

NORTHROP GRUMMAN



Northrop Grumman Ship Systems
Avondale Operations
Health Plan for Represented Employees

SUMMARY PLAN DESCRIPTION

Benefits Effective April 1, 2007

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INTRODUCTION

The Northrop Grumman Ship Systems Avondale Operations Health Plan for Represented Employees (“Avondale Health Plan”) gives you and your eligible dependents access to the following benefits at competitive rates:

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

You have the flexibility to choose the coverage levels that are right for you, and Northrop Grumman shares the cost.

If you have questions not answered in this guide, contact the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194. If you are calling from outside the United States, please call 1-718-354-1338. Benefits service representatives are available to help you Monday through Friday from 9:00 a.m. to 6:00 p.m. Eastern time, excluding holidays. If you are hearing impaired, you will need to use a relay service through your TTY/TDD service provider.

Alternatively, you can contact your local Benefits Office. Office hours are 6:30 a.m. to 5:00 p.m. Monday through Thursday.

Plan Features

- **A large service network** — You have access to a large network of doctors and hospitals through Blue Cross Blue Shield of Illinois (BCBS). To find a participating doctor or hospital, call BCBS at 1-800-516-1269 or visit their Web site at www.bcbs.com.
- **Low-cost care** — You can see your primary care physician (PCP) or a specialist for only \$15 per visit. If you need hospital care, there are no deductibles or copayments for covered services. (Please note that all hospital services must be pre-authorized by CareWise at 1-877-321-7392.)
- **No claims to file** — There is no need to file claims when you visit BCBS doctors and hospitals — your provider will file them for you.
- **Benefits for out-of-area medical services** — If you travel outside the BCBS network area, you are covered by an indemnity plan for treatment received outside the network area. If you receive care from a provider in the network area, you must use network hospitals and physicians for any benefits. If you use non-network providers in the network area, you will be responsible for all charges.

- **Prescription drug benefits** — When you purchase prescription drugs from a participating Express Scripts pharmacy or through the Express Scripts Mail Service Program, Northrop Grumman pays a portion of the cost. To find a participating pharmacy near you, call Express Scripts at **1-800-655-1971**, or visit Express Scripts' Web site, which is accessible through *Benefits OnLine* at <http://benefits.northropgrumman.com>.
- **Benefits for mental and nervous conditions** — Through ValueOptions, you can receive 24-hour crisis intervention, evaluation, outpatient counseling, and inpatient mental health services. To learn more about this benefit, or to find a service provider, contact ValueOptions at **1-800-982-8161** or log on to their Web site, which is accessible through *Benefits OnLine* at <http://benefits.northropgrumman.com>.

***Benefits OnLine* — Your Benefits Information Resource**

Looking for information about your health benefits? Just log on to *Benefits OnLine* at <http://benefits.northropgrumman.com> and click on the "Health" tab at the top of the screen. The site provides links to health information, carrier sites (including Blue Cross Blue Shield, CareWise, Express Scripts, Benesyst Inc., and ValueOptions) and health forms.

If you need care...

Review the Summary Schedule of Benefits carefully to be sure that you understand how our program works. Please contact the NGBC at **1-800-894-4194** or your local Benefits Office.

IMPORTANT!

Notification of all non-emergency hospital admissions must be provided within 72 hours of the admission. Contact information is provided on the back of your medical identification (ID) card. Failure to notify the Plan could result in non-payment of claims.

GENERAL INFORMATION

Eligibility

Employee Eligibility

You are eligible to participate in the Avondale Health Plan if you are an employee of Northrop Grumman Ship Systems Avondale Operations who is covered by a collective bargaining agreement through the Metal Trades Council and who is regularly scheduled to work at least 20 hours a week. Represented employees who work at the Gulfport and Tallulah sites are also eligible to participate in the Avondale Health Plan.

You are not eligible for the benefits described in this guide if you are:

- Any employee who is covered under another Northrop Grumman health plan
- Any individual who is providing services pursuant to an oral or written contract or leasing arrangement with an unrelated employer, including any individual who under the Company's standard personnel practices is deemed a subcontractor or a leased employee
- Any individual who, under the Company's standard personnel practices, is deemed an independent contractor (without regard to such person's status for federal income tax purposes and without regard to any subsequent determination that such person is a common law employee of the Company) and
- Any individual who under the Company's standard personnel practices, is deemed a contractor, jobber, or consultant.

All determinations shall be made in the sole discretion of the Company in a uniform nondiscriminatory manner.

Dependent Eligibility

If you are eligible for the Avondale Health Plan, you also may cover your eligible dependents. Eligible dependents include:

- Your legally recognized spouse
 - This does not include your legally separated or divorced spouse, even if the separation agreement or divorce decree states that coverage must be provided. If the court orders you to provide coverage for your legally separated or divorced spouse, you must arrange for coverage on your own.
- Your unmarried children who are:

- Under age 19
- Under age 25 and are full-time students in an accredited school
 - Your child is considered a full-time student if he or she is enrolled in at least 12 hours of a regular curriculum that leads to a diploma or degree at an accredited high school, technical school, college, or university.
 - 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.
 - Your child is considered a full-time student during semester breaks if he or she was enrolled the prior semester, unless your child secures a full-time permanent job, gets married, does not enroll when school resumes, or is no longer supported by you.
 - Northrop Grumman reserves the right to ask for proof of full-time student eligibility. Failure to comply with this provision will result in loss of coverage for the dependent.
- Eligible children include:
 - Your natural and adopted children, regardless of where they live
 - Stepchildren who live with you.

Questions About Eligibility

If you have questions about eligibility for coverage under the Avondale Health Plan, call the NGBC at 1-800-894-4194.

Participation

Only eligible persons who enroll in the Plan and pay their share of the cost of the Plan are participants.

Effective Date of Coverage

Your coverage becomes effective on the first day of the month following completion of 30 days of service, provided you have completed and submitted your enrollment for coverage, and your share of the cost is paid by payroll deductions.

If you have enrolled eligible dependents, their coverage will be effective on your coverage effective date. To begin coverage for your enrolled dependents, the following documents must be submitted prior to the effective date of coverage:

Spouse: Marriage Certificate
Social Security Number

Child: Birth Certificate
Social Security Number

Dependent coverage under the Plan is entirely voluntary, unless a qualified medical child support order has been filed.

Special Note About Qualified Medical Child Support Orders (QMCSOs)

If you are required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide medical coverage for your child, you must contact the NGBC immediately at 1-800-894-4194. The Avondale Health Plan will comply with all the terms of a QMCSO. A QMCSO is an order or judgment from a court or administrative body, which directs the Plan to cover a child of a participant under the health Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedure for determining if the order is valid. Coverage under the Plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact your local Benefits Office. A copy will be provided to you without charge.

When Coverage Ends

Your coverage in the Avondale Health Plan ends at the end of the month when the first of these events occurs:

- Your employment ends
- You are regularly scheduled to work fewer than 20 hours a week
- You or your dependents are no longer eligible to participate in the Avondale Health Plan
- Your dependent no longer meets the definition

- You fail to make a contribution or authorize a payroll deduction for coverage, if required
- You reach the end of a continuation period during a leave of absence
- The Avondale Health Plan terminates.

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

Annual Enrollment

The benefit plan year is July 1 through June 30.

Annual enrollment for participants is typically held in May, with coverage changes effective on the next July 1. If you did not enroll for coverage when you first became eligible, you may enroll during the next annual enrollment period. You may also enroll eligible dependents who were not previously enrolled at that time. The first time you enroll, you must provide a birth certificate and Social Security number for each dependent child, and a marriage certificate and Social Security number for your spouse.

Qualified Life Events

After you select your before-tax benefits for the benefit plan year, you cannot make a change until the next benefit plan year unless you experience a qualified life event.

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

- Change in marital status, including marriage, divorce, legal separation, annulment, and death of spouse
- Change in number of dependents, including birth, adoption, and death of dependent
- Change in employment status (termination or commencement of employment) for you, your spouse, or your dependent
- Change in work schedule, including a reduction or increase in hours of employment for you, your spouse, or your dependent, a switch between part-time and full-time status, a strike or lockout, and beginning or returning from an unpaid leave of absence
- Inability of you or your dependent to meet the health care provider's coverage requirements due to a change in age, student status, or similar circumstances

- Change in residence or worksite for you, your spouse, or your dependent that results in a loss of coverage
- Enrollment by you, your spouse, or a dependent in Medicare or Medicaid resulting in a loss of coverage
- 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)
- Any other changes allowed by IRS regulations.

The benefit change you may make must correspond to your situation. For example, if you have a baby or get married, you can change your coverage category to add your new dependent.

You have 31 days from the date of the qualified life event to make your benefit changes through the Northrop Grumman Benefits Center (NGBC) at **1-800-894-4194**. If you do not make your changes within 31 days, you must wait until the next annual enrollment.

If you get married, you must provide the Benefits Office with a copy of the marriage certificate and your spouse's Social Security number within 31 days of the marriage. In the event of a birth or the adoption of a child, you must provide the Benefits Office with a copy of the birth certificate and Social Security number.

Notify the NGBC at 1-800-894-4194 immediately when you experience a qualified life event.

Method of Payment

The Plan is paid for partially by the Company and partially by participants. The cost of dependent coverage is paid by those participants who elect dependent coverage or who are subject to a qualified medical child support order.

For your convenience, your share of the cost for your coverage is deducted from your payroll check before taxes are withheld. If, for any reason, the cost for your coverage is not deducted from your payroll check, it is your responsibility to make payment. Failure to do so will result in automatic cancellation of your coverage.

Coordination of Benefits

The benefits you receive from the Avondale Health Plan 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 the Avondale Health Plan and his or her employer's plan). When this happens, the Plan uses a non-duplication of benefits provision to coordinate payments with the other plan.

Under the non-duplication of benefits provision, the Avondale Health Plan options consider the benefit payments you receive from another group plan. If the Avondale Health Plan is secondarily liable, it will pay benefits so that the combined benefits paid by both plans will not exceed the benefits that would have been paid solely under Avondale's plan. In other words, all deductibles and copayment provisions under the Avondale Health Plan are applied to the amounts it covers as a secondary plan.

- Automobile insurance of any type and homeowner's or renter's insurance that covers medical expenses always pays first, before the Avondale Health Plan.
- If your spouse is covered under his or her employer's plan, that plan pays first.
- If your dependent child is covered by both the Avondale Health Plan and your spouse's employer's plan, the following plan pays first:
 - The plan that has no coordination of benefits provision
 - The plan of the parent whose birthday falls earlier in the year.
- When the parents are divorced or legally separated, the following plan pays first:
 - The plan of the parent with a court decree establishing responsibility
 - The plan of the parent who has custody
 - If the parent with custody has remarried, then the plan of the parent who has custody, or the plan of the stepparent.

The Plan does not cover any expenses incurred by you or your dependents as a result of an injury or illness for which another party may be responsible for causing, in whole or in part, and expenses incurred by you or your dependents to the extent that such expenses are eligible for coverage or payment under the terms of any automobile medical, automobile no-fault, uninsured or underinsured motorist, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

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

- Reimburse the Plan for the full amount of benefit payments made on your behalf
- Provide any documents that allow the Plan to recover the payments it made to you or to a medical professional
- Provide any other assistance to the Plan in enforcing these rights and not do anything to hinder the Plan.

The legal term for the Plan's right of recovery is subrogation. The Plan has the right to recover 100 percent of the benefits paid or to be paid by the Plan in connection with the injury or illness for which another person or insurance company may be responsible. The Plan's subrogation rights apply to any and all payments made or to be made to the injured person or the person's heir, guardian or other representative relating to the injury or illness. This includes, but is not limited to, payments as a result of judgment or settlement and payments from any automobile, homeowners, business or other insurance policy, including the covered person's own insurance policy. The Plan's rights apply regardless of whether the payments are designated as payment for pain and suffering, medical benefits or other specified damages. The Plan has the right of first recovery, regardless of whether the covered person has been made whole. This means that the Plan is entitled to recovery before attorneys' fees and other legal expenses are paid and even if the amount paid or payable relating to the injury or illness is less than the individual's total loss, including medical expenses, lost wages, pain and suffering and other damages.

You must notify Blue Cross Blue Shield of Illinois 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.

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

Under federal law, Northrop Grumman 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 Caesarian 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, Northrop Grumman 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, Northrop Grumman 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.

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

Summary Schedule of Benefits

Your benefits are summarized below. If you live in or receive care in a BCBS network area, your care must be provided by an in-network service provider for the Plan to pay benefits, except in cases of emergency. If you travel outside the BCBS network area and receive care outside the network area, the Plan will pay for benefits as shown under “Out-of-Service Area” in the chart below.

Benefit	In-Network (EPO)	Out-of-Service Area (Out-of-Area Indemnity Plan)
Inpatient (Hospital)		
Semiprivate & Other Charges (semiprivate room and board maximum is 365 days)	100% coverage	80% after \$250 annual deductible
Individual Out-of-Pocket Maximum	N/A	\$1,250
Ambulance (covered only to nearest hospital and only when an emergency exists)	80% after \$250 deductible	80% after \$250 annual deductible
Outpatient		
Emergency Room Treatment for Accident/Sudden and Serious Illness	100% coverage after \$50 deductible	80% after \$250 annual deductible
Other Services		
Physician Office Visits (Minor Surgery, X-Ray and Laboratory in Doctor's Office)	100% coverage after \$15 copay per office visit (PCP or specialist); no deductible	80% after \$250 annual deductible
Cardiac Rehab	100% coverage after \$15 copay per office visit (PCP or specialist); no deductible	80% after \$250 annual deductible
Physical, Speech and Occupational Therapy (maximum of 60 visits)	100% coverage after \$15 copay per office visit (PCP or specialist); no deductible	80% after annual deductible
Chiropractic Care	50% of covered expenses to maximum of \$500 per benefit plan year	50% of covered expenses to maximum of \$500 per benefit plan year
Durable Medical Equipment (must have precertification)	80% after \$250 deductible per person per benefit plan year; \$1,500 annual maximum	80% after \$250 annual deductible per person per benefit plan year; \$1,500 annual maximum
Home Health	100% coverage	80% after annual deductible
Skilled Nursing (maximum of 50 days)	100% coverage	80% after annual deductible

Benefit	In-Network (EPO)	Out-of-Service Area (Out-of-Area Indemnity Plan)
Annual Deductible	\$0	\$250 per person
Covered Expense per Person per Benefit Plan Year	100% after applicable deductibles and copays	80% of the first \$5,000 after the deductible, then 100%
Maximum Out-of-Pocket Charges per Person per Benefit Plan Year	N/A	\$1,250
Lifetime Plan Maximum Benefit per Individual	\$1 million	\$1 million

How the Medical Plans Work

To get the most out of your medical plan option, it is important to understand how the option works and how much you will pay when you access care.

Plan Deductible

The Out-of-Area Indemnity Plan has an annual deductible of \$250 per person. The In-network EPO does not have an annual deductible.

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

There is also a separate deductible for prescription drugs. Refer to “Prescription Drug Benefits” for details.

Copayments (Copays)

In the In-Network EPO, for some services — such as physician office visits — you pay a copayment, or copay, directly to the provider. Other services are covered at 100%.

There is no limit to the amount of the copayments you pay in a benefit plan year. Copayments do not apply to your out-of-pocket maximum.

Coinsurance

In the Out-of-Area Indemnity Plan, after you meet the benefit plan year deductible (if applicable), the Plan pays a percentage of your eligible expenses, and you pay the remaining amount. The amount you pay is called coinsurance. Coinsurance amounts apply to your out-of-pocket maximum. For information about coinsurance amounts under the Plan, see the Summary Schedule of Benefits.

Out-of-Pocket Maximum

The Out-of-Service Area option has an out-of-pocket maximum equal to \$1,250 per person per plan year.

The out-of-pocket maximum is the most you pay in coinsurance for covered services during a benefit plan year. After you reach your out-of-pocket maximum, the Out-of-Area medical plan option will pay 100% of your eligible expenses for the rest of the benefit plan year.

Expenses credited toward your out-of-pocket maximum do not carry over from one benefit plan year to the next. You begin each benefit plan year with \$0 credited toward your out-of-pocket maximum.

The amount you pay toward your benefit plan year deductible is included in your out-of-pocket maximum.

Expenses That Do Not Count Toward Your Out-of-Pocket Maximum

These expenses do not apply to your out-of-pocket maximum:

- Copayments
- Charges that exceed the benefit maximum for services such as preventive, chiropractic, or private duty nursing care
- Ineligible expenses, such as the cost of cosmetic surgery or experimental procedures
- Charges for prescription drugs, including those covered through Express Scripts
- Any penalties you incur for not obtaining the appropriate preauthorization
- Expenses that exceed the usual, reasonable, and customary (URC) charge, as determined by the plan administrator
- Charges for mental health and substance abuse treatment.

Lifetime and Benefit Plan Year Maximums

Expenses incurred are applied toward the lifetime maximum, which is the total amount the Avondale Health Plan pays for each enrolled individual. The lifetime maximum is applicable to all self-funded Northrop Grumman medical plans.

Usual, Reasonable, and Customary Charges

Usual, reasonable, and customary (URC) means the “going rate” for medical services in your geographic area, as determined by the claims administrator. The Out-of-Area medical plan option provides coverage based on URC amounts. When your expenses exceed the URC charge, the Plan reimburses you at the appropriate coinsurance level for your expenses up to the URC charge. You pay 100% of the amount over the URC charge.

Eligible and Ineligible Medical Expenses

The Plan pays expenses that are considered eligible, medically necessary, and within the usual, reasonable, and customary (URC) limits, as determined by the claims administrator. You pay any deductibles, copayments, coinsurance, and penalties associated with eligible expenses. You also pay any expenses that are not eligible and amounts that exceed URC limits.

Eligible Expenses

The Plan pays benefits for the following eligible services and supplies for enrolled participants and eligible enrolled dependents. If you do not find an expense listed here or if you want specific information about the cost or coverage for a certain item, call your claims administrator at the number provided on your ID card.

- Allergy serum, when it is mixed by your physician and administered in the physician’s office. Allergy serum prescriptions filled by your pharmacist may be covered under the prescription drug program, with claims administered by Express Scripts.
- Ambulance service to a local facility for a life-threatening condition or a condition that could cause serious harm to your body. The medical plan options also cover air ambulance service to the nearest appropriate facility when this service is medically necessary. There is no coverage for ambulance use in non-emergency situations.
- Anesthesia and its administration.

- Attention Deficit Hyperactivity Disorder (ADHD) treatment, as the disorder is defined by the American Psychiatric Association, including physician visits and related therapy.

ADHD is covered under the medical plan through ValueOptions. To get a referral to a specialist or facility, and be reimbursed for eligible expenses quickly, you should seek treatment for ADHD from ValueOptions.

- Autologous chondrocyte implantation (ACI) surgery (joint replacement therapy) when medically necessary and approved by Blue Cross Blue Shield of Illinois.
- Biological serum (medicines and other injectables), when it is mixed by your physician and administered in the physician's office (otherwise, it may be covered under the prescription drug program administered by Express Scripts).
- Birth control, including diaphragms (device and fitting), IUDs, and DepoProvera, when the procedure is performed in the doctor's office (otherwise, it may be covered under the prescription drug program administered by Express Scripts).
- Blood and blood plasma (except for the storage of your own blood).
- Cardiac rehabilitation phases 1 and 2, when received as a hospital outpatient within three months after your discharge from the hospital for a heart-related condition.
- Case management services.
- Chiropractic services performed by a doctor of chiropractic (D.C.).
- Colon cancer screening, limited to one per year for level 1 screening and one every two years for level 2 screening (after age 50).
- Cosmetic/reconstructive surgery and resulting implants to:
 - Restore a bodily function
 - Correct functionally significant congenital deformities for a child born while parents are covered under the Plan
 - Correct conditions resulting from accidental injuries
 - Correct conditions resulting from surgical scars, tumors, disease, or previous therapeutic processes
 - Restore breasts in connection with a mastectomy, specifically:
 - Reconstruction of the breast on which the mastectomy was performed
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas.

- Cosmetic surgery performed mainly to change a person's appearance is not an eligible expense. However, medically necessary surgery that results from a previous cosmetic surgery is considered an eligible expense.
- Precertification is required for all cosmetic surgery. See "Precertification" for details.
- Dental services to treat injuries to natural, rooted teeth (excluding damage to dental implants such as dentures, crowns, and bridges) resulting from an accident, including services provided by a physician, dentist, or dental surgeon. This includes replacement of the teeth and any related X-rays. For your expenses to be eligible, you must receive treatment within 90 days of the injury and you must remain enrolled in the medical plan.
- Diagnostic X-ray and laboratory services ordered by a physician to diagnose an illness or injury.
- Dietary formulas for a participant who requires processed food to be administered with a feeding device. The dietary formulary must be the sole nutritional source.
- Durable medical equipment, including rental of equipment, such as a wheelchair, hospital bed, or oxygen equipment. If it is more economical to buy rather than rent, the Plan may cover the purchase of equipment that you need for an extended period of time. The medical plan also covers the repair and necessary maintenance of equipment if not provided under a manufacturer's warranty or a purchase agreement.
- Emergency room services for the treatment of emergencies. If you are admitted to the hospital after an emergency room visit, precertification must be obtained within 72 hours. See "Precertification" for details.
- Expenses resulting from congenital deformities.
- Heart pacemakers.
- Hemodialysis.
- Home health care services, including medical and nursing care (excludes custodial care, such as personal assistance with routine tasks) provided by a home health agency, when the skills of a registered nurse are required. Requires precertification for services after the first six visits immediately following an acute inpatient admission. See "Precertification" for details.
- Hospice care for terminally ill patients.

- Hospital or surgical center expenses, including inpatient and outpatient charges for:
 - Semiprivate room and board
 - Services and supplies furnished by the hospital or surgical center for medical care, and for inpatient and outpatient services, including:
 - Drugs and medicines administered in the hospital
 - Electrocardiograms and basal metabolism tests
 - Medical equipment
 - Newborn care
 - Operating rooms
 - Oxygen and anesthesia materials
 - Recovery rooms
 - Treatment rooms
 - Use of blood transfusion and physiotherapy equipment
 - X-rays and laboratory tests.

Inpatient hospital admissions and surgery require precertification. See “Precertification” for details.

- Human organ and tissue transplants when approved by CareWise (excludes coverage for donor’s charges).
- Inhalation therapy.
- Mammograms are eligible expenses when medically necessary or necessary to support a diagnosis. Coverage is provided for low-dose mammography screening, one per year after age 35, up to a maximum of \$150.
- Maternity, including expenses for enrolled mother and child (see “Newborns’ and Mothers’ Health Protection Act” for details).
- Mastectomy (see “Cosmetic/reconstructive surgery” to restore the breasts in connection with a mastectomy)
- Medical and surgical supplies, such as:
 - Blood and blood plasma
 - Casts and splints
 - Ostomy supplies (covered through the prescription drug program administered by Express Scripts)
 - Oxygen and rental of equipment for its administration, up to the purchase price

- Surgical dressings
- Trusses, braces, and crutches.
- Occupational therapy when medically necessary and provided by a licensed occupational therapist, up to 60 visits for each covered individual per benefit plan year.
- Oxygen (and delivery of oxygen, when medically necessary and cost-appropriate).
- Pap smears when medically necessary or necessary to support a diagnosis. The Plan covers up to two Pap smears per year; no referral needed.
- Physical therapy when medically necessary and provided by a licensed physical therapist, up to 60 visits for each covered individual per benefit plan year.
- Physicians' services, including physicians' fees for medical care or treatment, such as visits in the hospital, at home, or in the physician's office.
- Physician assistant services, if accepted medical practice in your state. Call your claims administrator for details.
- Prescription drugs, as described in "Prescription Drug Benefits."
- Prostate screening (one per year after age 50).
- Prosthetics and orthotics, e.g., artificial limbs, eyes, larynx, leg brace and ankle/foot brace.
- Radiotherapy and chemotherapy services, including charges for treatment and related materials, equipment, and facilities.
- Skilled nursing facilities, including charges for room, board, and miscellaneous expenses related to the stay. Your admission must be recommended by your physician. The medical plan options pay benefits based on eligible expenses for a semiprivate hospital room and limit each stay to 60 days per condition.
- Speech therapy when medically necessary and provided by a licensed speech therapist, up to 60 visits for each covered individual per benefit plan year, to:
 - Restore speech after a loss or impairment of a demonstrated previous ability to speak (except speech loss or impairment caused by a mental, psychoneurotic, or personality disorder)
 - Develop or improve speech after surgery to correct a defect that existed at birth and impaired, or would have impaired, the ability to speak.
- Sterilization, including voluntary procedures such as tubal ligation and vasectomy. (Reversal of sterilization is not covered.)
- Surgery and surgical procedures, including:

- Charges by a physician for performing a surgical procedure and for the physician's pre-operative and post-operative exams
- Assistant surgeon's and/or anesthesiologist's charges for services required for the surgery (surgical assistant's charges may be also be eligible in some states; call your claims administrator for details)
- Charges for cutting, suturing, and treating burns, correcting fractures, reducing dislocation, and manipulating joints under general anesthesia
- Charges for performing electrocauterization, tapping (paracentesis), applying plaster casts, performing voluntary sterilization, performing endoscopy, or injecting sclerosing solution.

All inpatient surgery requires precertification. See "Precertification" for details.

- Transplants through the Centers of Excellence program that are not experimental or investigational. Precertification is required prior to the evaluation and work-up for the transplant. See "Precertification" for details.
- Urgent care facility services.

Ineligible Medical Expenses

The Plan is not designed to cover every expense you might have, nor is it designed to duplicate or overlap benefits provided by other insurance coverage you have, such as workers' compensation, government plans, or student and auto insurance plans. By not duplicating health plan coverage, it helps to hold the cost down and enables us to have coverage available for the time when you really need it.

The medical plan options limit or exclude some medical treatments, services, and supplies. The following list provides some examples of items that are not eligible for reimbursement; however, this list is not all-inclusive. If you do not find an item listed, call your claims administrator at the number provided on your ID card to determine if it is eligible under your medical plan option.

Ineligible treatments, services, and supplies include:

- Abortion, including surgical and non-surgical means.
- The cost of acupuncture and acupressure treatment.
- The cost of ambulance service for non-emergencies or patient convenience.
- Amniocentesis.
- Expenses related to artificial organs — other than limbs, larynx, and eyes — including surgery and related expenses for any type of artificial organ transplant.

- Breast implant removal or insertion except as described under “Important Notice About the Women’s Health and Cancer Rights Act.”
- The cost of caffeine or nicotine addiction, withdrawal, or dependence-related care, including prescription and non-prescription drugs.
- Charges above the usual, reasonable, and customary (URC) limits, as determined by the claims administrator in its sole discretion.
- Charges for an injury incurred while committing a crime.
- Charges for services or supplies that are not medically necessary, as determined by the claims administrator in its sole discretion.
- Charges for services that are not ordered by a physician for the diagnosis, care, or treatment of an illness, injury, or pregnancy.
- Charges that you are not legally required or obligated to pay, or charges that would not have been billed, such as for free immunizations provided at a local clinic or drugstore.
- The cost of comfort or convenience equipment or supplies, such as exercise and bathroom equipment, seat-lift chairs, air conditioners, humidifiers, dehumidifiers, and purifiers, hot water bottles, rubber gloves, shoes or related corrective devices, spas, computer “story boards” or “light talkers.”
- Expenses related to cosmetic/reconstructive surgery, except as described under “Eligible Medical Expenses.”
- Expenses related to court-ordered treatment, unless certified as medically or psychologically necessary.
- Expenses related to custodial care or maintenance therapy, including care for conditions not typically responsive to treatment.
- The cost of dental services, except those described under “Eligible Medical Expenses.” (This exclusion encompasses shortening or lengthening the maxilla or mandible for cosmetic purposes or correction of malocclusion.)
- Expenses related to educational programs for mental impairment or for developmental disorders such as cluttering and stuttering.

- Expenses related to experimental or investigational services or supplies. Any of the following criteria may be cause for classification as experimental or investigational:
 - Requiring federal or other governmental body approval, such as drugs and devices that do not have unrestricted market approval from the Food and Drug Administration (FDA) or final approval from any other governmental body for use in treatment of a specified condition; any approval that is granted as an interim step in the regulatory process is not a substitute for final or unrestricted market approval
 - Insufficient or inconclusive scientific evidence in peer-reviewed medical literature to permit the claims administrator's evaluation of the therapeutic value of the service or supply
 - Inconclusive evidence that the service or supply has a beneficial effect on health outcomes
 - Evidence that the service or supply is not as beneficial as any established alternatives
 - Insufficient information or inconclusive scientific evidence that, when utilized in a noninvestigational setting, the service or supply has a beneficial effect on health outcomes and is as beneficial as any established alternatives.

The claims administrator, in its sole discretion, determines whether services or supplies are experimental or investigational.

- Expenses related to eye surgery (such as radial keratotomy), eye glasses, hearing aids, or examinations for the prescriptions or fitting of eye glasses or hearing aids, or services or supplies for cosmetic purposes.
- The cost of foot treatment for:
 - Weak, strained, flat, unstable or unbalanced feet, metatarsalgia, or bunions (except open-cutting operations)
 - Corns, calluses or toenails, except the removal of nail roots and necessary services prescribed by a physician (M.D. or D.O.) to treat metabolic or peripheral-vascular disease.
- Expenses related to home health aides, private duty nursing, or a convalescent nursing home.
- The cost of homeopathic or related treatment.
- The cost of treating any illness or injury related to employment that is covered under workers' compensation or similar laws.
- Expenses related to infertility administration fees, such as egg and sperm costs and donor search fees.

- Expenses related to the installation or maintenance of electrical power, water supply, or sanitary waste disposal systems.
- Charges for massage therapy.
- Morbid obesity or treatment in obesity clinics, and any treatment for weight loss.
- The cost of care for the newborn child of an employee's enrolled dependent child, unless the newborn becomes an eligible dependent of the employee under the Avondale Health Plan.
- Nursing homes.
- The cost of over-the-counter medications or dietary supplements that do not require a prescription by law.
- Expenses related to penalties for failure to comply with precertification procedures (see "Precertification" for details).
- Expenses related to periodontal or periapical disease, or any condition other than a malignant tumor involving teeth, surrounding tissue or structure, except as described under "Eligible Medical Expenses."
- Personal nonmedical expenses, such as telephone and television charges while in a hospital.
- Fees for physician assistant services, if not accepted medical practice in your state.
- Physician charges for duplicating records.
- The cost of radial keratotomy (RK), photo refractive keratectomy (PRK), astigmatic keratectomy (AK), LASIK, or other similar surgical procedures to improve or correct vision problems.
- Expenses related to the reversal of voluntary sterilization.
- Routine physical checkups or health examinations.
- The cost of services furnished by a hospital or facility operated by the U.S. government or any authorized agency of the U.S. government or furnished at the expense of such government or agency, unless payment is legally required.
- The cost of services or supplies that any school system provides as required by law.
- The cost of services or supplies provided by any Northrop Grumman Medical Department.
- Charges related to services or treatment rendered by you or your spouse, child, parent, parent-in-law, brother, sister, brother-in-law, or sister-in-law.
- The cost of services received before coverage begins or after coverage ends.

- Expenses related to physical, occupational, or speech therapy for maintenance purposes.
- Expenses related to speech therapy to correct pre-speech deficiencies or to improve speech skills not fully developed, such as stuttering.
- Expenses related to transsexual surgery (sex-change operations), including counseling or therapy before or after the surgery.

The plan administrator shall have the sole and exclusive power to exercise discretion as to claims for coverage for any other items not specifically listed above. You should contact the following providers before obtaining a service or treatment if you have a question about whether the Plan covers the service or treatment.

Treatment/Benefit	Precertification required?	Who to contact with questions about coverage and/or precertification
Medical (e.g., doctor/specialist visit, excluding hospitalization)	No	Blue Cross Blue Shield (BCBS) 1-800-516-1269
Hospitalization (except for maternity, as described under "Newborns' and Mothers' Health Protection Act"), Home Health Care, Hospice, Skilled Nursing Facility	Yes	CareWise 1-877-321-7392
Mental and Nervous	Yes	ValueOptions 1-800-982-8161
Prescription Drugs	No	Express Scripts 1-800-655-1971

Ambulance Service

The EPO Plan and Out-of-Area Indemnity Plan cover ambulance service for emergency transportation to the nearest hospital where adequate care can be provided. For instance, if you have a heart attack, you will be brought to the nearest hospital that is equipped to stabilize your condition. Afterwards, if necessary, you may be transferred to another hospital that has a cardiac care unit.

The Plan does not cover ambulance service in non-emergency situations. In an emergency situation, 80% of your costs will be covered after you meet a \$250 deductible.

Emergency Room Coverage

The cost of emergency room care is covered 100% in-network after you pay a \$50 deductible. If you receive emergency room care outside the BCBS network, the Plan will pay 80% after you meet the annual deductible (\$250).

Precertification is required within 72 hours of an emergency hospital admission. See “Precertification” for details.

What Is an Emergency?

The emergency room is designed for the treatment of acute emergency conditions and, as a result, is more expensive. Avoid using the emergency room for routine treatment that your doctor can provide — even if your doctor’s office is closed. Depending on the state in which you live, you may be able to visit an urgent care center for routine treatment at times when your physician is unavailable.

An emergency is defined as “urgently needed medical services to sustain life or to prevent critical illness or injury.” For example, emergencies may include:

- Sudden and severe pain or injury, including obvious fractures
- Sprains
- Chest pain in an adult
- Severe shortness of breath or difficulty in breathing
- Severe or prolonged bleeding (e.g., cuts that require stitches)
- Loss of consciousness
- Convulsions.

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

Emergency Care While Traveling Outside Your Network Area

If you travel outside the BCBS network area and require emergency room care, your emergency room costs will be covered under the Out-of-Area Indemnity Plan (80% after the annual deductible). If you are admitted to the hospital, precertification is required within 72 hours of the emergency admission.

Precertification

Precertification is required for the following medical procedures:

- Hospital admissions and increases in lengths of stay (except for maternity, as

described under “Newborns’ and Mothers’ Health Protection Act”).

- Inpatient surgery
- Skilled nursing facility care
- Private duty nursing
- Home health care.

Precertification is also required within 72 hours of an emergency-based hospital admission or surgery.

If you do not receive precertification, you pay 100% of the cost for care.

CareWise manages the precertification process. In most cases, your provider will contact CareWise for precertification. Ultimately, however, precertification is your responsibility – not the doctor’s or hospital’s responsibility. You should always confirm that the pre-certification has been done.

Precertification helps manage medical costs by confirming the need for things like medical necessity and duration. For more information, call CareWise at 1-877-321-7392.

Precertification is required for certain mental health or substance abuse care through ValueOptions. See “Mental and Nervous Conditions” for details.

Case Management

CareWise will review your treatment and work with your doctors to determine the appropriateness of your treatment and length of your stay in the hospital, if applicable. CareWise will also work with you and your doctor to help you obtain the right follow-up care and services. This is called Case Management. The Plan provides you with access to the case management program at no cost, and is mandatory only in situations in which claims exceed or are expected to exceed \$250,000. Although participation is voluntary in other situations, you are encouraged to take advantage of the program to ensure benefits coverage for situations involving complex medical treatment.

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

- Review your medical needs to ensure that your treatment plan incorporates the best practices available and that you have the resources you need to comply with

your treatment plan

- Coordinate all your health care and ensure consistent quality care
- Help you navigate the health care system and make sure you obtain the highest level of coverage possible.

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

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

For more information about case management, call CareWise at **1-877-321-7392**.

Prescription Drug Benefits

The Plan provides benefit coverage for medically necessary prescription drugs. Express Scripts serves as the claims administrator for prescription drug claims. "Covered" drugs are those that are necessary for the treatment of a disease or illness, and are widely accepted as effective, appropriate and essential, based on the recognized standards of the medical community and as approved by Express Scripts for reimbursement. In addition, the drug therapy must be prescribed by a licensed physician, and must be in accordance with type, frequency and duration-of-treatment guidelines of national medical, research and governmental agencies. The Plan allows you to purchase covered prescription drugs from:

- Any Express Scripts participating pharmacy
- The Express Scripts Mail Service Program.
- CuraScripts Specialty Pharmacy Program

Your prescription drug coverage depends on where you purchase your prescriptions, and whether you purchase generic or brand-name drugs.

Note: Purchases from a non-participating pharmacy are not covered.

Purchases from a Participating Pharmacy

Express Scripts' network includes more than 55,000 retail pharmacies, including most major chain pharmacies and more than 20,000 independent community pharmacies. If you would like a list of pharmacies to confirm that a particular pharmacy continues to

participate in the Express Scripts network or to find the pharmacy closest to you, call Express Scripts at 1-800-655-1971.

You can also visit the Express Scripts Web site, which is accessible through *Benefits OnLine* at <http://benefits.northropgrumman.com>.

You must present your Express Scripts ID card and pay your coinsurance when you purchase your prescription at a Express Scripts participating pharmacy.

Express Scripts Prescription Drug Coverage	
What you pay if you go to a <i>retail pharmacy</i> (Use a retail pharmacy when you need to have a prescription filled immediately and for short-term medications.)	
Deductible	
Individual	\$250
Family	\$500 (two family members must meet the individual \$250 deductible before family deductible is satisfied)
Generic (30-day supply)	10% coinsurance (plan pays 90%)
Preferred brand (30-day supply)	20% coinsurance (plan pays 80%)
Brand (30-day supply)	20% coinsurance (plan pays 80%)
What you pay if you use the <i>Express Scripts Mail Service Program</i> (Use the Mail Service Program for your maintenance and/or long-term prescription drugs.)	
Deductible	
Individual	\$250
Family	\$500 (two family members must meet the individual \$250 deductible before family deductible is satisfied)
Generic (90-day supply)	10% coinsurance (plan pays 90%)
Preferred brand (30-day supply)	20% coinsurance (plan pays 80%)
Brand (30-day supply)	20% coinsurance (plan pays 80%)

If you want to switch your prescription from an out-of-network pharmacy to a Express Scripts participating pharmacy, go to the Express Scripts pharmacy you wish to use and tell the pharmacist where your prescription is currently being filled. The pharmacist will call the other pharmacy and switch your prescription for you.

Prescription Drugs That Are Not Covered

This prescription drug plan does not cover every prescription written by a physician.

Drugs that are not covered include:

- Vitamins and minerals
- Fluoride supplements
- Growth hormones (unless the drug is considered medically necessary by your doctor for your treatment of a disease or illness other than growth failure, deficiency in size, strength, bone mass or similar deficiency, and you obtain pre-authorization from Express Scripts)
- Immunization agents
- Levonorgestrel (Norplant)
- Minoxidil (Rogaine)
- Non-prescription drugs other than insulin
- Charges for administration or injection of any drug
- Drugs labeled “caution — limited by federal law to investigational use” or experimental drugs, even though a charge is made to the insured
- Drugs readily available “over-the-counter” regardless of whether written in prescription form
- Retin-A
- Appetite suppressants.

Express Scripts Mail Service Program

If you take any prescriptions on a regular basis — such as medications for high blood pressure or diabetes — you can save time and money by using the Express Scripts Mail Service Program.

When you purchase prescriptions from the Express Scripts Mail Service Program, you receive up to a 90-day supply of your medication for the cost of a 30-day supply, after you meet the deductible.

How to Use the Mail Service Program

To get the most value from the program, you must plan ahead and leave enough time for delivery. Here is how:

1. If you need your medicine immediately, ask your physician for two prescriptions — one for a short-term supply and one for mail service, which provides up to a 90-day supply with three refills.

2. Fill your short-term prescription at a Express Scripts pharmacy and pay the applicable copayment or coinsurance.
3. Complete a Mail Service Order Form and mail the form, the original mail order prescription (not a copy), and your copayment or coinsurance amount in a pre-addressed Express Scripts envelope. Call Express Scripts at **1-800-655-1971** to determine the amount of your copayment or coinsurance and to request forms and envelopes.

If you are traveling, you can have your prescription mailed to an address other than your home address (within the United States). Include the alternate address on your Mail Service Order Form or call Express Scripts at **1-800-655-1971**. (Prescriptions cannot be mailed outside the United States, so you must reside in the United States to be eligible for the Express Scripts Prescription Drug Program.)

4. You will receive your mail order prescription by mail in two to three weeks. You will receive a 90-day supply unless your physician prescribes a smaller supply or the law limits the supply of a particular drug. (Allow a few extra days for your first prescription or for a prescription that is shipped during a holiday period.)

In some instances, Express Scripts may contact your physician to request authorization to substitute one prescription drug for another. Each mail order prescription may be refilled up to three times, depending on how your doctor writes the prescription.

5. To refill eligible prescriptions, call **1-800-655-1971** or **1-800-344-8075** or go to the **Express Scripts Web site**, which is accessible through *Benefits OnLine*, if you pay by credit card. You must provide your ID number (from your plan ID card), your date of birth, and your credit card information.

If you pay by check or money order, you will need to submit another Mail Service Order Form for the refill. You can use the refill label, form, and envelope provided in your previous order.

The earliest you can refill your prescription is the date indicated on your prescription label. So, it is important to plan ahead when ordering through the mail. Mark your calendar in advance, so you do not run out.

If you are currently receiving prescription medications through a mail service program other than Express Scripts, ask your doctor to write a new prescription (for up to a 90-day supply *plus* refills) for the Express Scripts Mail Service Program.

Pre-authorization

Before filling a prescription, you may be required to obtain pre-authorization that the drug you have been prescribed is medically necessary. To find out if you need to obtain pre-authorization, call Express Scripts at 1-800-655-1971.

Special Note About Medicare Prescription Drug Choices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, you have more choices about your prescription drug coverage. Please review the important notice available at *Benefits OnLine* at <http://benefits.northropgrumman.com>. The notice contains important information about your Northrop Grumman prescription drug coverage and Medicare Part D prescription drug coverage. Please note that you may obtain a paper copy of the notice free of charge by calling the Northrop Grumman Benefits Center at 1-800-894-4194.

Mental and Nervous Conditions

ValueOptions is the exclusive provider of coverage for mental and nervous conditions, and the exclusive provider of chemical dependency treatment.

In order that treatment for mental and nervous conditions be covered by the Plan, treatment must be precertified and provided by ValueOptions. There is no plan benefit for services received from other sources.

To obtain information about services, arrange an evaluation appointment, or in the event of a mental health crisis, call ValueOptions at 1-800-982-8161.

Benefits

The benefits shown in the following chart are available only if precertified and provided by ValueOptions.

Benefit Type	Benefit Amount	Family Benefit Plan Year Deductible
Inpatient <ul style="list-style-type: none">■ Inpatient Mental Health Services■ Detoxification (employees only, no dependent coverage; maximum of two episodes per lifetime)	\$80 per day, up to a maximum of \$1,000 per admission, after deductible	\$250 for inpatient; \$250 for outpatient
Outpatient <ul style="list-style-type: none">■ 24-Hour Crisis Intervention■ Evaluation and Outpatient Counseling (maximum of 50 visits per year)	80% of charges after deductible	

IMPORTANT!

For information on coverage, contact ValueOptions at 1-800-982-8161.

Flexible Spending Accounts

Flexible spending accounts (FSAs) let you pay certain health and dependent day care expenses with before-tax dollars. Because you do not pay taxes on these dollars, you save money.

Through payroll deductions, you can set aside money in the FSAs to cover eligible health care and dependent day care expenses. The money comes out of each paycheck – before taxes – and is credited to a special account. You can withdraw money from the account to reimburse yourself for eligible expenses.

Overview

Your Options

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

- Set aside \$0 to \$5,000 of your before-tax dollars in the health care FSA for reimbursement of your eligible health care expenses
- Set aside \$0 to \$5,000 of your before-tax dollars in the dependent day care FSA for reimbursement of your eligible dependent day care expenses.

You can enroll in one or both of the FSAs — or you can choose not to participate — when you are first hired and during annual enrollment. Your choice remains in effect for the entire benefit plan year, and you cannot make changes until the next annual enrollment, unless you experience a qualified life event.

At the time of a qualified life event, you may have a negative balance in your health care FSA. A negative balance occurs when you contribute less money to your account than you receive in reimbursements. In this case, any changes you make to your contributions must allow you to repay the negative balance by the end of the benefit plan year.

Your Contributions

If you choose to enroll in one or both of the flexible spending account (FSA) options, your contributions are deducted from your paychecks on a before-tax basis throughout the year. The money then is credited to an account in your name.

You can contribute as little as \$52 each year to one or both FSAs. The most you can contribute is the smallest of the following:

- \$5,000
- Half your annual salary
- Your annual taxable income if you earn less than \$5,000.

Additional limits may apply to the dependent day care FSA if you are married. See “Contribution Limits if You Are Married” for details.

If you begin participating in an FSA at any time during the benefit plan year, your maximum contribution is the annual maximum of \$5,000 for the benefit plan year. For example, suppose you have a qualified life event effective February 1, and you enroll in the health care FSA. Your participation in the account will continue for five months (21 weeks), until June 30 (the end of the benefit plan year). You can elect from \$52 to \$5,000 for the remainder of the benefit plan year. The annual contribution amount you elect will be divided by the number of paychecks remaining, and deducted accordingly.

If you go on an unpaid leave of absence, your FSA contributions will stop while you are on leave, unless you elect COBRA for the HC FSA. When you return to work, your FSA contributions will be recalculated and reinstated. Your new contribution amount will be based on the number of pay periods remaining in the plan year, and is likely to be higher than your per-pay-period contributions from before you went on leave, since the remaining annual amount would be divided among fewer pay periods. When you return from leave, you can make a new election, but the new election amount cannot be less than the total of any reimbursements you have already received.

Health Care Flexible Spending Account

You can use the health care flexible spending account (FSA) for health care expenses that would be considered eligible deductions on your federal income tax return, but are not reimbursed by another health plan. For example, you can use the account for your out-of-pocket costs, including deductibles, coinsurance, and copayments.

You can also use the account to pay for expenses even if you are not enrolled for medical coverage. For example, you can submit your expenses for vision exams, eyeglasses, contact lenses, and vision correction laser surgery.

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

Eligible health care expenses can be for anyone who qualifies as your dependent for Federal tax purposes.

Eligible Health Care FSA Expenses

The health care flexible spending account (FSA) reimburses you for these eligible expenses:

- Medical plan copayments, deductibles and coinsurance
- Charges above the medical plans' usual, reasonable, and customary limits
- Expenses that are partially covered by your medical plan, such as the cost of:
 - Alcoholism/substance abuse (chemical dependency) treatment (including meals and lodging provided by a treatment center)
- Birth control devices
- Chiropractic or physical therapy
- Hearing aids and their batteries
- Infertility services
- Medical equipment, such as crutches or wheelchairs
- Mental health treatment
- Prescription drug copayments and coinsurance
- Retin-A (when medically necessary and not for cosmetic purposes)

- Speech therapy.
- Expenses for certain eligible over-the-counter (OTC) drugs, such as antacids, pain relievers and cold and allergy medications that are used to treat personal injury or sickness
- Certain expenses that are not covered by your medical plan (but can be reimbursed), such as the cost of:
 - Acupuncture
 - Dental bridges and dentures
 - Orthodontia
 - Periodontal cleanings
 - Eyeglasses or contact lenses (including contact lens solutions)
 - Contact lens replacement insurance
 - Home modifications to accommodate a disabled person (including disabilities caused by arthritis)
 - Laser eye surgery, such as LASIK, radial keratotomy and penetrating keratoplasty
 - Removal of lead-based paint to prevent your young child who has (or had) lead poisoning from eating paint
 - Massage therapy
 - Orthopedic shoes
 - Smoking-cessation programs (does not include expenses for drugs that do not require a prescription, such as nicotine gum or patches)
 - Sterilization reversal.
- TMJ post-surgery therapy and appliances
- Travel and lodging away from home for medical reasons (Limitations may apply. See [IRS Publication 502](#) for details.)
- Tuition and tutoring for a child with severe learning disabilities, including dyslexia
- Transportation to and from your health care provider (including Alcoholics Anonymous [AA] meetings)
- Vitamins by prescription
- Weight-loss programs prescribed by a physician for a specific ailment
- Nursing care for a Dependent (such as your Dependent elderly parents) if it is not custodial nursing home care

- Other expenses that are considered tax deductible by the IRS. These include the cost of many services and equipment for the disabled. For a complete list of eligible expenses, see IRS Publication 502.

Ineligible Health Care FSA Expenses

The health care flexible spending account (FSA) does not reimburse you for the following (even if your Doctor recommends them):

- Cosmetic treatment (unless the treatment corrects a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease). Cosmetic treatment includes, but is not limited to, teeth bleaching, laser peels, chemical peels, hair transplants and treatment for male pattern baldness
- Dance or swimming lessons
- Drugs prescribed for cosmetic purposes (such as Rogaine, a drug prescribed for hair-loss treatment)
- Electrolysis
- Expenses reimbursed through any health insurance policy or plan, such as your spouse's health plan or Medicare
- Expenses you or a family member incurred before the effective date of your health care FSA election, or change of your health care FSA election
- Expenses you or a family member incurs after the end of the benefit plan year and grace period
- Health club dues, YMCA dues, and related expenses
- Household help
- Liposuction
- Marriage or family counseling
- Maternity clothes, diaper service, and related expenses
- Nonprescription drugs or vitamins (unless prescribed by a physician as periodically necessary to treat a specific disease or condition)
- Custodial nursing home care
- Premiums for automobile insurance, including premiums to insure medical care for persons injured by or in your car
- Premiums for life, disability or accidental death and dismemberment (AD&D) insurance

- Premiums for medical insurance, including COBRA premiums
- Transportation to and from work (even if your condition requires special means of transportation)
- Trips or vacations taken for relief of a condition, change in environment, improvement of morale, or general health purposes
- Tuition for a child with disciplinary problems who is enrolled in a special school
- Uniforms
- Weight-loss programs (unless prescribed by a Doctor as medically necessary for the treatment of a specific disease or condition)
- Any other expenses considered not deductible on a federal income tax return (see IRS Publication 502).

Health Care FSA vs. Tax Deduction

Even though the health care flexible spending account (FSA) reimbursements can save you money on taxes, the federal income tax deduction can provide greater savings to some employees. To claim such a deduction, your health care expenses must exceed 7.5% of your adjusted gross income. Most employees find that their eligible health care expenses do not reach that level. Ask your tax advisor which method is best for your personal situation.

Dependent Day Care Flexible Spending Account

The dependent day care flexible spending account (FSA) provides before-tax reimbursement of eligible dependent day care expenses while you are working. If you are married, your spouse also must work (or actively search for work), unless he or she is:

- A full-time student at least five months of the year, or
- Mentally or physically disabled and unable to care for a Dependent.

If you are divorced or legally separated, you can use the dependent day care FSA if you have custody of your child for a longer period during the year than does your child's other parent. In addition, you must provide more than half of your child's financial support, and your child is claimed as a Dependent on your federal income tax return.

Eligible Dependents

Day care expenses that can be reimbursed through the dependent day care FSA include day care for:

- Children under age 13 whom you claim as exemptions on your federal income tax return
- A spouse who physically or mentally incapable of caring for him- or herself and who has the same principal place of residence as you for more than one-half of the taxable year
- Parents, grandparents, children age 13 or older, or other relatives or members of your household who:
 - Are claimed as a Dependent on your federal income tax return,
 - Spend at least eight hours each day in your home,
 - Receive more than half of their support from you,
 - Are physically or mentally incapable of caring for themselves, and
 - Have the same principal place of residence as you for more than one-half of the taxable year.

If your spouse is incapable of caring for him- or herself, the expenses you incur for his or her care must enable you to be gainfully employed, and your spouse must:

- Have a physical or mental condition that does not allow him or her to take care of personal, hygienic, or nutritional needs, or
- Require full-time attention for safety reasons.

The fact that your spouse is unable to engage in substantial gainful activity or perform his or her normal functions is not necessarily sufficient to qualify day care expenses for reimbursement under the Plan.

Eligible Dependent Day Care FSA Expenses

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

- The cost of day care provided in or out of your home (including Social Security taxes you pay on behalf of your provider) by an eligible babysitter
- The cost of day care provided at a licensed day care center or kindergarten that cares for at least six people and complies with local regulations (but not services from a facility that charges no fee)

- The cost of day care provided at a summer camp (but not tuition and other fees unrelated to day care)
- The cost of day care provided at a private school (but not tuition and other fees unrelated to day care if the child is in kindergarten or above)
- Any nonrefundable fees to secure your Dependent's place in a day care center, if care is provided to your Dependent at that center
- Any other expenses that would be considered eligible for a dependent care credit for federal income tax purposes. For a complete list of these expenses, see IRS Publication 503.

Your day care provider can be a babysitter if his or her services enable you and your spouse to work. However, please note that your day care provider cannot be any of the following:

- Your spouse
- Your child's other parent
- Your child who is under age 19 at the end of the benefit plan year
- A person whom you or your spouse claims as a Dependent for income tax purposes.

Ineligible Dependent Day Care Expenses

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

- Child support payments
- Clothing, entertainment or food expenses
- Day care expenses incurred during hours when you or your spouse is not working or works as a volunteer
- Expenses you incur while you or your spouse is away from work because of vacation, illness or leave of absence
- Expenses you or a family member incurred before the effective date of your dependent day care FSA election, or change of your dependent day care FSA election
- Expenses that are reimbursed by another plan, such as your spouse's or a government plan
- Expenses you incur before you enroll in the dependent day care FSA or after your participation ends

- Expenses you incur during any time you cannot claim your Dependent as an exemption on your federal income tax return
- Expenses you incur after the end of the benefit plan year (June 30)
- Finder's fees for placement of an au pair or nanny
- Full-time convalescent or nursing home expenses (except care for a mentally disabled child under age 13)
- Overnight camp expenses
- Transportation expenses for your caregiver or your Dependent
- Tuition, for kindergarten or beyond
- Any other expenses considered not eligible for a dependent day care credit for federal income tax purposes (see IRS Publication 503).

Contribution Limits if You Are Married

If this is your situation...	Then your maximum annual contribution is...
You or your spouse earns less than \$5,000	The amount the lower-paid spouse earns, up to \$5,000. If your spouse is a full-time student for at least five months of the year or your spouse is incapable of caring for him or herself, your spouse will be considered to have earned income of \$250 per month if you have one qualifying Dependent or \$500 per month if you have two or more qualifying Dependents
You and your spouse file a joint income tax return and your spouse also participates in a dependent day care flexible spending account	\$5,000 for you and your spouse's accounts combined

Dependent Day Care FSA vs. Tax Credit

Another way to reduce taxes with your dependent day care expenses is to claim the child care credit on your federal income tax return.

Here is how the tax credit works: You can claim a tax credit equal to 20% to 35% of your qualifying child care expenses. The percentage that applies to you is based on your household income. If you have one Dependent, the maximum expense that you can apply to the credit is \$3,000 each benefit plan year. That means your annual tax saving when you use the credit can be up to \$1,050 ($35\% \times \$3,000 = \$1,050$). If you have two or more eligible Dependents, you can consider up to \$6,000 in expenses, and your credit can be a maximum of \$2,100 ($35\% \times \$6,000 = \$2,100$).

You have the option to use both the dependent day care FSA and the tax credit approach. However, the IRS does not allow you to claim a tax credit for any expenses already reimbursed under the flexible spending account. In other words, you cannot “double deduct” and receive a tax saving twice for these expenses.

Moreover, the amount of expenses that qualify for a tax credit are reduced — dollar for dollar — by the amount that you receive from the dependent day care FSA. That means if you have one Dependent and you contribute \$3,000 or more to the flexible spending account, you cannot also claim the dependent care tax credit. This rule applies even if you have additional unreimbursed expenses.

Likewise, with two or more Dependents, the amount of expense you can consider in determining your tax credit will be reduced by the amount you receive from the dependent care FSA.

The combination of FSA reimbursements and tax credits that provides the greatest tax saving for you depends on your household income, the number of your eligible Dependents and your income-tax-filing status.

In general, if you are married, you file a joint income tax return, and your household income is \$25,000 or more before deductions, the flexible spending account can save you more in taxes than the federal child care tax credit. You may want to check with your tax advisor on any questions about flexible spending accounts.

GENERAL INFORMATION ABOUT THE FLEXIBLE SPENDING ACCOUNTS

See IRS Publication 503 for Details About Eligible Dependent Care Expenses

IRS publication 503 provides a detailed list of dependent care expenses eligible for reimbursement through a flexible spending account (FSA) account. The publication is available:

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

The Reimbursement Process

When you incur an eligible expense during the benefit plan year, you can use the money in your accounts to reimburse yourself. In addition, you can use the money in your FSA to reimburse yourself for eligible expenses incurred during the 2½-month “grace period” following the end of the benefit plan year (on June 30). Simply complete a flexible spending account (FSA) claim form, attach the proper documentation, and send it to the claims administrator — Benesyst, Inc. Send your completed claim forms and documentation substantiating the expense (for example, EOBs, cancelled checks, or invoices) to the address on the claim form.

Claim forms are available by calling the Benefits Office and asking for a supply, or you can download forms from Benefits OnLine.

Within several weeks of submitting a claim, you should receive your reimbursement check and a statement of your account balance. Reimbursement of expenses that are less than \$20 is delayed until the end of each benefit plan quarter.

Because your bills may arrive after you receive services, you can submit claims incurred during the benefit plan year until December 31 — after the benefit plan year and “grace period” ends.

Look for quarterly statements that show your contributions to the FSAs your reimbursements, and your account balances. You also can call the claims administrator at the number listed on your claim form to find out your current account balance or the status of a claim.

Note: The claims administrator reviews your claims. However, you are responsible for ensuring that the expenses are valid qualifying expenses. The claims administrator and Northrop Grumman are not responsible for verifying your claims.

The following sections provide additional details about reimbursements specific to each account.

2½-Month “Grace Period” for Incurring Eligible Expenses

Participants enrolled in a flexible spending account (FSA) can incur eligible expenses for a 14½-month period — the regular 12-month benefit plan year (July 1 – June 30) plus the 2½-month “grace period” (through September 15 following the end of the benefit plan year). The “grace period” applies only to claims that you complete and submit manually — it does not apply to expenses that are automatically reimbursed (see “Automatic Reimbursement through Blue Cross Blue Shield (BCBS)”). Any expenses incurred during the “grace period” that are eligible for automatic reimbursement will be paid from the current benefit plan year’s FSA only.

Claims for eligible expenses incurred between July 1 and September 15 following the end of the benefit plan year will be reimbursed first from the prior year’s FSA, then from the current benefit plan year’s FSA.

Keep in mind that the IRS limits the before-tax reimbursements you can receive in a single calendar year from the dependent care FSA to \$5,000. (If you are married, this limit applies to any reimbursements received by you and your spouse.) If you are reimbursed for more than \$5,000 in a calendar year, you will be responsible for paying taxes on the excess amount.

Note: Your before-tax contributions will continue to be deducted from your paycheck only during the 12-month benefit plan year (July 1 – June 30); the 2½-month “grace period” has no impact on when or how you contribute to the FSA(s).

Health Care FSA Reimbursements

When you submit your completed FSA claim form to Benesyst (the FSA claims administrator) attach an itemized bill, a receipt, or an explanation of benefits (EOB) for your expenses. (If you need copies of your EOBs, contact your medical plan claims administrator.)

You can submit health care expenses and receive reimbursement for up to the amount you select to contribute for the entire year, less any reimbursements that already were paid. Your future contributions will pay off the deficit in your account. See the example on the next page.

If you or your Dependents are enrolled in more than one health plan (such as your plan and your spouse’s plan or Medicare), you first have to submit your expenses to those plans. After you receive reimbursement from all your health plans, you can submit the balance of your eligible expenses for reimbursement under the health care FSA. Please include the EOB from both plans with your claim. (You can submit expenses for your eligible Dependents even if they are not covered under the health care plans.)

Here are two examples of how the health care FSA reimbursement process works:

	Example 1	Example 2
Your selected annual contribution	\$600	\$600
Your contributions as of August	\$100	\$100
Your submitted claim in August	\$600	\$800
Your reimbursement	\$600	\$600
Your account balance	(\$500)	(\$500)

- In example 1, you are reimbursed the full amount of your \$600 claim in August, even though you only contributed \$100 to your account so far. Your contributions during the rest of the benefit plan year will make up the \$500 negative balance in your account.
- In example 2, you submit a claim for \$800, but receive reimbursement for only \$600 – the total contribution you selected for the year.

Automatic Reimbursement through Blue Cross Blue Shield (BCBS) and Express Scripts: BCBS and Express Scripts can automatically file your eligible health care and prescription drug claims with the FSA administrator. This eliminates the need to submit claim forms to the FSA administrator in some instances because the amounts applied to your medical plan deductibles and coinsurance will be submitted on your behalf. However, you may still need to submit receipt for reimbursement in some situations. Automatic claims submission does not apply to non-BCBS/Express Scripts expenses such as those incurred through ValueOptions.

Dependent Day Care FSA Reimbursements

To receive reimbursement of your eligible Dependent day care expenses, submit your completed FSA claim form to Benesyst, the claims administrator. Include a bill that shows your day care provider's Social Security or tax identification number. (According to IRS rules, your expenses will not be reimbursed if you do not provide this number.)

For reimbursement of the cost of day care provided by your child's school, day care must be shown as a separate item on the tuition bill. Tuition for children in kindergarten or above is not an eligible expense.

You can be reimbursed for eligible expenses up to the balance in your account at the time your claim is processed. If you have enough money in your account, you will be reimbursed in full. If you do not have enough money in your account to pay your entire claim, you will receive an initial reimbursement equal to your current account balance. The remainder of your claim will be paid automatically after you make additional payroll contributions to your account. Depending on how much you contribute each week, you may receive one or several reimbursement checks.

For example, let's assume you submit a claim for \$400 and receive a reimbursement check for \$384 (the amount in your account in August). You will be reimbursed the remaining \$16 after you make additional payroll contributions to your account.

	Example
Your selected annual contribution	\$5,000
Your contributions as of August	\$384
Your submitted claim in August	\$400
Your reimbursement	\$384
Your account balance	\$0

Reimbursement Checklist

Each time you submit your health or dependent day care claims, use this checklist to ensure your paperwork is complete and to speed up reimbursement of your eligible expenses.

- I already incurred my eligible expenses

- I incurred my eligible expenses after I began my participation in the Plan
- I incurred my expenses before I ended my participation in the Plan
- I included a receipt from my health care or dependent day care provider that shows the:
 - Year, month, and day services were provided
 - Type of services provided (i.e., dependent day care or type of health care)
 - Name of the service provider
 - Cost of the services
 - Dependent day care provider’s tax identification number or Social Security number
- I was not reimbursed and cannot be reimbursed for these expenses under a health plan or another flexible spending account
- If I received partial reimbursement of these expenses under a health plan, I enclosed a copy of the explanation of benefits (EOB)
- I fully completed the claim form, signed it and dated it.

Plan Your Expenses Carefully: The “Use it or Lose It Rule” and Other IRS Regulations

Before you enroll in a flexible spending account (FSA), be sure to estimate your health care and dependent day care expenses for the year. In exchange for the tax savings you receive, the Internal Revenue Service (IRS) places some restrictions on the money you contribute.

For example, under the IRS “use-it-or-lose-it” rule, you lose any funds in your account that you do not use by the end of the benefit plan year. That means no refunds and no rollovers to the next year.

For example, let’s assume:

- You contributed \$1,000 to the health care FSA, but you submitted only \$800 in eligible expenses. You forfeit the \$200 balance in your account.
- In addition, you contributed \$2,000 to the dependent day care FSA and submitted \$2,200 in eligible expenses. You would be reimbursed the full \$2,000 you contributed for the year. But, you could not use the \$200 you forfeited in the health care spending account to cover the remaining \$200 of dependent day care expenses.

	Health Care FSA	Dependent Day Care FSA
Your annual contributions	\$1,000	\$2,000
Your total eligible expenses	\$800	\$2,200
Your reimbursement	\$800	\$2,000
Amount you forfeit	\$200	\$0

In addition, IRS rules regulate that you:

- Cannot transfer money from one flexible spending account to another
- Cannot change the set amounts you choose to contribute during the benefit plan year, unless you have a qualified life event
- Will lose your unused account balances if you leave Northrop Grumman in midyear for any reason (unless you elect to continue your health care FSA through COBRA. See “COBRA” for details). However, you can submit a claim for reimbursement of expenses that you incur before leaving Northrop Grumman.
- Cannot file for an income tax deduction or tax credit for expenses reimbursed through the FSAs.

How Your Other Benefits Are Affected

Your flexible spending account (FSA) contributions will not affect your other Northrop Grumman benefits that are based on your pay. These other benefits, such as life insurance, disability, and retirement benefits, will continue to be based on your full pay.

However, your contributions may affect your Social Security benefits. Your Social Security benefits are based on your average annual taxable income – up to the Social Security wage base – during your entire career. Because your FSA contributions lower your taxable income, your Social Security benefits at retirement or disability may be slightly less if:

- You earn less than the Social Security wage base for the current year (\$97,500 in 2007), or
- Your before-tax contributions reduce your taxable income below the Social Security wage base.

If you earn more than the Social Security wage base, your Social Security benefits are not affected. For most employees, the current tax savings outweigh any possible reduction in future Social Security benefits or other government-related benefits.

If You Take a Leave of Absence or Your Employment Terminates

If you take a medical, family or military leave of absence and you are receiving a paycheck from Northrop Grumman during your leave, your FSA contributions continue on a before-tax basis. If you are on an unpaid leave, your contributions stop. You can be reimbursed for eligible expenses incurred during the time you made contributions. Claims that you incur after your contributions stop are not eligible for reimbursement. Once you no longer receive a paycheck, if you want to continue your Health Care FSA, you can choose to continue with after-tax contributions through COBRA for the remainder of the plan year. You cannot continue your DC FSA.

If you voluntarily quit or are discharged, your FSA contributions stop on your termination date, and you can submit eligible expenses incurred through your termination date (unless you choose to continue with after-tax contributions through COBRA within 60 days of your termination date for your Health Care FSA).

GENERAL PLAN ADMINISTRATION

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

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

Benefit Claims

How to File a Benefit Claim

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

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

Most claim forms can be obtained at the Forms link at *Benefits OnLine*. You can also request claim forms by calling the Northrop Grumman Benefits Center (NGBC) at **1-800-894-4194** or by calling the claims administrator directly at the number provided on your ID card.

You must submit medical claims that you incur during the benefit plan year within 12 months* after the benefit plan year ends. For example, assume you incur a claim in October 2003. Since the benefit plan year ends on June 30, 2004, you have until June 30, 2005, to submit your claim for reimbursement. The Plan does not pay claims that are submitted after the 12-month deadline.

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

For details about how to file a claim for flexible spending account reimbursement, refer to that specific section.

Claims that are not a claim for a specific benefit under the Plan are called "Administrative Claims" (e.g., you believe that you are being charged too much for the benefit coverage you have elected). Because your claim is not for the payment of a specific benefit under the Plan, your claim is treated as an Administrative Claim. Administrative Claims must be submitted to the claims administrator within 90 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 90-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 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 Benefit Determinations

The timeframes for benefit determination for medical benefits vary depending on the type of claim.

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*	45 days	None
Medical: Pre-Service	15 days	45 days	15 days
Medical: Post-Service	30 days	45 days	15 days

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

- **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").

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

Example #1: If you have an urgent medical situation, the claims administrator must respond to your initial request for benefits within 72 hours, and no extensions are permitted. If the administrator needs more information from you to make a determination, you will have 48 hours from the time you are notified to supply that information. The time period during which you are gathering that additional information does not count toward the time limits that apply to the claims administrator.

If Your Claim Is Denied

If your claim for benefits 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:

- The specific reason for the denial
- Specific references to plan provisions on which the denial is based
- A description of additional material or information that you may need to revise the claim and an explanation of why such material or information is necessary

- A specific description of the Plan’s review procedures and applicable time limits, including a statement of your rights to bring a lawsuit under ERISA.

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

- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the guideline or protocol, free of charge upon request
- If the denial is based on an exclusion for medical necessity or experimental treatment, the denial must explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge
- If the denial involves urgent care, you will be provided an explanation of the expedited review procedures applicable to urgent claims.

Appealing a Denied Claim

If your claim for benefits is denied, you have the right to make an appeal:

- Call the claims administrator and ask why your claim was denied. You may discover that a simple error was made. If so, you may be able to correct the problem right over the telephone.
- If your claim is still denied, 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 once again, ask the claims administrator to submit your claim to the claims administrator’s level 1 appeals review committee.
- If your claim is denied by the level 1 appeals review committee, ask the claims administrator to submit your claim to the claims administrator’s level 2 appeals review committee.

Claims and Appeals Contact Information

Claims Administrator	Claims	Level 1 Appeals	Level 2 Appeals
Blue Cross Blue Shield Medical plan	Blue Cross Blue Shield of Illinois Claims Services P.O. Box 1220 Chicago, IL 60690	Blue Cross Blue Shield of Illinois Level One Appeals P.O. Box 1220 Chicago, IL 60690	Blue Cross Blue Shield of Illinois Appeals Committee P.O. Box A3464 Chicago, IL 60690-3464
CareWise	Blue Cross Blue Shield of Illinois Claims Services P.O. Box 1220 Chicago, IL 60690	CareWise Appeals 9200 Shelbyville Road Suite 700	CareWise Appeals 9200 Shelbyville Road Suite 700

Claims Administrator	Claims	Level 1 Appeals	Level 2 Appeals
		Louisville, KY 40222	Louisville, KY 40222
Express Scripts	Express Scripts Claims Services P.O. Box 66583 St. Louis, MO 63166	Express Scripts, Inc. Clinical Appeals - NGC Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439	Express Scripts, Inc. Clinical Appeals - NGC Mail Route BL0390 6625 West 78th Street Bloomington, MN 55439
ValueOptions	ValueOptions Claims Services 340 Golden Shore Long Beach, CA 90202	ValueOptions Appeals 340 Golden Shore Long Beach, CA 90202	ValueOptions Appeals 340 Golden Shore Long Beach, CA 90202

For the flexible spending accounts

- Claims for reimbursement should be sent to Benesyst (see “Flexible Spending Accounts” for details)
- Level 1 and Level 2 appeals should be sent to:

Employee Welfare Benefits Committee
Northrop Grumman Corporation
1840 Century Park East
Los Angeles, CA 90067-2199.

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

Timing of Your Appeal

If you make a claim for benefits and the claims administrator denies that claim, you have the right to appeal the denial. The appeal procedures must be exhausted before you can enforce your rights under ERISA (see “Employee Retirement Income Security Act of 1974” for details).

In the case of medical, dental, and vision claims, you have 180 days from the time that you receive a claim denial from the claims administrator to file an appeal. In the case of disability benefits, you have 60 days from the time you receive your denial to file an appeal. Following are the timeframes that apply when you file an appeal:

Type of Claim	Time to Appeal From	Time for Decision on	Extensions for Claims
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	Date Claim is Denied	Appeal	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

- **Pre-Service Claims.** There are two levels of appeal.
 - **Level 1 appeal:** You may file a level 1 appeal with the claims administrator within 180 days if your initial claim for benefits is denied and you would like to appeal that 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, and your appeal must be considered within an additional 15 days, with no extensions.
- **Post-Service Claims.** There are two levels of appeal.
 - **Level 1 appeal:** You may file a level 1 appeal with the claims administrator within 180 days if your initial claim for benefits is denied and you would like to appeal that 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, and your appeal must be considered within an additional 30 days, with no extensions.

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
- Have all relevant information considered on appeal, even if it was not submitted or considered in your initial claim.

If benefits are still denied on appeal, the notice that you receive from the final

review level (level 2 review) will provide:

- The specific reasons for the denial
- Reference to the plan provisions on which the decision was based
- A statement that you may receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim
- A statement describing any additional appeal procedures, and a statement of your rights to bring suit under ERISA. (See "Employee Retirement Income Security Act of 1974" for details.)

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

- If the denial is based on an internal rule, guideline, or protocol, the denial will say so and state that you can obtain a copy of the rule, etc., free of charge upon request
- If the denial is based on an exclusion for medical necessity or experimental treatment, the denial will explain the scientific or clinical judgment for determination, applying the terms of the Plan to the medical circumstances, or state that such an explanation will be provided upon request, free of charge.

At both the initial claim level, and on appeal, you may have an authorized representative submit your claim for you. In this case, the 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. However, even at the appeal level, neither you nor your representative has a right to appear in person before the claims administrator or the review panel.

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

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.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report and updated SPD. The plan administrator may charge a reasonable fee for the copies,
- Receive a summary of the plan's annual financial reports. You do not have to ask for your copy of the summary; the plan administrator sends you a Summary Annual Report (SAR) each year.
- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the "COBRA" section and the documents governing the plan for rules about your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties on the plan fiduciaries – the people responsible for operating the plan. At Northrop Grumman, plan fiduciaries may include employees who make certain discretionary decisions about the management or administration of the plan. Fiduciaries also may include outside investment advisors and trustees.

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

No one, including Northrop Grumman or any person, may discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcing Your ERISA Rights

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

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

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

Questions?

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

What Is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that sets standards for employee benefit plans — specifically related to your ability to obtain new coverage, the opportunity to select or change coverage after certain qualified life events, and health information privacy.

Obtaining New Medical Coverage Under HIPAA

HIPAA can help you and your family obtain new medical coverage if your coverage ends under the Avondale Health Plan. For example, if you take a new job with another company, you most likely will request coverage under your new employer's health care plan.

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

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

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

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

HIPAA requires health plans to provide individuals whose coverage terminates under the plan with proof of their medical coverage — called a Certificate of Creditable Coverage. Therefore, when you or your dependents stop participating in a Northrop Grumman health care plan (such as the Avondale Health Plan), Northrop Grumman must provide you with a Certificate of Creditable Coverage. The certificate is sent to you within 45 days of the date Northrop Grumman is notified of your termination.

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

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

Certificates of Creditable Coverage are issued to you:

- Automatically, when your coverage under the plan ends — whether or not you elect COBRA
- Automatically, when your COBRA coverage ends, if you elected COBRA coverage
- On request within 24 months of the date your coverage ends.

If you need to request a Certificate of Creditable Coverage, or if you are interested in more information about HIPAA, call the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194.

Special Enrollment Periods Provided Under HIPAA

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

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

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

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

HIPAA Privacy Rights

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

Permitted Uses and Disclosures of Protected Health Information

The HIPAA privacy rules generally allow the use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. The amount of health information used or disclosed will be limited to the “minimum necessary” for these purposes, as defined under the HIPAA rules.

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

- Northrop Grumman Corporation HIPAA Privacy Official
- Corporate Director, Benefits Administration
- Corporate Director, Benefits Services
- Corporate Director, Benefits Strategy and Design
- Corporate Manager, Health and Welfare Programs
- Corporate Manager, Executive Services
- Benefits Analyst, Health and Welfare Programs
- Head of Employee Benefits Practice Group

- Legal
- Employee assistance program.

Here's how additional information may be shared between the Avondale Health Plan and Northrop Grumman, as allowed under the HIPAA rules:

- The Avondale Health Plan may disclose "summary health information" to Northrop Grumman if requested, for purposes of obtaining premium bids to provide coverage under the plan, or for modifying, amending, or terminating the plan. Summary health information is information that summarizes participants' claims information, but from which names (and other identifying information) have been removed.
- The Avondale Health Plan may disclose to Northrop Grumman information on whether an individual is participating in the plan, or has enrolled or disenrolled in an insurance option offered by the Plan.

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

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

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

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

Default Procedure

It is the plan's procedure, upon request for assistance, to disclose your health information to your spouse, and his or her health information to you, and to disclose the health information of your over-age enrolled dependent (for example, your child who is over the age of 21) to you or your spouse, unless the person whose health information would otherwise be disclosed chooses to opt out of this default procedure. You may request the Plan not share your health information with your spouse by opting out of this default procedure. To opt out, you must contact the Northrop Grumman Benefits Center (NGBC) at **1-800-894-4194**. Your spouse and/or your over-age enrolled dependent may also opt out of this procedure by contacting the Northrop Grumman Benefits Center (NGBC). Once an individual has opted out of this default, the Plan generally will not disclose any of his or her health information to family members, unless some other part of the HIPAA regulations permits or requires it (for example, that individual becomes incapacitated). Any individual may change his or her opt-out election at any time by contacting the Northrop Grumman Benefits Center (NGBC) at **1-800-894-4194**.

Your Rights Under HIPAA

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

- Right to request restrictions on certain uses and disclosures of your health information and the plan's right to refuse:
 - You have the right to ask the plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. In addition, you have the right to ask the plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.
 - The Plan is not required to agree to a requested restriction. However, if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

- Right to receive confidential communications of your health information:
 - If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to allow you to receive communications of health information from the Plan by alternative means or at alternative locations.
 - If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement that disclosure of all or part of the information could endanger you.
- Right to inspect and copy your health information:
 - With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “Designated Record Set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. In addition, the Plan may deny your right to access, although in certain circumstances you may request a review of the denial.
 - If you want to exercise this right, your request to the Plan must be in writing.
- Right to amend your health information that is inaccurate or incomplete:
 - With certain exceptions, you have a right to request that the Plan amend your health information in a Designated Record Set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the Designated Record Set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).
 - If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment.
- Right to receive an accounting of disclosures of your health information:
 - You have the right to a list of certain disclosures the Plan has made of your health information. This is often referred to as an “accounting of disclosures.” You generally may receive an accounting of disclosures if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Privacy Notice.
 - If you want to exercise this right, your request to the Plan must be in writing.

Complaints

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

COBRA Continuation of Coverage

What is COBRA?

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

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

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

If you elect COBRA continuation:

- Initially, you and your dependents will keep the same type of plan coverage you were enrolled in while an active employee.
- You may keep the same coverage category you had as an active employee or choose a different category. For example, if your spouse and all of your dependents were enrolled under the Northrop Grumman medical plan, you could choose to enroll all, some or none under COBRA.

- Coverage is effective on the date of the event that qualified you for COBRA coverage, unless you waive COBRA coverage and subsequently revoke your waiver within the 60-day election period. In that case, your coverage begins on the date you revoke your waiver.
- You may change plan coverage and coverage category (including adding eligible dependents) during the annual enrollment period or if you have a qualified life event.
- You may add newly acquired dependents during the benefit plan year.
- You can enroll your newly eligible spouse or child under the same guidelines that apply to active employees.

COBRA Continuation Period

Qualifying Event	Maximum Continuation Period		
	Employee	Spouse	Child
You lose coverage because you reduce your work hours or take unpaid leave	18 months	18 months	18 months
You terminate employment for any reason (except gross misconduct)	18 months	18 months	18 months
You or your dependent is disabled (as defined by Title II or XVI of the Social Security Act) during the first 60 days after COBRA begins	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your spouse legally separate or divorce	N/A	36 months	36 months
You are already on COBRA and become disabled and entitled to Medicare, which causes your dependents to lose coverage	N/A	18 months	18 months
Your child no longer qualifies as a dependent	N/A	N/A	36 months

Newly Eligible Child

If you, the former Northrop Grumman employee, elect continuation coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Northrop Grumman-sponsored group health plan and the requirement of the federal law, these qualified beneficiaries can be added to COBRA coverage by providing your local human resources representative with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 30 days of birth, adoption, placement for adoption, or appointment as a legal guardian. The notice must include the name of the new qualified beneficiary, date of birth or adoption of new qualified beneficiary, and birth certificate or adoption decree.

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

Cost for COBRA

COBRA participants pay monthly premiums for their coverage on the following basis:

- For medical coverage, premiums are based on the full group rate per enrolled person set at the beginning of the benefit plan year, plus 2% for administrative costs. Your spouse or child who is a qualified beneficiary making a separate election is charged the same rate as a single employee.
- Health care flexible spending account contributions can be continued through the end of the benefit plan year on an after-tax basis, plus the 2% administrative charge.

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

Notification

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

If your dependents lose coverage due to divorce, legal separation, or loss of dependent status, you (or a family member) must notify the Northrop Grumman Benefits Center (NGBC) at 1-800-894-4194 within 60 days of the event so that COBRA can be offered and information on election rights can be mailed. Also, to extend coverage beyond 18 months because of disability, you must provide notice of the Social Security Administration's determination during the initial 18-month period and within 60 days of the date you receive your determination letter.

Your Duties Upon a Second Qualifying Event

If a covered family member experiences a second qualifying event during the original continuation coverage period following an employee's termination or reduction in hours of employment qualifying event, he or she must notify the local human resources representative. For example, an employee terminates employment and elects COBRA continuation coverage for himself and his spouse. During the 18-month continuation coverage period, the former employee and spouse divorce, causing the spouse to lose coverage. The spouse has the right to continue coverage for up to 36 months measured from the date of the employee's termination of employment (the original qualifying event). This notice must be provided in writing and must include the name of the employee, the name of the qualified beneficiary receiving COBRA coverage, and the type and date of second qualifying event.

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

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

Special Rules for Disability

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

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

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

Medicare

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

Trade Reform Act of 2002

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

When COBRA Ends

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

- You or your dependent becomes covered under another group health plan not offered by Northrop Grumman after the date of your COBRA election (unless the plan has pre-existing condition limitations that affect the enrolled person)

- You or your dependent becomes enrolled in Medicare after the date of your COBRA election (if you or your dependent is not entitled to or enrolled in Medicare, you or your dependent can continue coverage under COBRA until the maximum continuation period ends)
- You or your dependent fails to make a timely monthly payment
- After your initial 18-month period, you or your dependent ceases to be considered disabled for Social Security purposes and is not otherwise eligible for a longer continuation coverage period
- Northrop Grumman ceases to provide medical benefits to any employee.

COBRA and FMLA

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

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

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

- When you definitively inform Northrop Grumman that you are not returning at the end of the leave, or
- The end of the leave, assuming you do not return to work.

Questions About COBRA

If you have any questions about COBRA coverage or the application of the law, please contact 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 website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

Administrative Information

General Plan Facts

Employer	Northrop Grumman Corporation 1840 Century Park East Los Angeles, CA 90067-2199
Employer Identification Number (EIN)	95-1055798
Type of Plan	Welfare benefit plan
Plan Administrator	Employee Welfare Benefits Committee Northrop Grumman Corporation 1840 Century Park East Los Angeles, CA 90067-2199
Agent for Service of Legal Process	Northrop Grumman Corporation c/o Corporate Secretary Northrop Grumman Corporation 1840 Century Park East Los Angeles, CA 90067-2199
Benefit Plan Year	July 1 to June 30
Plan Number	503
Name of Plan	Northrop Grumman Electronic Systems — Space Division Consolidated Health Plan <i>The plan name shown is the official plan name. For purposes of this Summary Plan Description, this plan will be called the Northrop Grumman Ship Systems Avondale Operations Health Plan for Represented Employees.</i>

Specific Plan Facts

Medical Plan	
Insured by:	Northrop Grumman self-insures the medical plan
Claims administered by:	Blue Cross Blue Shield of Illinois P.O. Box 1220 Chicago, IL 60690 1-800-516-1269
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Northrop Grumman and participant contributions
Mental Health and Substance Abuse Treatment Plan	
Insured by:	ValueOptions 340 Golden Shore Long Beach, CA 90202 1-800-982-8161
Claims administered by:	ValueOptions 340 Golden Shore Long Beach, CA 90202 1-800-982-8161
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Northrop Grumman and participant contributions
Prescription Drug Plan	
Insured by:	Express Scripts P.O. Box 66583 St. Louis, MO 63166 1-800-655-1971
Claims administered by:	Express Scripts P.O. Box 66583 St. Louis, MO 63166 1-800-655-1971
Trustee:	State Street Bank and Trust Company Master Trust Division One Enterprise Drive North Quincy, MA 02171
Funded by¹:	Northrop Grumman and participant contributions

Health Care and Dependent Day Care Flexible Spending Account Plans	
Insured by:	Not applicable
Claims administered by:	Benesyst Inc. 800 Washington Ave. North #250 Minneapolis, MN 55401 1-800-670-7131
Trustee:	Benesyst Inc. Northrop Grumman FSA Claims 800 Washington Ave. North #250 Minneapolis, MN 55401 Phone: 1-800-670-7131 Fax: 1-800-310-8279 Web site: www.benesyst.net
Funded by ¹ :	Participant contributions

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

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

Foreign Language Notice

This booklet contains a summary in English of your plan rights and benefits under the Avondale Health Plan. If you have difficulty understanding any part of the booklet, contact the Employee Welfare Benefits Committee, the plan administrator, at 1840 Century Park East, Los Angeles, CA 90067-2199. Office hours are from 9 a.m. to 5 p.m. Pacific time, Monday through Friday. You also may call the Northrop Grumman Benefits Center at **1-800-894-4194** for assistance.

This guide is the Summary Plan Description (SPD) for the Avondale Operations Health Plan for Represented Employees. It is also considered part of the written instrument for the Plan for purposes of section 402 of ERISA. The benefits described in this guide are offered to certain represented employees of Northrop Grumman Corporation Ship Systems Avondale Operations.

The Avondale Health Plan is a self-funded plan with administrative services provided by Blue Cross Blue Shield (BCBS), Express Scripts, CareWise, Benesyst Inc., and ValueOptions. This SPD is a summary of the Plan and does not constitute an implied or express contract or guarantee of employment.

The content contained in this SPD provides highlights of important information about your participation in Avondale Health Plan. Complete details about the Plan are contained in the legal plan documents that govern plan operation and administration. If there is a discrepancy between the information provided in the SPD and the provisions of plan documents, the plan documents will govern.

Northrop Grumman reserves the right in its sole discretion to terminate, suspend, withdraw, amend, or modify the Plan, or any benefit or cost sharing arrangement under any plan, at any time and for any reason (subject to any relevant collective bargaining arrangements).

Northrop Grumman also reserves the right to take appropriate action against any person who knowingly presents a false or fraudulent claim for payment under the Plan, or who otherwise attempts to defraud the Plan, including (but not limited to) termination from participation in the Plan, termination of employment, and criminal prosecution.