




The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, coverage, you may access your summary plan description at https://totalrewards.northropgrumman.com/download/file_library/146/NGHPSPD_2021.pdf.

For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call (833) 762-0841 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | \$3,500/employee or \$5,250/employee + spouse or \$5,250/employee + children or \$6,750/employee + family for In- Network Providers . \$7,000/employee or \$10,500/employee + spouse or \$10,500/employee + children or \$13,500/employee + family for Out-of-Network Providers . | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible? | Yes. Preventive care for In- Network and Out-of-Network Providers and telemedicine visits with Live Health Online. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | \$6,500/employee or \$9,750/employee + spouse or \$9,750/employee + children or \$13,000/employee + family for In- Network Providers . \$13,000/employee or \$19,500/employee + spouse or \$19,500/employee + children or | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |

| | | |
|--|---|--|
| | \$26,000/employee + family for Out-of-Network Providers . | |
| What is not included in the out-of-pocket limit ? | Services deemed not medically necessary by Medical Management and/or Anthem, Premiums , balance-billing charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider? | Yes, Blue Card PPO. See www.anthem.com/ca or call (833) 762-0841 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an Out-of-Network Provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral . |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|--|--|---|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 30% coinsurance | 50% coinsurance | Coinsurance applies to both in-person and virtual visits with your provider . You pay a \$10 copay for each telemedicine visit with LiveHealth Online. |
| | Specialist visit | 30% coinsurance | 50% coinsurance | -----none----- |
| | Preventive care/screening/immunization | No charge | No charge | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | 30% coinsurance | 50% coinsurance | -----none----- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | Preauthorization is required for MRI, MRA and PET Scans. Please check with your plan for details. |
| <p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com</p> | Generic drugs | 20% coinsurance (retail) and 20% coinsurance up to a \$200 maximum/prescription (home delivery) | 50% coinsurance (retail) | Limited to a 30 day supply at retail or 90 day supply through mail order/CVS Pharmacy. Maintenance medications are required to be obtained via mail order or CVS pharmacy. Please check with your plan for details. Medical deductible applies. Preventive drugs not subject to deductible . |
| | Formulary Brand Name Drugs | 25% coinsurance (retail) and 25% coinsurance up to a \$200 maximum/prescription (home delivery) | 50% coinsurance (retail) | Limited to a 30 day supply at retail or 90 day supply through mail order/CVS Pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or CVS pharmacy. Please check with your plan for details. Medical deductible applies. Preventive drugs not subject to deductible . |
| | Non- Formulary Brand Name Drugs | 35% coinsurance (retail) and 35% coinsurance up to a \$200 maximum/prescription (home delivery) | 50% coinsurance (retail) | Limited to a 30 day supply at retail or 90 day supply through mail order/CVS Pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or CVS pharmacy. Please check with your plan for details. Medical deductible applies. Preventive drugs not subject to deductible . |
| | Specialty drugs | 25% coinsurance up to a \$400 maximum/prescription | Not covered | Medical deductible applies. Check with plan for details. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | -----none----- |
| If you need immediate medical attention | Emergency room care | 30% coinsurance | Covered as In- Network | 30% coinsurance for Emergency Room Physician Fee. Failure to obtain preauthorization for Emergency admission (require notification no later than 72 business hours after admission) may result in non-coverage. |
| | Emergency medical transportation | 30% coinsurance | Covered as In- Network | Failure to obtain preauthorization for air ambulance may result in non-coverage. |
| | Urgent care | 30% coinsurance | 50% coinsurance | You pay a \$10 copay /visit for each telemedicine visit with LiveHealth Online. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit 30% coinsurance Other Outpatient 30% coinsurance | Office Visit 50% coinsurance Other Outpatient 50% coinsurance | Office Visit Coinsurance applies to both in-person and virtual visits with your provider. Other Outpatient Preauthorization is required for daycare, partial hospitalization, and intensive outpatient care. |
| | Inpatient services | 30% coinsurance | 50% coinsurance | 30% coinsurance for Inpatient Physician Fee In- Network Providers . 50% coinsurance for Inpatient Physician Fee Out-of-Network Providers . Preauthorization is required. |
| | Office visits | 30% coinsurance | 50% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Preauthorization is required for inpatient stay that exceeds 48 hours of normal delivery and 96 hours after a cesarean delivery. |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance | 50% coinsurance | 100 visits/benefit period including private-duty nursing in and out of network combined. Preauthorization is required. |
| | Rehabilitation services | 30% coinsurance | 50% coinsurance | -----none----- |
| | Habilitation services | 30% coinsurance | 50% coinsurance | -----none----- |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | 100 visits/benefit period in and out of network combined. Preauthorization is required. |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | Includes two hearing aids/benefit year. Wigs and toupees are limited to \$1,500/benefit year. One pair of custom shoes or custom molded inserts prescribed by a physician per benefit year. Preauthorization is required for all rentals and purchases over \$1,500. |
| | Hospice services | 30% coinsurance | 50% coinsurance | Preauthorization is required. Failure to obtain pre-authorization may result in non-coverage. Bereavement is excluded. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | -----none----- |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | |

Excluded Services & Other Covered Services:

Services Your **Plan** Generally Does NOT Cover (Check your policy or **plan** document for more information and a list of any other **excluded services**.)

- Cosmetic surgery
- Long-term care
- Weight loss programs
- Dental care (adult)
- Routine eye care (adult)
- Dental Check-up
- Routine foot care unless you have been diagnosed with diabetes.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

- Abortion
- Chiropractic care 24 visits/benefit period.
- Most coverage provided outside the United States. See www.bcbsglobalcore.com
- Acupuncture 12 visits/benefit period.
- Hearing aids two/benefit period.
- Private-duty nursing only covered in the home. 100 visits/benefit period including [home health care](#).
- Bariatric surgery
- Infertility treatment \$25,000 maximum/lifetime.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your **plan** documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact:

ATTN: [Grievances](#) and [Appeals](#), PO Box 54159, Los Angeles, CA 90054-0159

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform

Does this [plan](#) provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [plan](#) tax credit to help you pay for a [plan](#) through the [Marketplace](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

| | |
|--------------------|----------|
| Total Example Cost | \$12,840 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing | |
|------------------------------|---------|
| Deductibles | \$3,500 |
| Copayments | \$0 |
| Coinsurance | \$2,784 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$6,344 |
|-----------------------------------|----------------|

Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

| | |
|--------------------|---------|
| Total Example Cost | \$7,460 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing | |
|------------------------------|---------|
| Deductibles | \$3,500 |
| Copayments | \$0 |
| Coinsurance | \$1,172 |

What isn't covered

| | |
|----------------------|------|
| Limits or exclusions | \$55 |
|----------------------|------|

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$4,727 |
|-----------------------------------|----------------|

Mia's Simple Fracture (in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$3,500
- [Specialist coinsurance](#) 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

| | |
|--------------------|---------|
| Total Example Cost | \$2,010 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing | |
|------------------------------|---------|
| Deductibles | \$2,010 |
| Copayments | \$0 |
| Coinsurance | \$0 |

What isn't covered

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$2,010 |
|-----------------------------------|----------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

(TTY/TDD: 711)

Albanian (Shqip): Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (833) 762-0841

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በጎረቤት ለማግኘት ሙብት አለዎት። አስተርጓሚ ለማግኘት (833) 762-0841 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (833) 762-0841.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (833) 762-0841:

Bassa (Bàsɔ̀ Wùdù): M̄ dyi dyi-diè-dɛ̀ b̄é b̄édé b̄á céè-dɛ̀ n̄ià ke dyí ní, ɔ̀ m̄ò n̄i dyí-b̄édè̀n-dɛ̀ b̄é m̄ k̄é gbo-kpá-kpá k̄è b̄ǎ́ kp̄ǎ́ d̄é m̄ b̄ídí-wùdù̀n̄ b̄ó pídyi. B̄é m̄ k̄é wuɖu-zìin-nyò d̄ò gbo wùdù̀ ke, d̄á (833) 762-0841.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (833) 762-0841 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (833) 762-0841 သို့ ခေါ်ဆိုပါ။

Chinese (中文) : 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電 (833) 762-0841。

Dinka (Dinka): Na n̄ɔŋ thiëc n̄e ke de yā thorë, ke yin n̄ɔŋ loŋ b̄é yi kuony ku w̄er alëu b̄é ḡɛɛr yic yin ne thoŋ du ke cin w̄ëu t̄äüë ke piny. Te k̄ɔr yin ba jam w̄ënë ran ye thok geryic, ke yin c̄ol (833) 762-0841.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (833) 762-0841.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (833) 762-0841 تماس بگیرید.

Language Access Services:

French (Français) : Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (833) 762-0841.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (833) 762-0841.

Greek (Ελληνικά) Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (833) 762-0841.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (833) 762-0841.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (833) 762-0841.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (833) 762-0841 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (833) 762-0841.

Language Access Services:

Igbo (Igbo): O buru na i nwere ajuju o buka gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buka. Ka gi na okowa okwu kwuo okwu, kpoo (833) 762-0841.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (833) 762-0841.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (833) 762-0841.

Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (833) 762-0841

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(833) 762-0841 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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