



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_2024FINAL.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 (844) 870-0616 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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 ?	In- Network Providers : \$4,500/individual or \$9,000/family. Out-of-Network Providers : \$9,000/individual or \$18,000/family.	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.
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 ?	See www.anthem.com/ca or call (844) 870-0616 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 Events	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	Preferred: \$15/visit Standard: \$20/visit Non-Preferred: \$40/visit	\$50/visit	LiveHealth Online visits covered at no charge.
	Specialist visit	Preferred: \$25/visit Standard: \$40/visit Non-Preferred: \$60/visit	\$70/visit	-----none-----
	Preventive care / screening /immunization	No charge	\$50/visit	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)	Preferred: \$40/visit Standard: \$60/visit Non-Preferred: \$90/visit	\$110/visit	-----none-----
	Imaging (CT/PET scans, MRIs)	Preferred: \$180/visit Standard: \$240/visit Non-Preferred: \$410/visit	\$500/visit	Preauthorization is required for MRI, MRA, and PET Scans. Please check with your plan for details.
If you need drugs to treat your illness or condition	Generic Drugs	\$10/prescription (retail) \$25/prescription (home delivery)	50% coinsurance (retail)	Limited to a 30 day supply at retail or 90 day supply through mail order/Retail 90 network pharmacy. Maintenance medications are required to be obtained via mail order or Retail 90 network pharmacy. Please check with your plan for details.

Common Medical Events	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)	
More information about prescription drug coverage is available at www.express-scripts.com	Formulary Brand Name Drugs	\$90/prescription (retail) \$225/prescription (home delivery)	50% coinsurance (retail)	Limited to a 30 day supply at retail or 90 day supply through mail order/Retail 90 network pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or Retail 90 network pharmacy. Please check with your plan for details.
	Non- Formulary Brand Name Drugs	\$120/prescription (retail) \$300/prescription (home delivery)	50% coinsurance (retail)	Limited to a 30 day supply at retail or 90 day supply through mail order/Retail 90 network pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or Retail 90 network pharmacy. Please check with your plan for details.
	Specialty drugs	\$370/prescription for 30 day supply	50% coinsurance	Check with plan for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Preferred: \$500/visit Standard: \$670/visit Non-Preferred: \$1,125/visit	\$1,350/visit	Preauthorization is required.
If you need immediate medical attention	Emergency room care	\$150/visit	\$150/visit	Failure to obtain pre-authorization for Emergency admission (require notification no later than 72 business hours after admission) may result in non-coverage.
	Emergency medical transportation	\$150/visit	\$150/visit	Failure to obtain preauthorization for air ambulance may result in non-coverage. Cost share reflects ground ambulance. Air ambulance is \$450/visit in or out of network.

Common Medical Events	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)	
	Urgent care	\$40/visit	\$40/visit	LiveHealth Online visits covered at no charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	Preferred: \$1,500/visit Standard: \$1,995/visit Non-Preferred: \$3,375/visit	\$4,050/visit	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit Preferred: \$15 Standard: \$20 Non-Preferred: \$40 Other Outpatient Preferred: \$500 Standard: \$670 Non-Preferred: \$1,125	Office Visit \$50 Other Outpatient \$1,350	Other Outpatient: Preauthorization is required for daycare, partial hospitalization, and intensive outpatient care.
	Inpatient services	Preferred: \$1,500/visit Standard: \$1,995/visit Non-Preferred: \$3,375/visit	\$4,050/visit	Preauthorization is required.
If you are pregnant	Office visits	Preferred: \$15/visit Standard: \$20/visit Non-Preferred: \$40/visit	\$50/visit	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	No charge	Preauthorization is required for inpatient stay that exceeds 48 hours of normal delivery and 96 hours after a cesarean delivery.
	Childbirth/delivery facility services	Preferred: \$1,500/visit Standard: \$1,995/visit Non-Preferred: \$3,375/visit	\$4,050/visit	
If you need help recovering or have other special health needs	Home health care	Preferred: \$40/visit Standard: \$60/visit Non-Preferred: \$90/visit	\$110/visit	100 visits/benefit period including private-duty nursing in and out of network combined. Preauthorization is required.
	Rehabilitation services	Preferred: \$25/visit Standard: \$40/visit Non-Preferred: \$60/visit	\$70/visit	60 visits combined with physical and occupational therapy.
	Habilitation services	Preferred: \$25/visit Standard: \$40/visit Non-Preferred: \$60/visit	\$70/visit	

Common Medical Events	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)	
	Skilled nursing care	Preferred: \$1,300/admission Standard: \$1,730/admission Non-Preferred: \$2,930/admission	\$3,510/visit	100 visits/benefit period in and out of network combined. Preauthorization is required.
	Durable medical equipment	Preferred: \$90/visit Standard: \$120/visit Non-Preferred: \$210/visit	\$250/visit	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.
	Hospice services	Preferred: \$215/visit Standard: \$300/visit Non-Preferred: \$500/visit	\$600/visit	Preauthorization is required. No limits. Failure to obtain preauthorization 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	-----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](#).)

- Cosmetic surgery
- Long-term care
- Dental care (adult)
- Weight loss programs
- 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 covered in the home. 100 visits/benefit period including [home health care](#).
- Bariatric surgery

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

[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 [plan](#) 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 [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:

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



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	\$0
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$1,500
■ Other copayment	\$15

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,540
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,540

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$500
■ Other copayment	\$120

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$645
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$645

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$25
■ Hospital (facility) copayment	\$150
■ Other copayment	\$190

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$365
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$365

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 (844) 870-0616

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 870-0616 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 (844) 870-0616.

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՝ (844) 870-0616:

Bassa (Bàsɔ̀ wùdù): M̈ dyi dyi-diè-djè b̈é b̈é d̈é b̈á c̈éè-djè n̈ià k̈e dyí ní, ɔ̀ m̈ò n̈i dyí-b̈é d̈é d̈é n̈i-djè b̈é m̈ k̈é gbo-kpá-kpá k̈é b̈ǎ kp̈ɔ̀ d̈é m̈ b̈í d̈í-wù d̈ùùn b̈ó pídyi. B̈é m̈ k̈é wu d̈u-zì n̈-nyò d̈ò gbo wù d̈ù k̈e, d̈á (844) 870-0616.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 870-0616 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန် (844) 870-0616 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 (844) 870-0616。

Dinka (Dinka): Na n̈ɔŋ thiëc n̈e ke de yā thor̈e, ke yin n̈ɔŋ loŋ b̈e yi kuony ku ẅer al̈eu b̈e g̈ɛer yic yin ne thoŋ du ke cin ẅeu ẗäaüe ke piny. Te k̈or yin ba jam ẅen̈e ran ye thok geryic, ke yin c̈ol (844) 870-0616.

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 (844) 870-0616.

Farsi (فارسی): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 870-0616 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 (844) 870-0616.

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 (844) 870-0616.

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 (844) 870-0616.

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 (844) 870-0616.

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 (844) 870-0616.

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 (844) 870-0616 ।

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 (844) 870-0616.

Igbo (Igbo): O bụrụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (844) 870-0616.

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 (844) 870-0616.

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 (844) 870-0616.

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 (844) 870-0616

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、(844) 870-0616 にお電話ください。

Language Access Services:

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅ (844) 870-0616 ។

Kirundi (Kirundi): Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 870-0616.

Korean (한국어): 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면 (844) 870-0616 로 문의하십시오.

Lao (ພາສາລາວ): ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ.
ເພື່ອໂອ້ນລັກກັບລາມເປພາສາ, ໃຫ້ໃບໂທຫາ (844) 870-0616.

Navajo (Diné): Díí naaltsoos biká'ígíí lahgo bina'ídiłkidgo ná bohónéedzá dóó bee ahóót'i' t'áá ni nizaad k'ehjí bee níł hodoonih t'áadoo báááh ilínígóó.
Ata' halne'ígíí la' bich'í' hadeesdzih ninízingo kojí' hodiłlnih (844) 870-0616.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 870-0616

Oromo (Oromifaa): Sanadi kanaa wajiin walqabaate gaffi kamiyyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 870-0616 bilbilla.

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