Insured and/or administered by:
Cigna Health and Life Insurance Company

The Northrop Grumman Group Benefits Plan

Benefits at a Glance
Policy #08010B
Plan Start: January 1, 2021

This plan provides minimum essential coverage.

Please Note: This is a high level summary of your benefits. Please see your certificate booklet for detailed benefits and exclusions.

Cigna Global Customer Service		
Universal International Free Number (UIFN) **Toll Free Telephone Number:** **Direct Telephone:** **Toll Free Fax Number:** **Direct Fax Number:**	International Access Code + UIFN Toll-free number 800.441.2668.1 1.800.441.2668 1.302.797.3100 (collect calls accepted) 1.800.243.6998 001.302.797.3150	
Secure Website:	www.CignaEnvoy.com. Registration is required. (See member kit for registration information.) Secure email available at this site.	
Mail Delivery:	Cigna Global Health Benefits P.O. Box 15050 Wilmington, DE 19850-5050 U.S.A.	Cigna Global Health Benefits 300 Bellevue Parkway Wilmington, DE 19809 U.S.A

Global Medical Plan	International (Outside of the U.S.)	U.S. In-Network	U.S. Out-of-Network
Lifetime Maximum	Unlimited		
Calendar Year Deductible • Per Individual	$100	$100	$200
• Per Family	$200	$200	$400
Coinsurance (The percentage of covered expenses the plan pays)	100%	80%	60%
Out-of-Pocket Maximum (excludes deductible) • Per Individual	$1,250	$1,250	$2,500
• Per Family	$2,500	$2,500	$5,000
Deductible Calculation	Claims for a family member are covered at plan coinsurance: · When that family member satisfies the Individual Deductible -OR- · When the Family Deductible is satisfied regardless of whether or not the Individual Deductible is satisfied.		
Out-of-Pocket Calculation	Claims for a family member are covered at 100% coinsurance: · When that family member satisfies the Individual Out-of-Pocket Maximum -OR- · When the Family Out-of-Pocket Maximum is satisfied regardless of whether or not the Individual Out-of-Pocket Maximum is satisfied		
Network Accumulation	Plan Deductible, Out-of-Pocket, maximums and service specific maximums (dollar and occurrence) will cross-accumulate across international and Domestic networks. Out-of-Pocket will: Exclude deductible payments; Include copay payments; Include pharmacy copays; Include pharmacy coinsurance payments; Exclude Pre-Admission Certification/Continued Stay Review penalties.		

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Certification Requirements – For services rendered inside the United States
Precertification for inpatient and outpatient services received in the U.S. may be required. • Providers must call our toll-free number, 1.800.441.2668 to pre-certify services. • You or your dependents are responsible for ensuring that Out-of-Network providers pre-certify services. • Failure to obtain precertification may affect Out-of-Pocket costs. • This is a summary only and further details can be found in the certificate booklet.

Global Medical Plan			
Open Access Plus (OAP) Network	**International (Outside of the U.S.)**	**U.S. In-Network**	**U.S. Out-of-Network**
Physician's Services • Physician's Office Visit	100% after deductible	$15 per office visit copay	60% after deductible
• Surgery Performed In the Physician's Office	100% after deductible	$15 per office visit copay	60% after deductible
Preventive Care Routine Preventive Care – all ages Immunizations – all ages	100% after deductible	100% not subject to deductible	60% after deductible
Travel Immunizations (Immunizations as required for travel)	100% after deductible	100% not subject to deductible	60% after deductible
Mammograms	100% after deductible	100% not subject to deductible	60% after deductible
PAP Smear	100% after deductible	100% not subject to deductible	60% after deductible
Prostate Specific Antigen (PSA)	100% after deductible	100% not subject to deductible	60% after deductible
Colorectal Cancer Screenings	100% after deductible	100% not subject to deductible	60% after deductible
Outpatient Facility Services	100% after deductible	80% after deductible	60% after deductible
Inpatient Hospital Facility Services • Facility	100% after deductible	80% after deductible	60% after deductible
• Physician	100% after deductible	80% after deductible	60% after deductible
Emergency Care (Refer to certificate for coverage and exclusions)	100% after deductible	80% after deductible	80% after deductible
Urgent Care Services (Refer to certificate for coverage and exclusions)	100% after deductible	$15 per office visit copay	$15 per office visit copay
Infertility Procedures directly related to diagnosis and treatment are covered, including IVF. Refer to the certificate for additional coverage details.	100% after deductible	80% after deductible	60% after deductible
Laboratory and Radiology Services (including pre-admission testing)	100% after deductible	80% after deductible	60% after deductible

Global Medical Plan			
Open Access Plus (OAP) Network	**International (Outside of the U.S.)**	**U.S. In-Network**	**U.S. Out-of-Network**
Outpatient Short –Term Rehabilitative Therapy (60 days for all therapies combined) **Includes Only:** Cardiac Rehab, Speech Therapy, Occupational Therapy, Pulmonary Rehab, Cognitive Therapy.	100% after deductible	$25 per office visit copay	60% after deductible
Physical Therapy – Unlimited	100% after deductible	100% not subject to deductible	60% after deductible
Chiropractic Services – Unlimited	100% after deductible	80% after deductible	60% after deductible
Maternity Care Services • Initial Visit to Confirm Pregnancy	100% after deductible	$15 per office visit copay	60% after deductible
• All Subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	100% after deductible	80% after deductible	60% after deductible
• Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	100% after deductible	$15 per office visit copay	60% after deductible
• Delivery – Facility (Inpatient Hospital, Birthing Center)	100% after deductible	80% after deductible	60% after deductible
Hearing Benefit • Exam: One every 24 month period	100% after deductible	100% not subject to deductible	60% after deductible
Hearing Aid Maximum Up to $1,000 per hearing aid unit necessary for each hearing impaired ear every 3 years for a dependent child under age 24.	100% after deductible	80% after deductible	60% after deductible

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Prescription Drug Benefits		
	International (Outside of the U.S.)	
Purchased outside the United States	100%	
Certain Preventive Care Medications covered under this plan and required as part of preventive care services (detailed information is available at www.healthcare.gov are payable at 100% with no Copayment or Deductible, when purchased from a Pharmacy. A written prescription is required.		
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 30-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 30-day supply at a non-Network Pharmacy
Tier 1 – Generic Drugs on the Prescription Drug List	No charge after $7 Copay	40% subject to deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No charge after $20 Copay	40% subject to deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $20 Copay	40% subject to deductible
Prescription Drug Products at Retail Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy
Tier 1 – Generic Drugs on the Prescription Drug List	No charge after $21 Copay	40% subject to deductible
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No charge after $60 Copay	40% subject to deductible
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $60 Copay	40% subject to deductible
Prescription Drug Products at Home Delivery Pharmacies	The amount you pay for up to a consecutive 90-day supply at a Network Pharmacy	The amount you pay for up to a consecutive 90-day supply at a non-Network Pharmacy
Tier 1 – Generic Drugs on the Prescription Drug List	No charge after $21 Copay	In-network coverage only
Tier 2 - Brand Drugs designated as preferred on the Prescription Drug List	No charge after $60 Copay	In-network coverage only
Tier 3 - Brand Drugs designated as non-preferred on the Prescription Drug List	No charge after $60 Copay	In-network coverage only

Pharmacy Plan Features for Prescriptions Drugs Purchased Inside the United States only	
Dispense As Written	If you request to fill a brand name drug that has a generic equivalent available, you will be financially responsible for the difference in cost between the brand name and then generic drug, plus any required brand name drug copayments and/or coinsurance, if applicable. However if your doctor has determined a generic drug is not an acceptable alternative for you, you will only be responsible for the payment of the appropriate brand name drug copayment and/or coinsurance, if applicable.
Prescription Drug List	Performance 3-Tier
Step Therapy	Certain drugs are subject to step therapy requirements. To identify whether a particular drug is subject to step therapy, please refer to your prescription drug list.
Prior Authorization	Coverage for certain drugs require your Physician to obtain prior authorization from Cigna. To identify whether a particular drug requires prior authorization, please refer to your prescription drug list.
To see if your medication is covered, you can view Cigna's Prescription Drug List by going to www.Cigna.com/druglist and selecting Performance 3-Tier	

Global Vision Care			
	International (Outside the U.S.)	**U.S. In-Network**	**U.S. Out-of-Network**
Examinations One Eye Exam every 24 months	100% after deductible	100% not subject to deductible	60% after deductible

Global Dental Care - Total Cigna DPPO Network		
Calendar Year Maximum (for Class I, II, III)		$1,500
Lifetime Maximum (for Class IV)		$1,000
Calendar Year Deductible		$25 Individual / $50 Family
Class I	**Preventive Care** For diagnostic and preventative services including: • Oral Exam - 2 per person, per year • Cleanings - 2 per person, per year • Bitewing X-rays - 2 per person, per year • Fluoride Applications - 1 per person, per year (Up to age 19) • Sealants - 1 per tooth, per 3 years • Full Mouth X-rays – 1 per person, per 3 years • Panoramic X-rays - 1 per person, per 3 years	100% not subject to deductible
Class II	**Basic Restorative** For Basic Restorations: • Endodontics • Periodontics • Prosthodontics Maintenance • Oral Surgery • Fillings • Root Canal • Periodontal Scaling and Root Planing • Repair to Bridgework and Dentures	80% after deductible
Class III	**Major Restorative** For Major Restorations: • Dentures • Bridgework • Crowns	50% after deductible
Class IV	**Orthodontia** Class IV Orthodontia applies only to a Dependent Child less than 19 years of age.	50% not subject to deductible
Class V	**Implants**	Not Covered

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