

Northrop-Grumman Corporation

Network - Copay Benefit Summary - Benefits Effective 07/01/2007

This is a summary of benefits for your Network Copay plan. *All in-network services must be performed by the Primary Care Physician (PCP), referred by the PCP or approved by the local Healthplan. All CIGNA Pharmacy and CIGNA Pharmacy Plus deductibles, out-of-pocket maximums, copays and annual maximums do not integrate with the employer medical program.*

Please note the following:

- Programs includes: Healthy Babies, 24 HIL and Healthy Rewards
- Optional Programs include: Well Aware
- The standard accumulation of deductibles, OOP maximums and benefit maximums is on a “contract” year basis

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan
	In-Network
Lifetime Maximum	\$2,000,000
Coinsurance Levels	All services will be covered at a 100% coinsurance level; with or without applicable copays.
Contract Year Deductible	None



Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan
	In-Network
Out-of-Pocket Maximum	None
Automatic Annual Reinstatement	\$25,000
Physician Services	
Primary Care Physician Office Visit	No charge after the \$20 PCP per office visit copay; No charge if only x-ray and/or lab services performed and billed.
Specialty Care Physician Office Visit Office Visits Consultant and Referral Physician Services	No charge after the \$40 Specialist per visit copay; No charge if only x-ray and/or lab services performed and billed.
Note: OB/GYN provider is considered a Specialist.	
Surgery Performed in the Physician's Office	No charge after the \$20/\$40 per office visit copay
Allergy Treatment/Injections	No charge after either the office visit copay or the actual charge, whichever is less.
Allergy Serum (dispensed by the provider in the office)	No charge
Preventive Care	
Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (Including immunizations)	No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.
Note: Well-Woman OB/GYN visit will be subject to the plan's Specialist copay.	
Immunizations (Including immunizations for travel)	No charge
Routine Mammogram, PSA, Pap Smear (Applies to any place of service)	No charge
	Note: The associated wellness exam is subject to the office visit copay.

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	Second Opinions (Services will be provided on a voluntary basis)
Outpatient Pre-Admission Testing Primary Care Physician Office Visit Specialist Physician Office Visit Outpatient Hospital Facility Independent X-ray and/or Lab Facility	No charge if only x-ray and/or lab services; PCP OV copay will apply if other office visit services also provided. No charge if only x-ray and/or lab services; Specialist OV copay will apply if other office visit services also provided. No charge No charge
Inpatient Hospital – Facility Services Copay Semi-Private Private Room Intensive Care Unit	\$200 per admission copay , then 100% Limited to the negotiated rate Limited to the negotiated rate Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room and Treatment Room	100% (No Copay)
Inpatient Hospital Doctor's Visits/Consultations	No charge
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	Multiple Surgical Reduction
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	No charge
Emergency Care and Urgent Care Services Physician's Office Hospital Emergency Room Urgent Care Facility or Outpatient Facility Ambulance	<p>No charge after the \$20/\$40 per office visit copay</p> <p>No charge after the \$250 per visit copay** Copay waived if admitted.</p> <p>No charge after the \$20 per visit copay** Copay waived if admitted.</p> <p>No Charge**</p> <p>** If not a true emergency, services are not covered.</p> <p>International medical Air Ambulance/evacuation is covered by AXA. If this service is required, the following individuals (at Northrop Grumman) should be contacted: Ms. Kathleen Sholinsky (310) 201-1633.</p>
Inpatient Services at other Health Care Facilities Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Combined maximum : 120 days per contract year No prior hospitalization required	<p>No charge</p> <p>Note: If the plan includes an Inpatient Hospital Facility copay, the copay does not apply.</p>

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	<p>Laboratory and Radiology Services</p> <p>MRIs, CAT Scans and PET Scans</p> <p>Other Laboratory and Radiology Services:</p> <p style="padding-left: 40px;">Outpatient Hospital Facility</p> <p style="padding-left: 40px;">Independent X-ray and/or Lab facility</p>
<p>Acupuncture</p> <p>Maximum: Up to 20 visits per contract year may be authorized/processed for the following diagnoses:</p> <ul style="list-style-type: none"> • Adult post-operative dental pain, when due to injury of sound natural teeth • Nausea and vomiting associated with chemotherapy • Nausea associated with pregnancy <p>Services for all other diagnoses are not covered.</p>	<p>No charge after the \$40 Specialist per office visit copay</p>
<p>Outpatient Private Duty Nursing Services</p> <p>Maximum: 120 visits per contract year.</p>	<p>No charge</p>
<p>Outpatient Physical Therapy</p> <p>Maximum: 50 visits per contract year.</p>	<p>No charge after the \$20 Per office visit copay</p>



Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	<p>Outpatient Occupational Therapy</p> <p>Maximum: 50 visits per contract year.</p>
<p>Outpatient Pulmonary Therapy</p> <p>Maximum: Unlimited</p>	<p>No charge after the \$20 Per office visit copay</p>
<p>Outpatient Speech Therapy</p> <p>Maximum: 50 visits per contract year.</p>	<p>No charge after the \$20 Per office visit copay</p>
<p>Self Referral Chiro Rider -</p> <p>Office Visits</p> <p>Maximum: 40 visits per contract year.</p>	<p>No charge after the \$40 Specialist per office visit copay.</p>
<p>Cardiac Rehabilitative Therapy</p> <p>Office Visits</p> <p>Maximum: Unlimited</p>	<p>No charge after the \$20 Per office visit copay.</p>
<p>Home Health Care</p> <p>Maximum: 120 Days per contract year</p> <p>Note: The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. a maximum of 8 visits per day).</p>	<p>No charge</p>

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	<p>Hospice</p> <p style="padding-left: 40px;">Inpatient Services</p> <p style="padding-left: 40px;">Outpatient Services</p>
<p>Bereavement Counseling</p> <p>Services provided as part of Hospice Care Program:</p> <p style="padding-left: 40px;">Inpatient Hospice</p> <p style="padding-left: 40px;">Outpatient Hospice</p> <p>Services provided by a Mental Health professional:</p>	<p>No charge</p> <p>No charge</p> <p>Covered under the Mental Health Benefit</p>
<p>Maternity</p> <p>Initial Visit to Confirm Pregnancy Note: OB/GYN visits will be subject to the plan's Specialist copay.</p> <p>All Subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Office Visits in addition to the global maternity fee when performed by an OB or specialist</p> <p>Delivery (Inpatient Hospital, Birthing Center)</p>	<p>No charge after the PCP or Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed</p> <p>No charge</p> <p>No charge after the Specialist per office visit copay; No charge if only x-ray and/or lab services performed and billed.</p> <p>Same as plan's Inpatient Hospital Facility benefit</p>
<p>Abortion</p> <p>Includes elective and non-elective procedures</p> <p style="padding-left: 40px;">Office Visit</p> <p style="padding-left: 40px;">Inpatient Facility</p> <p style="padding-left: 40px;">Outpatient Surgical Facility</p> <p style="padding-left: 40px;">Physician's Services</p>	<p>No charge after the PCP or Specialist per office visit copay.</p> <p>Same as the plan's Inpatient Hospital Facility benefit</p> <p>Same as the plan's Outpatient Facility Services benefit</p> <p>No charge</p>

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan
	In-Network
Family Planning Office Visits Including Tests and Counseling Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excludes reversals) Inpatient Facility Outpatient Facility Physician's Services	No charge after the PCP or Specialist per office visit copay. Note: Charges billed by a separate outpatient diagnostic facility will be covered under the plan's Laboratory and Radiology benefit. Same as the plan's Inpatient Hospital Facility benefit Same as the plan's Outpatient Facility Services benefit No charge



Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	<p>Infertility Treatment - Optional Buy-up Benefit #2</p> <p>Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> • Testing and treatment services performed in connection with an underlying medical condition. • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial Insemination, In-vitro, GIFT, ZIFT <p style="margin-left: 40px;">Office Visit (Tests, Counseling)</p> <p style="margin-left: 40px;">Surgical Procedure Copay:</p> <p style="margin-left: 40px;">Inpatient Facility</p> <p style="margin-left: 40px;">Outpatient Facility</p> <p style="margin-left: 40px;">Physician's Services</p> <p style="margin-left: 40px;">Lifetime Maximum:</p>

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	<p>Organ Transplants Includes all medically appropriate, non-experimental transplants</p> <p style="padding-left: 40px;">Office Visit</p> <p style="padding-left: 40px;">Inpatient Facility</p> <p style="padding-left: 40px;">Inpatient Physician's Services</p> <p style="padding-left: 40px;">Travel Maximum</p>
<p>Durable Medical Equipment</p>	<p>No charge</p> <p>Unlimited maximum (subject to the Plan's Lifetime Maximum)</p>
<p>External Prosthetic Appliances</p> <p>Deductible: None</p>	<p>No charge</p> <p>Unlimited maximum (subject to the Plan's Lifetime Maximum)</p>
<p>Foot Orthotics</p> <p>Covers Physician prescribed orthopedic shoes or inserts.</p>	<p>No charge</p> <p>Unlimited maximum (subject to the Plan's Lifetime Maximum)</p>
<p>Wigs</p> <p>Maximum: \$1,500 per contract year.</p>	<p>No charge</p>
<p>Coverage for wigs is provided only when a covered person has hair loss associated with (a) chemotherapy or radiation treatment, (b) endocrine imbalance, (c) metabolic diseases including alopecia areata in women, (d) psychological disorders, or (e) acute traumatic scalp injuries associated with hair loss will be evaluated on an individual case basis.</p>	

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	<p>Dental Care Limited to charges made for a continuous course of dental treatment started within 12 months of an injury to sound, natural teeth.</p> <p>Doctor's Office</p> <p>Inpatient Facility</p> <p>Outpatient Surgical Facility</p> <p>Physician's Services</p>
<p>Surgical TMJ Treatment Provided on a limited, case by case, basis. Excludes Non-Surgical TMJ treatment. Subject to medical necessity.</p> <p>Doctor's Office</p> <p>Inpatient Facility</p> <p>Outpatient Surgical Facility</p> <p>Physician's Services</p>	<p>No charge after the \$40 Specialist per office visit copay</p> <p>Same as the plan's Inpatient Hospital Facility benefit</p> <p>Same as the plan's Outpatient Facility Services benefit</p> <p>No charge</p>
<p>Hearing Services</p> <p>Hearing Exam</p> <p>Hearing Aid</p> <p>Contract Year Maximum: - \$500* per Plan Year</p> <p>*The \$500 maximum applies separately to each ear.</p>	<p>No charge after Specialist's \$40 per office visit copay</p> <p>100%</p> <p>Note: Coverage is provided for charges for the exam (one each ContractYear), hearing aid, fitting of the aid, and replacement of the aid. Replacement Frequency - once every three Plan years. Hearing aid batteries are not covered.</p>
<p>Routine Foot Disorders</p>	<p>Not Covered</p>
<p>Vision Care</p>	<p>PCP Only: No charge after \$20 per visit copay. Covers routine screening only (One per Contract Year) and applies only to children under age 19.</p>

Benefits	CIGNA HealthCare Network Copay Plan Northrop-Grumman Corporation Active Plan In-Network
	Pre-Existing Condition Limitation
Pre-Admission Certification - Continued Stay Review Standard : PHS+ Inpatient Pre-Admission Certification - Continued Stay Review (required for all inpatient admissions) Outpatient Prior Authorization - PHS+ Model only (required for selected outpatient procedures and diagnostic testing).	Coordinated by Provider/PCP Coordinated by Provider/PCP
Case Management	Coordinated by Healthplan. This is a service designated to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost-effective care while maximizing the patient's quality of life.

Mental Health & Substance Abuse:

Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:

- All MH and SA services will be provided by CIGNA Behavioral Health (CBH). All claims will be processed by CBH.

Program Feature	CIGNA Behavioral Health Northrop-Grumman Corporation Active Plan
	In-Network
Deductible	None
Inpatient Care Hospital Expenses: Room & Board, Drug, X-ray, Lab & Physician Charges, Detoxification Contract Year Maximum	Pre-certification Required 100% coverage after \$200 copay. 60 days combined Mental Health & Substance Abuse
Emergency & Urgent Care Services Hospital Emergency Room (if not admitted) Ambulance	\$250 copay 100% coverage If not a true emergency, services are not covered.
Intermediate Levels of Care Includes: Residential Day Treatment/Partial Hospitalization Contract Year Maximum	Pre-certification Required 100% coverage after \$200 copay Conversion from Inpatient MH & SA 60 days maximum: Residential: 2 Days for 1 Inpatient Day Day Treatment/Partial Hospitalization: 2 Days for 1 Inpatient Day Combined with Inpatient maximum using conversion ratio above
Outpatient Care Includes: Group Therapy & Substance Abuse Structured Outpatient Program (including outpatient detox) Contract Year Maximum	\$20 co-pay per visit 60 visits combined Mental Health & Substance Abuse:
Lifetime Maximums Substance Abuse:	\$2,000,000 Mental Health & Substance Abuse combined with Medical 2 Course(s) of Treatment
Pre-Certification	Required for all In-Network Inpatient and Intermediate Levels of Care. Failure to obtain preauthorization will result in \$0 payment.

CIGNA Pharmacy Plan:

- The following are included in the pharmacy plan:
 - Insulin syringes and needles, diabetic test strips and lancets,
 - Pre-natal vitamins and certain prescription vitamins, such as, Folic Acid Preparations (i.e., Folic Acid), Vitamin D Preparations (i.e., Calderol, D.H.T., Hytakerol, Rocaltrol, Vitamin D), and Vitamin K Preparations (i.e., Mephyton),
 - Certain self-injectable drugs subject to quantity limitations: Ana-Kit, Arixtra, D.H.E. 45, Epipen, Epipen Jr., Fragmin, Glucagon, Heparin, Imitrex, Innohep and Lovenox.
 - Certain self-injectable drugs not subject to quantity limitations: Insulin and Cyanocobalamin.
- The open prescriber panel provision is applied to the pharmacy plan. Therefore, members' prescriptions are covered if purchased at any participating pharmacy, regardless of the physician's status (participating or non-participating) within our network.
- Infertility drugs are covered, subject to the overall infertility lifetime maximum. Infertility injectable drugs are covered under the medical plan. Oral fertility drugs are covered under the pharmacy plan.

Benefits	CIGNA Pharmacy Plan Northrop-Grumman Corporation Active Plan
	In-Network
Retail	<p><u>Copay:</u> Generic: Greater of 10% or \$5 Preferred Brand: Greater of 10% or \$20 Non-Preferred Brand: Greater of 10% or \$40</p> <p><u>Maximum:</u> No more that a 30 days supply per prescription order or refill.</p>
Mail Order	<p><u>Copay:</u> Generic: Greater of 10% or \$5 Preferred Brand: Greater of 10% or \$20 Non-Preferred Brand: Greater of 10% or \$40</p> <p><u>Maximum:</u> No more that a 90 days supply per prescription order or refill.</p>
<p>Out-Of-Pocket Maximums: <i>Individual</i> <i>Family (Aggregate)</i></p> <p><i>Both Retail and Mail Order Copay and Coinsurance amounts will apply toward the Out-of-Pocket Maximums.</i></p>	<p>\$1,500 per contract year \$3,000 per contract year</p> <p>Pharmacy Out-of-Pocket Maximums do not integrate with the employer's medical program.</p>

Once the Individual Out-of-Pocket Maximum has been satisfied by one family member during a contract year, no additional copay or coinsurance will apply, and the plan will pay 100% of covered drug expenses (Retail and/or Mail Order) incurred by that family member during the remainder of that contract year.

Once the Family Out-of-Pocket Maximum has been satisfied by two or more family members, during a contract year, no additional copay or coinsurance will apply, and the plan will pay 100% of covered drug expenses (Retail and/or Mail Order) incurred by all family members during the remainder of that contract year.

Benefit Exclusions (by way of example but not limited to):

Your plan provides coverage for medically necessary services. Your plan does not provide coverage for the following except as required by law:

1. Services that are not medically necessary, except specifically outlined preventive care;
2. Charges which the person is not legally required to pay;
3. Charges made by a hospital owned by or performing services for the U.S. government if the charges are directly related to a sickness or injury connected to military service;
4. Custodial services not intended primarily to treat a specific injury or sickness, or any education or training;
5. Experimental or investigational procedures and treatments;
6. Cosmetic surgery or therapy, except when performed (a) to repair or correct severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities, (b) for treatment of tumors, (c) for treatment of trauma, (d) for treatment of disease, or (e) for treatment of complications of medically necessary, non-cosmetic surgery. Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by the Healthplan Medical Director.
7. Non surgical treatment of TMJ disorders;
8. Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance or government licenses and court ordered forensic or custodial evaluations.
9. Treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an injury to sound natural teeth; (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; or (c) charges made by the outpatient department of a Hospital in connection with surgery.
10. Reversal of voluntary sterilization procedures, and certain infertility services;
11. Transsexual surgery and related services;
12. Treatment for erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction;
13. Therapy to improve general physical condition;
14. Personal or comfort items such as personal care kits, television, and telephone rental in hospitals;
15. Eyeglasses, hearing aids or examinations and prescription fitting, except as provided in the Certificate;
16. Certain internal or external prostheses, or replacement of external prostheses due to wear and tear, loss, theft or destruction;
17. Surgical treatment for correction of refractive errors, including radial keratotomy;
18. Prescription and non-prescription drugs, except as provided in the benefits section of the Certificate;
19. Routine foot care;
20. Amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder;
21. Any injury resulting from, or in the course of, any employment for wage or profit;
22. Any sickness which is covered under any workers' compensation or similar law.
23. Charges for over the counter disposable or consumable supplies
24. Charges for orthotic devices, except that medically necessary, custom foot orthotics are covered under the plan
25. Charges in excess of reasonable and customary limitations;
26. Charges for medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
27. Certain Durable Medical Equipment (DME). DME is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to: crutches; hospital beds; wheel chairs; respirators; and dialysis machines.
28. Non-medical ancillary services, including but not limited to vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, work hardening, driving safety and services, training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.



29. Cosmetics, dietary supplements, helath and beauty aids, and nutritional formulae.
30. Charges for acupressure treatment.

This Benefit Summary highlights some of the benefits available under your plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are administered by Connecticut General Life Insurance Company.

