This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.aetna.com or by calling 1-877-458-4975.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**Network:** $650/person, up to $2,000 max; **Non-Network:** $1,500/person, up to $4,500 max; Network and Non-Network are not combined. **Out-of-Area (OOA):** same as Network benefit (combined Network and Non-Network). **NOTE:** You may be able to offset some of the cost associated with the deductible by completing Healthy Actions to earn credits in your HealthFund.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Network: Medical:** $2,150 per person up to a $5,000 maximum (includes $650/$2,000 deductible); **Pharmacy**: $2,000 per person up to a $4,000 maximum **Non-Network: Medical:** $6,500 per person, up to a $14,500 maximum (includes $1,500/$4,500 deductible); **Out-of-Area (OOA):** same as Network benefit (combined Network and Non-network)	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Preventive Care, Recognized Charges overages and services not covered under the Plan.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
If you visit a health care **provider's** office or clinic	Primary care visit to treat an injury or illness	15% after deductible	35% (20% OOA) after deductible	―――――――――――none―――――――――――
	Specialist visit	Aexcel Designated Provider: 10% after deductible; Non-Aexcel Designated Provider: 15% after deductible	35% (20% OOA) after deductible	―――――――――――none―――――――――――

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
	Other practitioner office visit	15% after deductible	35% (20% OOA) after deductible	Chiropractic: limited to 20 visits/calendar year; Acupuncture: limitations apply.
	Preventive care/screening/ immunization	No charge, no deductible	No charge, no deductible	Age and frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	15% after deductible	35% (20% OOA) after deductible	————————none————————
	Imaging (CT/PET scans, MRIs)	15% after deductible	35% (20% OOA) after deductible	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-866-544-6909.	Generic drugs	Retail: 10% up to $25 max; Mail: 10% up to $50 max	Retail: 50%; Mail: Not covered	Retail: Up to a 30-day supply; Mail Order: Up to a 90-day supply. No deductible.
	Preferred brand drugs	Retail: 30% up to $75 max; Mail: 30% up to $150 max;	Retail: 50%; Mail: Not covered	Retail: Up to a 30-day supply; Mail Order: Up to a 90-day supply. No deductible. Generic Drug Substitution Rule: If you request a brand-name drug when your physician permits a generic substitution, you will pay the generic drug coinsurance plus the difference between the generic drug cost and the brand-name cost.
	Non-preferred brand drugs	Retail: 50% up to $175 max; Mail: 50% up to $350 max;	Retail: 50%; Mail: Not covered	Retail: Up to a 30-day supply; Mail Order: Up to a 90-day supply. No deductible. Generic Drug Substitution Rule: If you request a brand-name drug when your physician permits a generic substitution, you will pay the generic drug coinsurance plus the difference between the generic drug cost and the brand-name cost.
	Specialty drugs	Applicable copay	Retail: Applicable copay; Mail: Not covered	Retail: Up to a 30-day supply; Mail Order: Up to a 90-day supply. No deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% after deductible	35% (20% OOA) after deductible	Precertification required for certain procedures.
	Physician/surgeon fees	15% after deductible	35% (20% OOA) after deductible	———————none———————

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	15% after deductible	15% after deductible	————————none————————
	Emergency medical transportation	15% after deductible	15% after deductible	————————none————————
	Urgent care	15% after deductible	35% (20% OOA) after deductible	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	15% after deductible	35% (20% OOA) after deductible	Precertification required. An out of network provider or facility may bill you for charges – in addition to deductible and coinsurance, as applicable – which exceed the Plan's reimbursement for a covered service. You may be responsible for these charges.
	Physician/surgeon fee	15% after deductible	35% (20% OOA) after deductible	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required for certain services.
	Mental/Behavioral health inpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required.
	Substance use disorder outpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required for certain services.
	Substance use disorder inpatient services	15% after deductible	35% (20% OOA) after deductible	Precertification required.
If you are pregnant	Prenatal and postnatal care	Aexcel Designated Provider: 10% after deductible; Non-Aexcel Designated Provider: 15% after deductible	35% (20% OOA) after deductible	————————none————————

Common Medical Event	Services You May Need	Your Cost If You Use a(n) Network	Your Cost If You Use a(n) Non-Network	Limitations & Exceptions
	Delivery and all inpatient services	15% after deductible	35% (20% OOA) after deductible	––––––––––––none––––––––––––
If you need help recovering or have other special health needs	Home health care	15% after deductible	35% (20% OOA) after deductible	Up to 120 visits/calendar year (Home Health Care and Private Duty Nursing visits combined); precertification required (combined Network and Non-Network limit).
	Rehabilitation services	15% after deductible	35% (20% OOA) after deductible	Limited to 60 visits/calendar year; combined for habilitative, speech, physical and occupational therapies. Office and outpatient treatment combined.
	Habilitation services	15% after deductible	35% (20% OOA) after deductible	Limited to 60 visits/calendar year; combined for habilitative, speech, physical and occupational therapies. Office and outpatient treatment combined.
	Skilled nursing care	15% after deductible	35% (20% OOA) after deductible	Up to 120 days/calendar year; precertification required (combined Network and Non-Network limits)
	Durable medical equipment	15% after deductible	35% (20% OOA) after deductible	Precertification required for recognized charges in excess of $5,000
	Hospice service	15% after deductible	35% (20% OOA) after deductible	Precertification required.
If your child needs dental or eye care	Eye exam	Covered only as part of routine physical exam	Covered only as part of routine physical exam	––––––––––––none––––––––––––
	Glasses	Not Covered	Not Covered	––––––––––––none––––––––––––
	Dental check-up	Not Covered	Not Covered	––––––––––––none––––––––––––

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Children's glasses
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care - adult
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Private-duty nursing

IMPORTANT: For additional limitations & exclusions please refer to the SPD.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Lockheed Martin Employee Service Center (LMESC) at 1-866-562-2363 or www.lmpeople.com. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-877-458-4975.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-562-2363.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-562-2363.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-866-562-2363.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-562-2363.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,740
- **Patient pays** $1,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$700
Copays	$0
Coinsurance	$900
Limits or exclusions	$200
Total	**$1,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,720
- **Patient pays** $1,680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$700
Copays	$600
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,680**

Note: These costs do not reflect any HealthFund credits, which offset your deductible and coinsurance. HealthFund credits are earned by completing certain Healthy Actions. For more information, please contact the *LM HealthWorks* Plan at 1-877-458-4975 or visit www.lmhwplan.com.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.