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, log on to www.yourtotalrewards.com/rtx or call 1-800-243-8135. 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 1-800-243-8135 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network** **$3,000** Individual/**$4,500** Individual + Spouse/Child(ren)/**$6,000** Family **Out-of-Network:** **$6,000** Individual/**$9,000** Individual + Spouse/Child(ren)/**$12,000** Family	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 plan, 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 services are covered before you meet your deductible.	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 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?	**In-Network:** **$5,000** Individual/**$7,500** Individual + Spouse/Child(ren)*/**$10,000** Family* **Out-of-Network:** **$10,000** Individual/**$15,000** Individual + Spouse/Child(ren)/**$20,000** Family *No individual will pay more than $7,500.	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and/or health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.yourtotalrewards.com/rtx or call 1-800-243-8135 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
		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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	20% coinsurance applies for non-preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	No charge for preventive services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	No charge for preventive services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	**Retail or Mail Order:** 20% coinsurance	**Retail:** 40% coinsurance **Mail Order:** Not applicable	Up to 30-day supply. Up to 90-day supply. No charge for certain generic preventive drugs (retail and mail order available).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (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	Preferred brand drugs	**Retail or Mail Order:** 20% coinsurance	**Retail:** 40% coinsurance **Mail Order:** Not applicable	Up to 30-day supply. Up to 90-day supply. If brand dispensed when generic is available, you pay additional cost of brand, which is not included in the deductible or out-of-pocket limit.
	Non-preferred brand drugs	**Retail or Mail Order:** 20% coinsurance	**Retail:** 40% coinsurance **Mail Order:** Not applicable	Up to 30-day supply. Up to 90-day supply. If brand dispensed when generic is available, you pay additional cost of brand, which is not included in the deductible or out-of-pocket limit.
	Specialty drugs	See your costs above for preferred and non-preferred brand.	Not covered	See mail order limitations and exclusions above for preferred brand and non-preferred brand drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required out-of-network. If preauthorization is not received, a financial penalty may apply or service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance if true emergency; otherwise, 40% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	20% coinsurance if true emergency; otherwise, 40% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required out-of-network. If preauthorization is not received, a financial penalty may apply or service may not be covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Must be noncustodial
	Rehabilitation services	20% coinsurance	40% coinsurance	Outpatient physical and occupational therapy limited to specific medically necessary diagnoses, as determined by health plan.
	Habilitation services	20% coinsurance	40% coinsurance	None
	Skilled nursing care	20% coinsurance	40% coinsurance	Must be prescribed and performed in a noncustodial facility.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required. If preauthorization is not received, a financial penalty may apply or item may not be covered.
	Hospice services	20% coinsurance	40% coinsurance	Must be provided by a licensed agency; incudes respite care.
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	• Routine foot care
• Dental care (Adult)	• Routine eye care (Adult)	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Hearing aids	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Infertility treatment	• Private-duty nursing
• Chiropractic care		

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/agencies/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: www.yourtotalrewards.com/rtx or call 1-800-243-8135. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/agencies/ebsa.

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 1-800-243-8135.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-243-8135.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-243-8135.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-243-8135.

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	**$3,000**
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	$3,000
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

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

The plan's overall deductible	**$3,000**
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	$3,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	**$3,000**
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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