Your HMO Benefit




For Retirees in Hawaii and Puerto Rico

JCPenney
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Summary Plan Description Insert

Effective January 1, 2007

This addition to the summary plan description (SPD) contains important information about your HMO benefit. To get a copy of this addition or the SPD in Spanish or to request assistance in Spanish, contact PowerLine at 1-888-890-8900.

Este suplemento de la descripción resumida del plan contiene información importante sobre su beneficio del plan HMO. Para obtener una copia en español de este suplemento o de la descripción resumida del plan, o para pedir ayuda en español, póngase en contacto con PowerLine al 1-888-890-8900.

HMO Benefit

JCPenney is committed to providing retirees with healthcare that is affordable, simple and competitive. The HMO options are available to retirees in Hawaii and Puerto Rico. This insert to the Summary Plan Description (SPD) provides details about the HMO benefits.

FAQs:

Key Terms:

Definitions of key terms can be found throughout this document. A collection of definitions can be found in the "Key Terms" chapter in the *Your Retiree Benefits Book 1 — Health and Welfare*.

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HMO Benefit

The HMO options are administered by either Health Plan Hawaii or Humana, depending on where you live. You may contact Health Plan Hawaii or Humana for more information, to request a free copy of the policy, exclusions, limitations, and claims and appeals procedures, to request a list of primary care physicians (PCPs) or with a question regarding how a specific benefit works.

This information is intended to be a summary of your benefits and does not include all plan and/or policy provisions, exclusions, and limitations. If there is a discrepancy between this document and the plan or policy, the terms of the plan or policy will govern. You may obtain a copy of the plan by contacting the Company. You may obtain a copy of the policy by contacting the insurer. The Company reserves the right to terminate or amend its benefit plans at any time.

Benefits At-a-Glance

Medical Option	Eligibility	Coverage Levels	Key Features
HMO			
Humana (HMO)	All eligible retirees who live in Puerto Rico	• Retiree Only • Retiree + Spouse/ DP • Retiree + Child(ren) • Retiree + Family	• Preventive care generally covered at 100% • No annual deductible • No excess charges • No claim forms • Primary Care Physicians (PCP) oversee and manage a participant's healthcare
The Hawaii Medical and Dental Plan	All eligible retirees who live in Hawaii		

Eligibility

See the "Eligibility & Enrollment" chapter in *Your Retiree Benefits Book 1 — Health and Welfare* for more information on eligibility, enrolling and dependents.

Option Overview

The HMO options provide you with a full range of healthcare services. Because your care — except for emergencies — is directed by an HMO network physician, your healthcare needs and expenses can be managed more closely.

Each HMO has different benefits and requirements. This insert describes only general provisions that apply to all HMO participants. It is your responsibility to read the coverage description provided by your HMO for specific details. You should also review the Health Plan Comparison Chart included in your enrollment material.

HMO Considerations

HMO Network

The HMO service area network (network) is the geographic area in which the HMO provides medical coverage. The network is determined by the number of primary care physicians (PCPs) or providers practicing within a specified number of miles from the center of a zip code. In metropolitan areas, the network has at least two (2) PCPs accepting new patients within a 15-mile radius and one hospital within a 30-mile radius. In rural areas, the network has at least two (2) PCPs accepting new patients within a 30-mile radius and one hospital within a 45-mile radius. At least 90% of the PCPs in a given network must be accepting new patients.

You may receive a free list of providers by calling the HMO or by logging on to the HMO's Web site. Please refer to your enrollment worksheet or your ID card (if you are currently enrolled) for your HMO's telephone number and/or Web site address.

What is an HMO?

A Health Maintenance Organization (HMO) is a managed care form of insurance, using hospitals, doctors and other providers with which the HMO has a contract. Typically, care provided in an HMO follows a set of care guidelines provided through the HMO's network of providers. HMO providers manage their patients' healthcare and work to reduce unnecessary services.

HMO Benefit

Other Considerations

- **Less Flexibility –** HMOs serve specific geographic areas. Except for emergency care, you must be treated by an HMO network physician or hospital to receive benefits. In most cases, if you receive treatment outside the service area or from a non-HMO medical care provider, you will pay the full cost of your treatment.
- **Predictable Cost for Services –** You pay a specified copayment for most services provided by an HMO network physician or hospital.
- **Wide Range of Services –** HMO medical care services vary, but most offer preventive, behavioral healthcare, routine and major medical care. Some HMOs also offer dental care.
- **Managed Care –** Your HMO PCP oversees and coordinates your overall healthcare, including referring you to HMO specialists.
- **No Claim Forms –** Usually, you don't have to file claims for medical care services provided by your PCP or another HMO provider.
- **No Excess Charges –** With a managed care program, you don't have to worry about certifying expenses or paying charges that are above the reasonable and customary (R&C) amount.
- **Annual Deductible –** Typically, there is no annual deductible for in-network care. It is your responsibility to check with your HMO for more information.

Coverage for Dependents Who Live in Another City

If your covered dependent lives in another city (for example, a child who is away at school), call your HMO for information about HMO-affiliated providers in that area. If your dependent lives outside the HMO coverage area, benefits generally will **not** be available, except for emergency care, unless your dependent travels to a participating network area.

Summary of Coverage

For the specific coverages available under your HMO, see the materials provided by the HMO or talk directly to an HMO representative. These materials are available automatically and without cost to all participants and beneficiaries who request them. Contact the HMO at the telephone number on your enrollment worksheet or ID card.

Each HMO, not JCPenney or the Medical Plan, is responsible for the medical care and services it arranges. Your coverage, other than eligibility, is described in the written materials available from the HMO. It is important to review your HMO's material carefully for all provisions and exclusions. If you do not have this information or you need more specific information, call your HMO directly.

How the HMO Works

Your Responsibilities

It is your responsibility to choose a physician in the HMO network to be your PCP. If you receive care from an HMO provider other than the PCP the HMO has you enrolled with, you may not receive reimbursement. Because your PCP closely manages your medical care, you don't assume as much responsibility for ensuring that the services you receive are covered expenses. However, if you choose to use medical care providers outside the HMO network, you will have to pay all expenses yourself.

Choosing a Provider

You and your covered dependent must choose a PCP who will manage your healthcare needs. PCPs are usually internists, pediatricians, family doctors or general practitioners. The PCP you select provides most of your routine medical care and some specialty care. If you need more complex or specialized treatment, your PCP will refer you to an HMO specialist. You and your covered dependents may each choose the same PCP or different PCPs.

For information on HMO healthcare providers and affiliated hospitals, look in your HMO enrollment package, check the HMO's Web site or call the member services number on the back of your HMO ID card. Generally, you and your covered dependents must go to an HMO facility for treatment.

If you do not select a PCP, one may be assigned for you. If you do not receive care from the PCP on file for you with the HMO, you may not receive reimbursement.

Changing Your Provider

Refer to your HMO booklet for rules on changing network providers. You may be limited in how often you may change and how quickly the change goes into effect. After a change, usually a new ID card will be issued.

Your HMO ID Card

You will receive an HMO ID card two to six weeks after your enrollment is complete. If you enroll during annual enrollment, you should receive your HMO ID card before your coverage effective date — which is January 1 of the plan year. Always show your HMO ID card when you visit a healthcare provider, including your PCP.

Why do I need to choose a PCP?

HMOs utilize a network of providers to oversee and manage participants' healthcare needs. Your PCP understands your situation and health needs and can ensure that you receive the appropriate level of treatment.

HMO Benefit

Paying Your Expenses

You pay a copayment to the medical care provider each time you are treated. The HMO is responsible for the remaining expenses. The following table shows the ranges for the various copayment amounts charged and benefits provided by the HMOs offered by the Company. It is your responsibility to check with your HMO for the exact copayment amounts you are required to pay.

Medical Care	Copayment/Benefit
Physician's visit • PCP office visit (Routine care; diagnosis and treatment of an illness or injury; lab and X-ray during office visit)	$14 - $17 copayment*
• Specialist office visit	$14 - $17 copayment*
Preventive care	Generally covered at 100% *
In-patient care	Generally covered at 100% *
Emergency room visit • Real emergency	$20 - $30 copayment*
• Non-emergency	Not covered*
Outpatient surgery	Varies depending on services*

**Check with your plan for exact coverage.*

If you receive care outside the HMO's network of healthcare providers — except in an emergency — you will have to pay all expenses yourself. If you require emergency care, you can visit a member hospital within your HMO network and pay a copayment as determined by your HMO. If you are outside of your HMO's network, emergency care is generally covered. It is your responsibility to understand your HMO's definition of "emergency" and to follow the correct procedures for emergency care.

Deductibles

Generally, there is no annual deductible for in-network care with HMO coverage. However, your HMO may have separate deductibles for specific services, such as hospital admissions. Check with your HMO for any deductible amounts that may apply.

Out-of-Pocket Maximum

The out-of-pocket maximum (OOPM) is the most you may pay for covered expenses during a plan year. Once you reach the OOPM, the HMO pays 100 percent of your eligible expenses for the rest of the year.

The HMO OOPMs range from $1,000 to $6,000. It is your responsibility to check with your HMO to see what your out-of-pocket maximum is.

Key Terms:

Copayment – The amount you pay to your PCP or HMO provider at the time services are received.

Deductible – The amount you must pay in a plan year before the HMO will reimburse you for medical expenses. Typically, HMOs don't have annual deductibles for in-network care, but may have individual deductible for some services.

Out-of-pocket maximum – The most you pay for covered expenses for in-network care during a plan year.

Lifetime Maximum Benefit

The Company does not set a lifetime maximum benefit on HMO coverage. However, your HMO may have a lifetime maximum benefit limit.

A lifetime maximum benefit applies to medical benefits provided by the Company. The Medical Plan will pay up to $2 million in benefits during a participant's lifetime, including expenses for behavioral healthcare, prescription drugs and expenses incurred during employment with any participating employer that participates in the Medical Plan. This includes benefits paid under the CDHP, PPO, OOA and MOFD options under the Medical Plan and Prescription Drug Program.

Medically Necessary Services

Medically necessary services or supplies are those widely accepted by the medical profession in the U.S. as effective, appropriate and essential, based on recognized standards of the healthcare specialty involved. Each HMO determines whether a particular course of treatment is medically necessary. Do not contact the Company or PowerLine if you have a claim or question about what is medically necessary under your HMO — only your HMO can make this determination.

Reasonable and Customary Charges

Reasonable and Customary (R&C) charges are those within the range of fees typically charged by most healthcare providers in the area where treatment is provided. Because HMOs charge set fees for services, R&C limitations generally do not apply.

Experimental, Investigational or Unproven

Each HMO determines whether a drug, device, procedure or treatment may be considered experimental, investigational or unproven. If it is determined to be experimental, investigational or unproven, the HMO may not offer the service or cover the expense. If you are unsure about whether a particular treatment falls into this category, contact your HMO for more details.

Pre-Certification

Because your PCP closely manages your medical care, most HMOs do not require pre-certification. You should contact your HMO directly for further information or to see if pre-certification provisions apply.

Pre-Existing Conditions

Most HMOs do not have pre-existing condition clauses and provide you with coverage from your first day of participation. However, you should check the HMO's coverage provisions if you or your dependents are concerned about pre-existing condition exclusions before you enroll in the HMO.

Covered Expenses

Coverage varies widely from one HMO to another and is described in the written materials available from your HMO. It is important to carefully review the HMO's current booklet for all provisions and exclusions. If you do not have this information or you need more specific information (such as a list of benefits), contact the HMO directly.

What if I need to see a specialist?

If you have a medical condition or experience an injury or illness that requires specialist care, your PCP will provide you with a referral. Some HMOs allow women to see an OB/GYN within the plan without a specialist referral from their PCP. Check with your HMO for details.

Medical Expenses

In addition to routine and major medical care, most HMOs provide coverage for preventive treatment – such as well-woman exams, mammograms, well-baby care, physical exams, prostate screenings and medical tests. Coverage for behavioral healthcare/substance abuse treatment is also provided through most HMOs.

Dental Expenses

Some HMOs cover certain dental expenses, but the coverage may not be as extensive as that offered under the Dental Plan. See the "Dental Plan" chapter for more information on dental benefits and the "Coordination of Benefits" section of the "Legal Notices" chapter in *Your Retiree Benefits Book 1 — Health and Welfare*.

Prescription Drugs

Prescription drug benefits under the HMO options are provided through the HMOs.

Behavioral Health Care/Substance Abuse Treatment

Behavioral healthcare and substance abuse treatment benefits under the HMO options are provided through the HMOs.

Expenses Not Covered

For a list of expenses that are not covered, read the coverage description provided by your HMO or contact your HMO.

General Information

The following information is important to your understanding of HMO processes.

By participating in the Medical Plan, you and your dependents agree to all Medical Plan provisions, including but not limited to the HMO's subrogation rights and right of reimbursement.

Filing a Claim or Appeal

Claims related to your eligibility for Medical Plan or The Hawaii Medical and Dental Plan coverage are determined by the Benefit Determination Review Team (BDRT). You should file a written claim for eligibility or enrollment (including name, Social Security Number, Unit Number, location, reason for claim and plan involved) with the BDRT as soon as possible. Your claim should be submitted in writing or by completing the Claim Initiation Form. Call PowerLine at 1-888-890-8900 to request the form. Send your letter or Claim Initiation Form to the BDRT at:

JCPenney – Benefit Determination Review Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

The BDRT will respond to any claim it receives within 60 days (unless the eligibility or enrollment claim arises in connection with a denied claim for healthcare or disability benefits, in which case faster timeframes apply). If more time is needed to respond to your claim due to special circumstances, the BDRT will notify you that it needs an extension of up to 60 days.

If your claim for eligibility or enrollment in the benefit plans is denied, you have the right to file an appeal. When your claim is denied, you will be advised of the reasons for the denial and provided with information on how and when to file an appeal.

See the "Administrative Information" chapter for more information on filing an appeal of a denied claim for eligibility or enrollment.

HMO Benefit Claims

Generally, you don't file claim forms for services provided by your PCP or another HMO provider. For information about coverage or a claim, call the HMO. The claims procedures for the HMO are provided automatically and without charge as part of the Certificate of Coverage, as a separate document.

The HMO itself governs benefits and providers. The HMO governs the benefit claims process and most administrative aspects of your coverage (except eligibility), including:

- Processes for filing benefit claims
- Appeal of denied benefit claims
- Collection of benefit overpayments
- Coordination of benefits between the HMO and any other coverage you or a covered dependent may have (including Medicare, Medicaid and Workers' Compensation insurance)
- Coverage of dependents who do not live with you
- Rights to reimbursement and subrogation when payments are available from other plans, insurance sources or legal settlements (including auto insurance), and
- Other administrative processes.

For information about specific services and reimbursement levels, as well as the rules for obtaining benefits, you should contact the HMO directly at the telephone number shown in your Enrollment Worksheet or ID card. Upon request, the HMO will send you written materials without charge that explain:

- The services provided
- Conditions under which services may be received or denied
- Claims procedures, and
- Procedures for review of denied claims.

The Hawaii Medical and Dental Plan or Health Plan Hawaii is exempt from the requirements of ERISA. Plan benefits are required by Hawaii law and are paid by the insurer.

Subrogation and Reimbursement

Refer to your HMO materials for any subrogation or reimbursement rights that your HMO may claim against you or any other third party.

Failure to Provide Information

If you fail or refuse to provide information required by the HMO, the HMO may cease paying all benefits until you cooperate. Refer to your policy or contact your HMO for more information.

Help with HMO Matters

If you have problems or questions related to your HMO, first call your HMO's member services department at the phone number provided on the back of your HMO ID card. In most cases, member services will be able to resolve your problem or concern.

If you are not satisfied with the answer you receive from your HMO, call PowerLine and ask to speak to an advocate. An advocate is a PowerLine specialist who understands HMO billing, benefits administration and claims processing. An advocate will help you work with the HMO to resolve your problem. If you appeal the HMO's decision about your benefit coverage, a PowerLine advocate can also help you work through the HMO's appeal process.

Coordination of Benefits

If you and any of your dependents are covered by more than one group health plan or any other insurance plan or policy, reimbursements are coordinated between plans so that benefits are not duplicated.

When you are covered by more than one health plan or any other insurance plan or policy, the plan that pays benefits first is called the "primary plan." The primary plan pays benefits without considering what the other plan may pay. Because HMOs vary greatly on administration of this clause, it is your responsibility to contact your HMO directly for more information. Refer to your policy or contact your HMO for more information.

When Coverage Ends

Generally, coverage ends after:

- You or your dependent loses eligibility
- You go on an unpaid leave
- Premiums are not paid
- Your employment ends
- You or your dependent dies
- The benefit is no longer offered by your participating employer
- The HMO option is amended to end coverage for a group or class that includes you or your dependents

- The HMO option is cancelled or ends and is not replaced, or
- You make a misrepresentation or fraudulent claim for benefits.

If your coverage ends, you and your covered dependents may be eligible to continue coverage under COBRA.

Continuing Your Coverage

You may be able to continue your benefits coverage for you and/or your eligible dependents under certain circumstances. If you:

- **Lose Benefits Eligible Status –** See "Life Events and Your Coverage" at the end of this chapter and the "Legal Notices" chapter for more information.
- **Die –** See the "Eligibility and Enrollment" chapter for more information.

Converting Coverage

Generally, Medical Plan coverage cannot be converted from group insurance to an individual policy. However, your HMO may allow you to convert your HMO coverage to an individual policy, if required by state law. Call your HMO's member services number on the back of your HMO ID card for information.

In addition, individual health insurance coverage may be available to anyone who wants to purchase it and avoid a break in coverage. A break in coverage of 63 or more days could result in limitations on coverage of pre-existing conditions. Call your state insurance department for information on individual healthcare coverage available in your state.

Additional Important Information

Additional information related to your coverage, benefits, rights and responsibilities under the Medical Plan, as well as information about the Medical Plan's administration, can be found in the "Eligibility and Enrollment" and "Administrative Information" chapters of *Your Retiree Benefits Book 1 — Health and Welfare*.

Life Events and Your Coverage

Within 60 days of a life event, you must notify PowerLine of any change of status. Proof of the event may be required. Any change requested must be consistent with your life event.

If You ...	What Happens to Your Medical Coverage
Retire	You and your dependents are automatically enrolled in retiree coverage, if eligible. Also, you and your dependents will be given a COBRA election.
Get married/form a partnership	You may enroll, add, change options or drop coverage for yourself and/or your new dependent(s).
Have a spouse/DP who loses benefits coverage	You may enroll, add, change options or drop coverage for yourself and your family.
Get divorced/ separated/ annulment/ terminate partnership	You may enroll, drop or change coverage options for yourself and your children. Spouse/DP coverage ends on the last day of the month in which the divorce or legal separation occurs or the partnership ends unless otherwise required by state law. Qualified Medical Child Support Orders (QMCSO) may require you or your spouse to cover your children. See QMCSO in the "Legal Notices" chapter for more information.
Have or adopt a child	You may enroll, add, change options or drop coverage for yourself and/or your new dependent(s).
Have a child who loses eligibility	Child coverage ends on the last day of the month before he or she reaches age 19, or age 24 if a full-time student or is no longer incapacitated. Child coverage also ends on the first of the month in which your child marries.
Are rehired and regain Benefits Eligible status	You must drop retiree coverage and reenroll in active coverage.
Are employed by another employer and become eligible for coverage	You must drop retiree coverage. You may later reenroll by providing proof of continuous creditable coverage.
Have a child who dies	You must call to drop child coverage unless you have other children covered.
Experience the death of your spouse/DP	You must call to drop coverage for your spouse/DP. You and your children may continue coverage or enroll with proof of continuous creditable coverage as long as they remain eligible and continue the required premium payments.

If You ...	What Happens to Your Medical Coverage
Die	If you were covered as a retiree, your spouse/DP and children may enroll in or continue coverage as long as they remain eligible and continue the required premium payments. If your surviving spouse/DP is an active Benefits Eligible Associate and covered under the retiree plan, he or she must enroll as an active Associate to continue coverage, along with any covered children. If your surviving spouse/DP loses coverage, he or she may reenroll as your surviving spouse/DP. Dependent children can be covered only if your surviving spouse/DP is covered under the plan. If you have no surviving spouse/DP or your spouse/DP does not enroll for coverage as a surviving spouse/DP, your eligible children may continue their coverage under COBRA. Your surviving spouse/DP may continue coverage if he or she remarries or forms a partnership, but may not enroll a new spouse/DP or new children. Your surviving spouse/DP and any eligible children must show proof of continuous coverage from the date of your retirement through the date of your death under: • The JCPenney Medical Plan, or • Other continuous creditable coverage. If your surviving spouse/DP and children don't elect coverage within 60 days of your death, they can't enroll in the plan later.

JCPenney
WINNING TOGETHER Principles

associates .....
We value, develop, and reward the contributions and talents of all associates

integrity .....
We act only with the highest ethical standards

performance .....
We provide coaching and feedback to perform at the highest level

recognition .....
We celebrate the achievements of others

teamwork .....
We win together through leadership, collaboration, open and honest communication, and respect

quality .....
We strive for excellence in our work, products, and services

innovation .....
We encourage creative thinking and intelligent risk taking

community .....
We care about and are involved in our communities

we do this for our .....

customers .....
We build lasting relationships by offering superior service and value

shareholders .....
We aspire to superior financial performance

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