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, or to get a copy of the complete terms of coverage, visit www.cigna.com. 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 1-866-444-3272 to request a copy. If there is a conflict between the SBC and the Summary Plan Description (SPD), the SPD controls.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,600 Individual; $3,200 Family (in-network and out-of-network are NOT combined) Out-of-Network: $5,600 Individual; $11,300 Family (in-network and out-of-network are NOT combined)	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 (limitations may apply); breast feeding equipment and supplies; women's family planning.	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?	Yes. PCP/Specialist deductible	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Network: $3,200 Individual; $6,850 Family (includes deductible); Out-of-Network: $11,200 Individual; $23,200 Family (includes deductible)	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain preauthorization for services, preventive care (limitations may apply), and benefits exceeding plan limits	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. For a list of preferred providers, please see www.cigna.com or call 1-855-820-6604.	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 (You will pay the least)	Out-of-Network (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	20% after deductible	40% after deductible	——————none——————
	Specialist visit	20% after deductible	40% after deductible	——————none——————
	Preventive care/ screening/immunization	Covered at 100%, no deductible	40% after deductible (age and frequency limits apply)	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. Age and frequency limitations apply.
If you have a test	Diagnostic test (x-ray, blood work)	Laboratory: 20% after deductible; covered at 100% (if preventive) X-Ray: 20% after deductible	40% after deductible	Limitations may apply.
	Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	Enhanced imaging review; limitations may apply.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-888-296-6955.	Generic drugs	Retail: 20% after deductible (min $4/max $15) Mail Order: 20% after deductible (min $10/max $35)	Reimbursed at contracted in-network level	Retail: 30-day supply; 90-day retail supply at a CVS pharmacy only for applicable mail coinsurance Mail Order: In-Network - 90-day supply; Out-of-Network - 30-day supply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-888-296-6955.	Preferred brand drugs	Retail: 20% after deductible (min $20/max $50) Mail Order: 20% after deductible (min $50/max $125)	Reimbursed at contracted in-network level	Retail: 30-day supply; 90-day retail supply at a CVS pharmacy only for applicable mail coinsurance Mail Order: In-Network - 90-day supply; Out-of-Network - 30-day supply Generic Drug Substitution Rule: Dispensed as Written (DAW 2 penalty)
	Non-preferred brand drugs	Retail: 20% after deductible (min $40/max $80) Mail Order: 20% after deductible (min $100/max $200)	Reimbursed at contracted in-network level	Retail: 30-day supply; 90-day retail supply at a CVS pharmacy only for applicable mail coinsurance Mail Order: In-Network - 90-day supply; Out-of-Network - 30-day supply Generic Drug Substitution Rule: Dispensed as Written (DAW 2 penalty)
	Specialty drugs	Same as non-specialty	Reimbursed at contracted in-network level	Retail: In-Network - Limited to a 30-day supply through CVS Specialty Pharmacy; 90-day supply available for HIV and Transplant medications; Out-of-Network - 30-day supply; 90-day retail supply at a CVS pharmacy only for applicable mail coinsurance Mail Order: In-Network - Limited to a 30-day supply through CVS Specialty Pharmacy; 90-day supply available for HIV and Transplant medications; Out-of-Network - 30-day supply Generic Drug Substitution Rule: Dispensed as Written (DAW 2 penalty)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	40% after deductible	Limitations may apply.
	Physician/surgeon fees	20% after deductible	40% after deductible	Limitations may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% after deductible	20% after deductible	Limitations may apply.
	Emergency medical transportation	20% after deductible	20% after deductible; 40% after deductible if not an emergency	Covers medically necessary transports only.
	Urgent care	20% after deductible	40% after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	40% after deductible	Room and board subject to the payment of semi-private room rate.
	Physician/surgeon fee	20% after deductible	40% after deductible	Limitations may apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	40% after deductible	Preauthorization may be required; contact the plan for details.
	Inpatient services	20% after deductible	40% after deductible	Preauthorization may be required; contact the plan for details.
If you are pregnant	Office visits	20% after deductible	40% after deductible	Plan provisions/limitations apply.
	Childbirth/delivery professional services	20% after deductible	40% after deductible	Limitations may apply.
	Childbirth/delivery facility services	20% after deductible	40% after deductible	Limitations may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% after deductible	40% after deductible	120 visits per calendar year, one visit = up to 4 hours; combined with private duty nursing (combined in-network and out-of-network limits)
	Rehabilitation services	20% after deductible	40% after deductible	75 visits for physical therapy, 75 visits for occupational therapy, and 75 visits for speech therapy (combined in-network and out-of-network); subject to medical necessity.
	Habilitation services	20% after deductible	40% after deductible	75 visits for physical therapy, 75 visits for occupational therapy, and 75 visits for speech therapy (combined in-network and out-of-network); subject to medical necessity. Visit limits do not apply to the treatment of mental health conditions and substance use disorder.
	Skilled nursing care	20% after deductible	40% after deductible	Limited to 100 days per calendar year; combined in-network and out-of-network limit
	Durable medical equipment	20% after deductible	40% after deductible	Pre-authorization may be required; limitations may apply.
	Hospice services	20% after deductible	40% after deductible	————————none————————
If your child needs dental or eye care	Children's eye exam	Covered at 100%	40% after deductible	At age 3, 4, 5, 6, 8, 10, 12, 15 and 18 or as doctor advises; 1 per calendar year
	Children's glasses	Limited to 1 per calendar year	Limited to 1 per calendar year	————————none————————
	Children's dental check-up	Not covered	Not covered	————————none————————

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.)

- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

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

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: 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/. Or you may contact the plan at 1-866-562-2363. 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 on how 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: 1-855-820-6604.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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 premium tax credit to help you pay for a plan through the Marketplace.

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 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	**$1600**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,600
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

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

The plan's overall deductible	**$1600**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,600
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,420**

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

The plan's overall deductible	**$1600**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,600
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$1,840**

Note: These amounts assume the participant does not participate in health plan incentive activities, which may be used to reduce out-of-pocket costs. For more information on health plan incentive activities, please see the Benefits Compass website or contact the Lockheed Martin Employee Service Center at 1-866-562-2363.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.