

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross PPO - Nationwide*	
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Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network
General Information		
Lifetime Maximum Benefit	Unlimited	Unlimited
Annual Maximum Benefit	Unlimited	Unlimited
Coinsurance Percentage	80%	50%
Precertification Requirements		
Precertification Penalty	Covered benefits reduced by 30% if no precertification obtained where required	Covered benefits reduced by 30% if no precertification obtained where required
Health Savings Account (HSA)	N/A	N/A
Health Reimbursement Account (HRA)	N/A	N/A
R & C	N/A	Applies to Non-Contracted Providers
Deductibles		
Individual Annual Deductible	\$500, (Does not apply to Out-of-Network)	\$750, applies to In-Network
Family Annual Deductible	\$1,500 (Does not apply to Out-of-Network)	\$2,250 applies to In-Network
Applies to Out-of-Pocket Maximum	Yes	Yes
Prescription benefits are covered under medical deductible	RX Deductible does not apply to medical deductible.	RX Deductible does not apply to medical deductible.
Out-of-Pocket Mx per Plan Year	See Individual and Family Out of Pocket	See Individual and Family Out of Pocket
Individual Out-of-Pocket Maximum Per Year	\$3,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	\$9,000 (Out of Pocket amounts accumulate separately for In and Out of Network)
Family Out-of-Pocket Maximum Per Year	\$6,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	\$18,000 (Out of Pocket amounts accumulate separately for In and Out of Network)
Outpatient Services		
Primary Care Physician Visits	\$20 copay	50%
Specialist Visit	\$35 copay	50%
Lab tests and X-ray	80%	50%
Specialized Imaging	80%	50%
Outpatient Surgery	80%	50%
Allergy Testing	80%	50%
Allergy Injections	80%	50%
Preventive Care		
Well Child Care Office Visit	100%	50%
Well Child Age limit	to age 19	to age 19
Adult Routine Physical Exams	100%	50%
Adult Immunizations	100%	50%
Routine Mammogram	100%	50%
Pap Smear	100%	50%
Prostate Screening (PSA)	100%	50%
Colon Cancer Screenings	100%	50%
Cardiovascular screenings	100%	50%
Hearing Evaluations	100%	50%
Inpatient Hospital		
Deductible per Confinement	N/A	N/A
Deductible per Day	N/A	N/A
Hospital Services	80% - Pre-authorization required for all inpatient admissions.	50% - Pre-authorization required for all inpatient admissions.
Physicians and Surgeons' Services	80%	50%
Emergency Services		
Emergency Room Treatment	\$150, Waived if admitted	\$150, Waived if admitted
Non-emergency or non-urgent use of ER	80%	50%
Ambulance	80%	80% Emergencies Only
Urgent Care Facility Services	\$20 copay	50%
Physician Office Visit	\$20 copay	50%
After Hours	\$20 copay	50%
Maternity Care		
Physician Office Visit	\$20 copay Copayment applies to initial office visit ONLY.	50%
Maternity Care - Inpatient Delivery	80.00%	50%
Midwife delivery services	80.00%	50%

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Mental Health		
Deductible per Confinement	N/A	N/A
Deductible per Day	N/A	N/A
Mental Health Inpatient	80% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions
Mental Health-Inpatient Plan Maximums	None	None
Mental Health Outpatient	\$20 copay	50%
Mental Health - Group Therapy	\$20 copay	50%
Mental Health-Outpatient Plan Maximums	None	None
Severe Mental Illness	80%	50%
Substance Abuse	80%	50%
Deductible per Confinement	N/A	N/A
Deductible per Day	N/A	N/A
Detoxification	80%	50%
Substance Abuse - Inpatient Treatment;	80% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions
Substance Abuse-Inpatient Plan Maximums	None	None
Substance Abuse-Outpatient	\$20 copay	50%
Substance Abuse-Outpatient Plan Maximums	None	None
Rehabilitation Therapy		
Inpatient Rehabilitation	80%	50%
Outpatient Physical, Occupational, and Speech Therapy	80%	50%
Alternative Care		
Chiropractic Care	80% up to 24 visits per calendar year. Visit max combined for Physical Therapy, Occupational Therapy, Acupuncture	50% up to 24 visits per calendar year. Visit max combined for Physical Therapy, Occupational Therapy, Acupuncture
Acupuncture	80% Combined max with Chiropractic Care, Physical Therapy, Occupational Therapy. Additional 10 visits allowed	50% Combined max with Chiropractic Care, Physical Therapy, Occupational Therapy. Additional 10 visits allowed
Acupressure	Not covered	Not covered
Massage Therapy	Covered only as part of office visit to a licensed chiropractor or physical therapist .	Covered only as part of office visit to a licensed chiropractor or physical therapist .
Other Services		
Private-Duty Nursing Care	Not covered	Not covered
Durable Medical Equipment	80%	50%
Prosthetic and Orthotic Appliances	80%	50%
Smoking Cessation	Not covered	Not covered
Weight control program	Not covered	Not covered
Bariatric surgery	80% - requires utilization review; covered only at COE	Not covered
TMJ	80%	50%
Podiatry Services	80%	50%
Home Health Care	100% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network
Skilled Nursing Facility Care	80% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network
Hospice Care	100%, deductible does not apply	50%
Hearing Aids	80% (Limit of one every 3 years)	50% (Limited of one every 3 years)
Family Planning		
Tubal ligation	100% no deductible	50%
Vasectomy	80%	50%
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A
Contraceptive Devices	100% no deductible	50%
Infertility Testing	Not covered	Not covered
Infertility Treatments - Office Visit	Not covered	Not covered
Infertility Treatments - Surgery	Not covered	Not covered
In Vitro Fertilization	Not covered	Not covered
Infertility Treatments - Lifetime Maximum	N/A	N/A
Vision Care		
Eye Examination	Not covered	Not covered
Lenses	80% Covered after cataract surgery	50% Covered after cataract surgery
Frames	80% Covered after cataract surgery	50% Covered after cataract surgery
Contact lenses- necessary	80% Covered after cataract surgery	50% Covered after cataract surgery
Contact lenses-elective	Not covered	Not covered
Lasik Eye Surgery	Not covered	Not covered

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Organ and Tissue Transplants		
Organ Transplant -Inpatient	80%	Not covered
Organs covered	80%	Not covered
Transplant Travel	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply
Transplant donor expenses	Covered; subject to plan limitations	Covered; subject to plan limitations
Lifetime Maximum	N/A	N/A
Prescription Drug Coverage		
Annual Prescription Deductible - Family	N/A	N/A
Annual Prescription Deductible - Individual	\$200 Brand Name Drugs Only	\$200 Brand Name Drugs Only
Out-of-Pocket Maximums - Individual	\$3,600, combined for in and out of network	\$3,600, combined for in and out of network
Out-of-Pocket Maximums - Family	\$7,200, combined for in and out of network	\$7,200, combined for in and out of network
Annual Maximum Benefit	N/A	N/A
Lifetime Maximum Benefit	N/A	N/A
Generic Substitution	N/A	N/A
Retail Refill Penalty	N/A	N/A
Prescription Drug Retail		
Retail - Generic	\$5 copay	\$5 copay, then 50% of the cost of the medication
Retail - Brand Formulary	\$30 copay, after \$200 brand deductible	\$30 copay, then 50% of the cost of the medication after \$200 brand deductible
Retail - Brand Non-Formulary	\$60 copay, after \$200 brand deductible	\$60 copay, then 50% of the cost of the medication after \$200 brand deductible
Single Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Subject to applicable formulary/non-formulary copay after brand deductible
Multi Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Subject to applicable formulary/non-formulary copay after brand deductible
Injectable Medications	20% up \$100 copay maximum for Self-Injectable Specialty medications only	20% up \$100 copay maximum for Self-Injectable Specialty medications only
Prescription Drug Mail Order		
Mail-Order - Generic	\$10 copay	Not covered
Mail-Order - Brand Formulary	\$60 copay, after \$200 brand deductible	Not covered
Mail-Order - Brand Non-Formulary	\$120 copay, after \$200 brand deductible	Not covered
Single Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Not covered
Multi Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Not covered
Injectable Medications	20% up \$100 copay maximum	Not covered
Day Supply	Non-Specialty - 90 Day; Specialty - 30 Day	Not covered
Other Services - Prescription Drugs		
Over the Counter	Not covered	Not covered
Prenatal Vitamins	Rx Only	Rx Only
Diabetic Supplies	\$0 copay for preferred strips; regular copay for supplies	Regular copays plus 50% of the maximum allowed amount plus any costs over the allowed amount
Lifestyle Drugs	Regular copays; may be subject to prior authorization	Regular copays plus 50% of the maximum allowed amount plus any costs over the allowed amount
Contraceptives - Injectable	\$0 copay per ACA guidelines	Not covered
Fertility Drugs	Not covered	Not covered
Smoking Cessation	\$0 copay per ACA guidelines	Not covered
Cosmetic Medications	Not covered	Not covered
Nutritional Supplements	Metabolic Infant Formula only.	Metabolic Infant Formula only.