of appeal: 15 days from the receipt of the appeal for each level	None
Medical: Post-Service claims	180 days for each level of appeal	Two levels of appeal: 30 days from the receipt of the appeal for each level	None

Administrative	65 days	One level of appeal: 60 days from the receipt of the appeal	60 days

- **Urgent Medical Claims.** There is only one level of appeal that is required for urgent claims. You may file an urgent claim appeal with the claims administrator within 180 days if your initial claim for benefits is denied. Your appeal must be considered within 72 hours, with no extensions. You may file a lawsuit under ERISA if your appeal of an urgent claim is denied. However, if you wish, you may file a voluntary level 2 appeal of an urgent claim denial with the claims administrator within 180 days, and your appeal will be considered within 72 hours, with no extensions. For urgent claims, the level 2 appeal is voluntary – it is your choice to request it or not-and you are not required to file a voluntary level 2 appeal in order to file a lawsuit. If you would like additional information to help you decide whether to file a voluntary level 2 appeal of an urgent claim denial, please call the 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.
- **Administrative Claims.** There is one level of appeal. You may file an appeal with the claims administrator within 65 days after you receive the claim denial. Your appeal must be considered within 60 days, with a 60-day extension permitted, if necessary.

Claims and Appeals Contact Information

Claims Administrator	Claims	Level 1 Appeals	Level 2 Appeals
Anthem PPOs and Medigap-Type Medical Plan Options	All claims must be submitted to your local Anthem Blue Cross Plan. Please contact customer service with questions.	Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365	Anthem Blue Cross P.O. Box 4310 Woodland Hills, CA 91365
CVS/Caremark (Prescription Drug Program)	CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136	CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Fax: 1-866-443-1172	CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136 Fax: 1-866-443-1172
Administrative Claims	HII Benefits Center P.O. Box 64116 The Woodlands, TX 77387-4116	HII Administrative Committee Huntington Ingalls Industries, Inc. P.O. Box 64116 The Woodlands, TX 77387- 4116	N/A

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

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 was not 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;
- 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 discussion 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; and
- 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; and

- 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.

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

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, subject to any plan imposed limitations period. 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 Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Health Insurance Portability and Accountability Act (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 (PHI), includes virtually all individually identifiable health information held by the Plan — whether received in writing, in an electronic medium, or as an oral communication.

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 PHI without your permission for purposes of health care treatment, payment activities, and health care operations. The amount of PHI used or disclosed will be limited to the "minimum necessary" for these purposes, as defined under the HIPAA rules.

The Plan may disclose your PHI without your written authorization to Huntington Ingalls Industries for plan administration purposes. Huntington Ingalls Industries may need your PHI to administer benefits under the Plan. Huntington Ingalls Industries agrees not to use or disclose your PHI 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 PHI 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 is how additional PHI may be shared between the Plan and Huntington Ingalls Industries, as allowed under the HIPAA rules:

- The Plan 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 information that summarizes participants' claims information, but from which names (and other identifying information) have been removed.

- The Plan may disclose to Huntington Ingalls Industries information on whether an individual is participating in the Plan, or has enrolled or disenrolled in an option offered by the Plan.

In addition, you should know that Huntington Ingalls Industries cannot and will not use PHI obtained from the Plan for any employment-related actions. However, PHI 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 PHI 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.

PHI 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 will generally be given the opportunity to agree or object to these disclosures (although exceptions may be made: for example, if you are not present or if you are incapacitated). In addition, your PHI may be disclosed without authorization to your legal representative.

Except as described in the Huntington Ingalls Industries Retiree Medical Plan Privacy Notice ("Privacy Notice") and Plan document, other uses and disclosures of PHI 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 to the extent the Plan has taken action relying on it.

Your Rights Under HIPAA

You have the following rights with respect to your PHI the Plan maintains. These rights are subject to certain limitations, as discussed below.

- Right to request restrictions on certain uses and disclosures of your PHI and the Plan's right to refuse:
  - — You have the right to ask the Plan to restrict the use and disclosure of your PHI 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 PHI 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 PHI 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, send your written request to Huntington Ingalls Corporate HIPAA Privacy Officer, 4101 Washington Avenue, Bldg. 909-7, Newport News, VA 23607.
  - — 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 PHI created or received after you are notified that the Plan has removed the restrictions. The Plan may also disclose PHI about you if you need emergency treatment, even if the Plan has agreed to a restriction.
- Right to receive confidential communications of your PHI:
  - — If you think that disclosure of your PHI by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to allow you to receive communications of PHI from the Plan by alternative means or at alternative locations.
  - — If you want to exercise this right, send your written request to Huntington Ingalls Corporate HIPAA Privacy Officer, 4101 Washington Avenue, Bldg. 909-7, Newport News, VA 23607. You will be required to provide a statement that disclosure of all or part of the PHI could endanger you.
- Right to inspect and copy your PHI:
  - — With certain exceptions, you have the right to inspect or obtain a copy of your PHI 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 the Plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain

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

— If you want to exercise this right, send your written request to Huntington Ingalls Corporate HIPAA Privacy Officer, 4101 Washington Avenue, Bldg. 909-7, Newport News, VA 23607.

- Right to amend your PHI that is inaccurate or incomplete:

  — With certain exceptions, you have a right to request that the Plan amend your PHI 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 PHI 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, send your written request to Huntington Ingalls Corporate HIPAA Privacy Officer, 4101 Washington Avenue, Bldg. 909-7, Newport News, VA 23607. You will be required to provide a statement to support the requested amendment.

- Right to receive an accounting of disclosures of your PHI:

  — You have the right to a list of certain disclosures the Plan has made of your PHI. 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, send your written request to Huntington Ingalls Corporate HIPAA Privacy Officer, 4101 Washington Avenue, Bldg. 909-7, Newport News, VA 23607.

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 Huntington Ingalls Corporate HIPAA Privacy Officer, 4101 Washington Avenue, Bldg. 909-7, Newport News, VA 23607.

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 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 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 or CDHP).
- 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 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 your Plan coverage and coverage category (including adding eligible dependents) during the annual enrollment period 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 HII Benefits Center at 1-877-216-3222.

COBRA Continuation Period

Qualifying Event	Maximum Continuation Period		
	Retiree	Spouse	Child
You die	N/A	36 months	36 months
You and your spouse legally separate or divorce	N/A	36 months	N/A
Your child no longer qualifies as a dependent	N/A	N/A	36 months

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 Plan and the requirement of the federal law, these qualified beneficiaries can be added to COBRA coverage by contacting the HII Benefits Center. This notice must be provided within 31 days of birth, adoption, placement for adoption, or appointment as a legal guardian. The notice must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

If you fail to notify the HII 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

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 HII Benefits Center at 1-877-216-3222 within 60 days of the event so that COBRA can be offered and information on election rights can be mailed.

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.
- 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

In order to protect your and your family's rights, you should keep the HII Benefits Center informed of any changes in your or your family members' addresses. You should also keep a copy, for your records, of any notices you send.

Survivor Options

In the event of the covered retiree's death, the covered surviving 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 surviving 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 period or if he or she experiences a qualifying life event.

Notes

Covered dependent children may continue to 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 Plan provided that the surviving spouse pays the full cost.

Surviving spouses of Newport News Grandfathered Salaried retirees are eligible to continue coverage in this Plan until they remarry. Upon remarriage, the surviving spouse will be eligible for COBRA.

Future of the Plans

Huntington Ingalls Industries has the absolute right in its sole discretion to amend or terminate any benefit 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 will notify 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 HII Administrative Committee or a committee or persons authorized to take such action.

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 depends 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.

Administrative Information

General Plan Facts

Employer/Plan Sponsor	Huntington Ingalls Industries, Inc. **A list of the Huntington Ingalls Industries, Inc. affiliated companies that participate in the Plan is available upon written request to the Plan Administrator.**
Employer Identification Number (EIN)	90-0607005
Type of Plan	Welfare benefit plan
Type of Administration	Self-insured
Plan Administrator	HII Administrative Committee Huntington Ingalls Industries, Inc. P.O. Box 64116 The Woodlands, TX 77387-4116 1-877-216-3222
Agent for Service of Legal Process	Huntington Ingalls Industries, Inc. 4101 Washington Avenue Newport News, VA 23067 c/o Corporate Secretary Service of process may also be made to the Plan Administrator.

Benefit Plan Year	July 1 through June 30
Plan Name and Number	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.

Specific Plan Facts

Medical Plan	
Insured by:	Huntington Ingalls Industries self-insures the High, Medium and Low PPOs and Medigap-Type medical plan options.
Claims administered by:	Refer to the claims administrators and addresses provided in the chart under "Claims and Appeals Contact Information" in the "Benefit and Administrative Claims" section. For all other plan options, refer to your medical ID card for claims administration details.
Sources of contributions:	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.

Prescription Drug Benefits	
Insured by:	Huntington Ingalls Industries self-insures prescription drug benefits provided through the Prescription Drug Program.
Claims administered by:	For the Prescription Drug Program option, claims are administered by: CVS/Caremark P.O. Box 52136 Phoenix, AZ 85072-2136
Funded by:	Huntington Ingalls Industries and participant contributions.

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

GLOSSARY

Note! Terms included in this Glossary may be used in the Benefits Booklets/summaries that are referred to throughout this SPD. If there are any inconsistencies between the terms as defined here and in the applicable Benefits Booklets/summaries, the Benefits Booklet/summary's definition will apply.

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

Benefit plan year — The 12-month period from July 1 through June 30. The benefit plan year applies in determining when you can become a participant in the plan options. For the medical plan options, the benefit plan year is the period during which your deductible, out-of-pocket maximum, and annual maximums are tracked.

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

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 HII Benefits Center or the Huntington Ingalls Industries Administrative Committee.

Coinsurance — Your percentage share of the cost of eligible expenses. For example, in the Medium PPO plan option, 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.

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 Retiree Medical Plan and your spouse's employer's plan.

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

Coverage category — The number of family members, such as you only or you and family, that you enroll in the plan options. Coverage categories may vary under the Huntington Ingalls Industries Retiree Medical plan options.

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

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

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

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

Employer contribution — The amount Huntington Ingalls Industries contributes toward the premium cost of your benefits (if any).

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 the Plan. At Huntington Ingalls Industries, Plan fiduciaries may include employees who make certain discretionary decisions about the management or administration of the Plan.

Group — The employer (such as Huntington Ingalls Industries), union, trust, association, or organization

through which you and your dependents are entitled to benefit coverage.

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.

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.

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.

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.

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 Retiree Medical Plan and your spouse's employer's plan. Under this method, payments from the Huntington Ingalls Industries Retiree Medical Plan plus payments from the other plan do not exceed the amount the Huntington Ingalls Industries Retiree Medical 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.

HII Benefits Center— 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 HII Benefits Center at 1-877-216-3222 Monday through Friday from 9:00 a.m. to 6:00 p.m. Eastern time. The HII Benefits Center is closed on major holidays.

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

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

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

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

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

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 Huntington Ingalls Industries Administrative Committee is the plan administrator.

Plan options — The medical and prescription drug options available to you and your family within the Huntington Ingalls Industries Retiree Medical Plan.

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

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

Premium — The cost of your medical plan options. The medical plan options 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.

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.

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 option.

Subrogation — The Plan'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/retiree rights, and claims appeal procedures. This guide and the separate Benefits Booklets/summary comprise the SPD for the Huntington Ingalls Industries Retiree Medical Plan.