

# **NORTHROP GRUMMAN**

## **Benefits Effective 07/01/2005**

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.*

<b>Benefits</b>	<b>CIGNA HealthCare Network Copay Plan NORTHROP GRUMMAN Active Plan</b>
	<b>In-Network</b>
<b>Lifetime Maximum</b>	\$2,000,000
<b>Coinsurance Levels</b>	All services will be covered at a 100% coinsurance level; with or without applicable copays.
<b>Contract Year Deductible</b>	None
<b>Out-of-Pocket Maximum</b>	None
<b>Automatic Annual Reinstatement</b>	\$25,000
<b>Physician Services</b>	
<b>Primary Care Physician Office Visit</b>	No charge after the \$10 PCP per office visit copay
<b>Specialty Care Physician Office Visit</b> Office Visits Consultant and Referral Physician Services	No charge after the \$20 Specialist per visit copay
Surgery Performed in the Physician's Office	No charge after the \$10/\$20 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
<b>Preventive Care</b>	
Routine Preventive Care: Well-Baby, Well-Child, Adult and Well-Woman (Including immunizations)	No charge after the \$10 per office visit copay
Immunizations	No charge
<b>Routine Mammogram, PSA, Pap Smear</b> (Applies to any place of service)	No charge  <b>Note:</b> The associated wellness exam is subject to the office visit copay.

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	<b>In-Network</b>
<b>Second Opinions</b> (Services will be provided on a voluntary basis)	No charge after the \$20 Specialist per office visit copay
<b>Outpatient Pre-Admission Testing</b>	
Primary Care Physician Office Visit	No charge if only x-ray and/or lab services; PCP OV copay will apply if other office visit services also provided.
Specialist Physician Office Visit	No charge if only x-ray and/or lab services; Specialist OV copay will apply if other office visit services also provided.
Outpatient Hospital Facility	No charge
Independent X-ray and/or Lab Facility	No charge
<b>Inpatient Hospital — Facility Services</b>	
Copay	None (\$0)
Semi-Private	Limited to the negotiated rate
Private Room	Limited to the negotiated rate
Intensive Care Unit	Limited to the negotiated rate
<b>Outpatient Facility Services</b>	
Operating Room, Recovery Room, Procedures Room and Treatment Room	100% (No Copay)
<b>Inpatient Hospital Doctor's Visits/Consultations</b>	No charge
<b>Inpatient Hospital Professional Services</b>	
Surgeon	No charge
Radiologist	
Pathologist	
Anesthesiologist	
<b>Multiple Surgical Reduction</b>	Not Applicable

<b>Benefits</b>	<b>CIGNA HealthCare Network Copay Plan NORTHROP GRUMMAN Active Plan</b>
	<b>In-Network</b>
<b>Outpatient Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	No charge
<b>Emergency Care and Urgent Care Services</b>  Physician's Office  Hospital Emergency Room  Urgent Care Facility or Outpatient Facility  Ambulance	No charge after the \$10/\$20 per office visit copay  No charge after the \$100 per visit copay** Copay waived if admitted.  No charge after the \$20 per visit copay** Copay waived if admitted.  No Charge**  ** If not a true emergency, services are not covered.  <b>International medical Air Ambulance/evacuation is covered by AXA.</b>
<b>Inpatient Services at other Health Care Facilities</b>  Includes: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities  Combined maximum : 120 days per contract year  No prior hospitalization required	No charge

<b>Benefits</b>	<b>CIGNA HealthCare Network Copay Plan NORTHROP GRUMMAN Active Plan</b>
	<b>In-Network</b>
<b>Laboratory and Radiology Services</b>  <b>MRIs, CAT Scans and PET Scans</b>  <b>Other Laboratory and Radiology Services:</b>  Outpatient Hospital Facility  Independent X-ray and/or Lab facility	No charge (No Copay)    No charge  No charge
<b>Acupuncture</b>  Maximum: Up to 20 visits	No charge after the \$20 Specialist per office visit copay
<b>Outpatient Private Duty Nursing Services</b>  Maximum: 120 visits per contract year.	No charge
<b>Outpatient Physical Therapy</b>  Maximum: 50 visits per contract year.	No charge after the \$20 Specialist per office visit copay
<b>Outpatient Occupational Therapy</b>  Maximum: 50 visits per contract year.	No charge after the \$20 Specialist per office visit copay
<b>Outpatient Pulmonary Therapy</b>  Maximum: Unlimited	No charge after the \$20 Specialist per office visit copay
<b>Outpatient Speech Therapy</b>  Maximum: 50 visits per contract year.	No charge after the \$20 Specialist per office visit copay
<b>Self Referral Chiro Rider -</b>  Office Visits  Maximum: 40 visits per contract year.	No charge after the \$20 Specialist per office visit copay.

<b>Benefits</b>	<b>CIGNA HealthCare Network Copay Plan NORTHROP GRUMMAN Active Plan</b>
	<b>In-Network</b>
<p><b>Cardiac Rehabilitative Therapy</b></p> <p>Office Visits</p> <p>Maximum: Unlimited</p>	No charge after the \$20 Specialist per office visit copay.
<p><b>Home Health Care</b></p> <p><b>Maximum:</b> 120 Days per contract year</p> <p><b>Note:</b> 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>	No charge
<p><b>Hospice</b></p> <p>Inpatient Services</p> <p>Outpatient Services</p>	No charge No charge
<p><b>Bereavement Counseling</b></p> <p>Services provided as part of Hospice Care Program:</p> <p>Inpatient Hospice</p> <p>Outpatient Hospice</p> <p>Services provided by a Mental Health professional:</p>	No charge No charge Covered under the Mental Health Benefit
<p><b>Maternity</b></p> <p>Initial Visit to Confirm Pregnancy</p> <p>All Subsequent Prenatal Visits, Postnatal Visits, and Delivery</p> <p>Delivery (Inpatient Hospital, Birthing Center)</p>	No charge after the \$10 PCP or \$20 Specialist per office visit copay No charge Same as plan's Inpatient Hospital Facility benefit

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	<b>In-Network</b>
<p><b>Abortion</b> Includes elective and non-elective procedures</p> <p>Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Surgical Facility</p> <p>Physician's Services</p>	<p>No charge after the \$10 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><b>Family Planning</b></p> <p>Office Visits Including Tests and Counseling</p> <p>Surgical Sterilization Procedures for Vasectomy/Tubal Ligations (excludes reversals)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$10 per office visit copay</p> <p>Note: Charges billed by a separate outpatient diagnostic facility will be covered under the plan's Laboratory and Radiology benefit.</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>



<b>Benefits</b>	<b>CIGNA HealthCare Network Copay Plan NORTHROP GRUMMAN Active Plan</b>
	<b>In-Network</b>
<p><b>Infertility Treatment -</b></p> <p>Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> <li>• Testing and treatment services performed in connection with an underlying medical condition.</li> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial Insemination, <b>In-vitro</b>, <b>GIFT</b>, <b>ZIFT</b></li> </ul> <p>Office Visit (Tests, Counseling)</p> <p>Surgical Procedure Copay:</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Maximum:</p>	<p>No charge after the \$20 Specialist per office visit copay</p> <p>None</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>\$25,000</p> <p>Note: Charges for prescription medication prescribed for treatment of Infertility and covered under the CIGNA Pharmacy portion of the plan will also be subject to the \$25,000 Lifetime Maximum.</p>
<p><b>Organ Transplants</b></p> <p>Includes all medically appropriate, non-experimental transplants</p> <p>Office Visit</p> <p>Inpatient Facility</p> <p>Inpatient Physician's Services</p> <p>Travel Maximum</p>	<p>No charge after the \$20 Specialist per office visit copay</p> <p>Same as the plan's Inpatient Hospital Facility benefit</p> <p>No charge</p> <p>\$10,000 Per Transplant/Per Lifetime Maximum (only available when using a Lifesource Facility)</p>
<p><b>Durable Medical Equipment</b></p>	<p>No charge</p> <p>Unlimited maximum (subject to the Plan's Lifetime Maximum)</p>

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	<b>In-Network</b>
<b>External Prosthetic Appliances</b>  Deductible: None	No charge  Unlimited maximum (subject to the Plan's Lifetime Maximum)
<b>Foot Orthotics</b>  Covers Physician prescribed orthopedic shoes or inserts.	No charge  Limited to 1 pair per person per plan year (subject to the Plan's Lifetime Maximum)
<b>Wigs*</b>  Maximum: \$1,500 per contract year.	No charge
*Coverage 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.	
<b>Dental Care</b> Limited to charges made for a continuous course of dental treatment received within 12 months of an injury to sound, natural teeth.	
Doctor's Office	No charge after the \$10/\$20 per office visit copay
Inpatient Facility	Same as the plan's Inpatient Hospital Facility benefit
Outpatient Surgical Facility	Same as the plan's Outpatient Facility Services benefit
Physician's Services	No charge
<b>Surgical TMJ</b>  Provided on a limited, case by case, basis. Always excludes appliances and orthodontic treatment. Subject to medical necessity.	
Doctor's Office	No charge after the \$20 Specialist per office visit copay
Inpatient Facility	Same as the plan's Inpatient Hospital Facility benefit
Outpatient Surgical Facility	Same as the plan's Outpatient Facility Services benefit
Physician's Services	No charge

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	<b>In-Network</b>
<b>Hearing Services</b>	
Hearing Exam	No charge after Specialist's \$20 per office visit copay
Hearing Aid	100%
Contract Year Maximum: - \$500* per Plan Year	<b>Note:</b> Coverage is provided for charges for the exam (one each Contract Year), hearing aid, fitting of the aid, and replacement of the aid. Replacement Frequency - once every 36 months. Hearing aid batteries are not covered.
*The \$500 maximum applies separately to each ear.	
<b>Routine Foot Disorders</b>	Not Covered
<b>Pre-Existing Condition Limitation</b>	Not Applicable
<b>Pre-Admission Certification—Continued Stay Review</b> (required for all Inpatient Admissions)	Coordinated by PCP
<b>Case Management</b>	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.
<b>Mental Health &amp; Substance Abuse:</b>	
<b>Please note the following regarding Mental Health (MH) and Substance Abuse (SA) benefit administration:</b>	
<ul style="list-style-type: none"> <li>• All MH and SA services will be provided by CIGNA Behavioral Health (CBH). All claims will be processed by CBH.</li> <li>• Substance Abuse includes Alcohol and Drug Abuse services.</li> <li>• Maximums are separate between MH and SA services.</li> <li>• Transition of Care benefits are provided for a 60-day time period.</li> </ul>	

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	<b>In-Network</b>
<p><b>Mental Health</b></p> <p><b>Inpatient</b> Maximum: 30 Days per contract year</p> <p><b>Outpatient</b> Maximum: 30 Visits per contract year</p> <p><b>Group Therapy</b> Subject to the plan's Outpatient MH benefit maximum based on a 1:1 ratio.</p>	<p>Subject to the same coinsurance and copay level as the medical plan's Inpatient Hospital Facility benefit.</p> <p>No charge after \$10 per visit copay.</p> <p>No charge after \$10 per visit copay</p>
<p><b>Substance Abuse Rehabilitation (Alcohol &amp; Drug)</b></p> <p><b>Inpatient</b> Maximum: 30 Days per contract year Maximum of 2 confinements per lifetime.</p> <p><b>Outpatient</b> Maximum: 30 Visits per contract year</p> <p><b>Group Therapy</b> Subject to the plan's Outpatient SA benefit maximum based on a 1:1 ratio.</p>	<p>Subject to the same coinsurance and copay level as the medical plan's Inpatient Hospital Facility benefit; subject to the plan deductible.</p> <p>No charge after \$10 per visit copay</p> <p>No charge after \$10 per visit copay</p>
<p><b>Mental Health &amp; Substance Abuse - Partial Hospitalization, Outpatient Structured Program, Telephonic Consultation and Residential Treatment programs:</b></p> <p><i>The following administration will apply:</i></p> <p><i>Partial Hospitalization: MH and/or SA partial hospitalization services maximum is equal to 2X the Inpatient benefit maximum; e.g. day limits are combined (2:1 ratio). The coinsurance level for partial hospitalization services is the same as the coinsurance level for inpatient MH/SA services.</i></p> <p><i>Substance Abuse Outpatient Structured Program (includes outpatient detoxification): Subject to the same benefit levels/maximums as the plan's Outpatient SA benefits.</i></p> <p><i>Telephonic Consultation: No charge for 1-3 telephonic counseling and/or designated non-clinical services.</i></p> <p><i>Residential Treatment: Mental Health and Substance Abuse Residential Treatment services maximum is equal to 2X the Inpatient benefit maximum; e.g. day limits are combined (2:1 ratio). The coinsurance level for Residential Treatment services is the same as the coinsurance level for inpatient MH/SA services.</i></p>	

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	<b>In-Network</b>					
<p><b>Mental Health &amp; Substance Abuse - Utilization Review/Case Management</b></p> <p><b>Standard Inpatient and Outpatient Review Option (applies to all plans):</b> CBH provides utilization review and case management services for In-network Inpatient and Outpatient services.</p>						
<b>Vision Care</b>	<p>PCP Only: No charge after \$10 per visit copay. Covers routine screening only (One per Contract Year).</p>					
<p><b>Prescription Drugs (ASO)</b></p> <p><b>Three-Tier “Greater Of” Option:</b> No Mandatory Generic, Incentive Formulary</p>	<p><b><u>Retail:</u></b></p> <p style="padding-left: 40px;">Generic: Greater of 10% or \$5 Preferred Brand: Greater of 10% or \$20 Non-Preferred Brand: Greater of 10% or \$40</p> <p><b><u>Mail Order:</u></b> The “greater of” structure applies to retail and mail order. The same retail coinsurance percentage is utilized for retail and mail order. The mail order dollar copay is the same as the Retail Copay.</p> <table border="0" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><b><u>Retail</u></b></th> <th style="text-align: left; border-bottom: 1px solid black;"><b><u>Mail Order Copays</u></b></th> </tr> </thead> <tbody> <tr> <td style="padding-left: 40px;">Greater of Coinsurance (10)% or \$5/\$20/\$40</td> <td style="padding-left: 40px;">Greater of Coinsurance (10)% or \$5/\$20/\$40</td> </tr> </tbody> </table>		<b><u>Retail</u></b>	<b><u>Mail Order Copays</u></b>	Greater of Coinsurance (10)% or \$5/\$20/\$40	Greater of Coinsurance (10)% or \$5/\$20/\$40
<b><u>Retail</u></b>	<b><u>Mail Order Copays</u></b>					
Greater of Coinsurance (10)% or \$5/\$20/\$40	Greater of Coinsurance (10)% or \$5/\$20/\$40					
<p><b>Out-Of-Pocket Maximums:</b> <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>\$750 per contract year \$1,500 per contract year</p> <p>Pharmacy Out-of-Pocket Maximums do not integrate with the employer's medical program.</p>					
<p><i>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.</i></p> <p><i>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.</i></p>						
<b>Out-Of-Network Benefits:</b>	No Benefit.					

## **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 (other than abnormalities of the jaws or TMJ disorder), (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.  
Also covered, is cosmetic surgery or therapy performed which qualifies as (a) reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are essential and medically necessary; or (b) reconstructive surgery following a mastectomy, including surgery and reconstruction of the other breast to achieve symmetry.
7. Reports, evaluations, examinations, or hospitalizations not required for health reasons, such as employment, insurance or government licenses and court ordered forensic or custodial evaluations.
8. Treatment of the teeth or periodontium, unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within twelve 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.
9. Reversal of voluntary sterilization procedures, and certain infertility services;
10. Transsexual surgery and related services;
11. Treatment for erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction;
12. Therapy to improve general physical condition;
13. Personal or comfort items such as personal care kits, television, and telephone rental in hospitals;
14. Eyeglasses, hearing aids or examinations and prescription fitting, except as provided in the Certificate;
15. Certain internal or external prostheses, or replacement of external prostheses due to wear and tear, loss, theft or destruction;
16. Surgical treatment for correction of refractive errors, including radial keratotomy;
17. Prescription and non-prescription drugs, except as provided in the benefits section of the Certificate;
18. Routine foot care;
19. 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;
20. Any injury resulting from, or in the course of, any employment for wage or profit;
21. Any sickness which is covered under any workers' compensation or similar law.
22. Charges for over the counter disposable or consumable supplies, including orthotic devices.
23. Charges in excess of reasonable and customary limitations;
24. 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; an dialysis machines.
25. 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.
26. Cosmetics, dietary supplements, helath and beauty aids, and nutritional formulae.

***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.***

