Author Frankrick and Day OF Particular		
Active Employees and Pre-65 Retirees	Anthem Blue Cross	S PPO - Nationwide*
(Non-Medicare Only)	he general features of the plans based on the	our knowledge at the time of this printing
	documents that contain the complete provi	
	e to you by the respective carriers. Final in	
	ntract and membership agreements on file	
Department.	na act and monaction, agreement on me	
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	2370	
Precertification Penalty	Covered benefits reduced by 30% if no	Covered benefits reduced by 30% if no
	precertification obtained where required	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	14/7	7 (ppilod to 11011 Contracted 1 To Table 1
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
Tarring Furnaci Decadotible	ψ1,000 (Boos not apply to out of Network)	ψ2,200 applies to 111 Network
Applies to Out-of-Pocket Maximum	Yes	Yes
Prescription benefits are covered under	RX Deductible does not apply to medical	RX Deductible does not apply to medical
medical deductible	deductible.	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	·	\$9,000 (Out of Pocket amounts accumulate
Year	seperately for In and Out of Network)	seperately for In and Out of Network)
. 54.	a separately for in and dat or rectionly	
Family Out-of-Pocket Maximum Per Year	\$6,000 (Out of Pocket amounts accumulate	\$18,000 (Out of Pocket amounts
. ,	seperately for In and Out of Network)	accumulate seperately 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%

100% 100%

100%

N/A

N/A

80% - Pre-authorization required for all

inpatient admissions.

80%

\$150, Waived if admitted

80%

80%

\$20 copay

\$20 copay

\$20 copay

\$20 copay Copayment applies to initial office visit ONLY.

80.00%

80.00%

50%

50%

50%

N/A

N/A

50% - Pre-authorization required for all inpatient admissions.

50%

\$150, Waived if admitted

50%

80% Emergencies Only

50%

50% 50%

50%

50%

50%

Colon Cancer Screenings

Cardiovascular screenings

Physicians and Surgeons' Services

Non-emergency or non-urgent use of ER

Hearing Evaluations

Inpatient Hospital
Deductible per Confinement

Deductible per Day

Emergency Services

Physician Office Visit

Physician Office Visit

Midwife delivery services

Emergency Room Treatment

**Urgent Care Facility Services** 

Maternity Care - Inpatient Delivery

Hospital Services

Ambulance

After Hours

Maternity Care

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Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network
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	50% - Pre-authorization required for all
	inpatient admissions	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%
	N/A	N/A
Deductible per Confinement		
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	None	None
Maximums	INOLIG	INOTIC
Rehabilitation Therapy	2007	500/
Inpatient Rehabilitation	80%	50%
Outpatient Physical, Occupational, and	80%	50%
Speech Therapy		
Alternative Care		
Chiropractic Care	80% up to 24 visits per calendar year. Visit	50% up to 24 visits per calendar year. Visit
	max combined for Physical Therapy,	max combined for Physical Therapy,
	Occupational Therapy, Acupuncture	Occupational Therapy, Acupuncture
Acupuncture	80% Combined max with Chiropractic Care,	50% Combined max with Chiropractic Care
'	Physical Therapy, Occupational Therapy.	Physical Therapy, Occupational Therapy.
	Additional 10 visits allowed	Additional 10 visits allowed
Acupressure	Not covered	Not covered
Massage Therapy	Covered only as part of office visit to a	Covered only as part of office visit to a
wassage merapy	licensed chiropractor or physical therapist .	licensed chiropractor or physical therapist .
Other Services	licensed chiropractor or physical therapist.	licensed chiropractor or physical therapist .
Other Services Private-Duty Nursing Care	licensed chiropractor or physical therapist .  Not covered	licensed chiropractor or physical therapist .  Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment	licensed chiropractor or physical therapist .  Not covered 80%	licensed chiropractor or physical therapist .  Not covered 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances	licensed chiropractor or physical therapist .  Not covered	licensed chiropractor or physical therapist .  Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment	Not covered 80% 80% Not covered	licensed chiropractor or physical therapist .  Not covered 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered	Not covered 50% 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation	Not covered 80% 80% Not covered	Not covered 50% Not covered 50% Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program	Not covered 80% 80% Not covered volume 1 covered Not covered sow - requires utilization review; covered	Not covered 50% 50% Not covered Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered	Not covered 50% 50% Not covered Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery TMJ	Not covered 80% 80% Not covered a0% - requires utilization review; covered only at COE	Not covered 50% 50% Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery TMJ Podiatry Services	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered Not covered So% - requires utilization review; covered only at COE 80%	Not covered 50% Not covered 50% Not covered Not covered Not covered Not covered Not covered Sown Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery TMJ Podiatry Services Home Health Care	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network	Not covered 50% 50% Not covered Not covered Not covered Not covered Not covered Sow Sow Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network	Not covered 50% 50% Not covered 150% 50% 50% 50% 50% 50% up to 180 visits combined in and out of network 50% up to 180 visits combined in and out of network
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hospice Care	Not covered 80% 80% Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% up to 180 visits combined in and out or network 50% up to 180 visits combined in and out or network 50% up to 180 visits combined in and out or network 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery TMJ Podiatry Services Home Health Care Skilled Nursing Facility Care Hospice Care Hearing Aids	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network	Not covered 50% 50% Not covered 150% 50% 50% 50% 50% 50% up to 180 visits combined in and out of network 50% up to 180 visits combined in and out of network
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery TMJ Podiatry Services Home Health Care	Not covered 80% 80% Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% up to 180 visits combined in and out of network 50% up to 180 visits combined in and out of network 50% up to 180 visits combined in and out of network 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery TMJ Podiatry Services Home Health Care Skilled Nursing Facility Care Hospice Care Hearing Aids	Not covered 80% 80% Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% up to 180 visits combined in and out or network 50% up to 180 visits combined in and out or network 50% up to 180 visits combined in and out or network 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hospice Care Hearing Aids Family Planning Tubal ligation	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered Not covered So% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% up to 180 visits combined in and out or network 50% up to 180 visits combined in and out or network 50% 50% (Limited of one every 3 years)
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hospice Care Hearing Aids Family Planning	Not covered 80% 80% Not covered 100% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 100% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years) 100% no deductible 80% Not covered unless prescription is covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% up to 180 visits combined in and out or network 50% up to 180 visits combined in and out or network 50% (Limited of one every 3 years)
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs	Not covered 80% 80% Not covered 100% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years) 100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary.	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% 50% N/A
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Devices  Output  During Care  Private Care  Contraceptive Devices	Not covered 80% 80% Not covered 100% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years) 100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary.	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% 50% N/A 50%
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Devices Infertility Testing	Not covered 80% 80% Not covered 100% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years) 100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% Up to 180 visits combined in and out of network 50% up to 180 visits combined in and out of network 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit	Not covered 80% 80% Not covered 100% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years) 100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hospice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery	Not covered 80% 80% Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered Not covered Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered Not covered Not covered Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization Infertility Treatments - Lifetime Maximum	Not covered 80% 80% Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered Not covered Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out of network 50% up to 180 visits combined in and out of network 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization Infertility Treatments - Lifetime Maximum	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered Not covered Not covered Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Lifetime Maximum Vision Care	Not covered 80% 80% Not covered Not covered Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered Not covered Not covered Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered Not covered Not covered Not covered Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization Infertility Treatments - Lifetime Maximum Vision Care Eye Examination	Not covered 80% 80% Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out of network 50% 50% (Limited of one every 3 years) 50% N/A 50% Not covered
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization Infertility Treatments - Lifetime Maximum Vision Care Eye Examination Lenses	Not covered 80% 80% Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out of network 50% 50% (Limited of one every 3 years) 50% 50% Not covered So% Covered after cataract surgery
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization Infertility Treatments - Lifetime Maximum Vision Care Eye Examination Lenses Frames	Not covered 80% 80% Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out onetwork 50% 50% (Limited of one every 3 years) 50% Not covered So% Covered after cataract surgery 50% Covered after cataract surgery
Other Services Private-Duty Nursing Care Durable Medical Equipment Prosthetic and Orthotic Appliances Smoking Cessation Weight control program Bariatric surgery  TMJ Podiatry Services Home Health Care  Skilled Nursing Facility Care  Hespice Care Hearing Aids Family Planning Tubal ligation Vasectomy Contraceptive Drugs  Contraceptive Devices Infertility Treatments - Office Visit Infertility Treatments - Surgery In Vitro Fertilization Infertility Treatments - Lifetime Maximum Vision Care Eye Examination Lenses	Not covered 80% 80% Not covered Not covered Not covered 80% - requires utilization review; covered only at COE 80% 80% 100% up to 180 visits combined in and out of network 80% up to 180 visits combined in and out of network 100%, deductible does not apply 80% (Limit of one every 3 years)  100% no deductible 80% Not covered unless prescription is covered under the pharmacy formulary. 100% no deductible Not covered	Not covered 50% 50% Not covered So% 50% 50% 50% 50% 50% 50% 50% Up to 180 visits combined in and out of network 50% 50% (Limited of one every 3 years) 50% 50% Not covered So% Covered after cataract surgery

Active Employees and Pre-65 Retirees	Anthem Blue Cross PPO - Nationwide*							
(Non-Medicare Only) *Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing.								
and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits								
					Department.			
					Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	
Organ and Tissue Transplants								
Organ Transplant -Inpatient	80%	Not covered						
Organs covered	80%	Not covered						
Transplant Travel	Covered benefit for specialized transplants	Covered benefit for specialized transplants						
Transplant Travel	performed at a designated COE facility:	performed at a designated COE facility:						
	benefit limitations may apply	benefit limitations may apply						
Transplant donor expenses	Covered; subject to plan limitations	Covered; subject to plan limitations						
Lifetime Maximum	N/A							
	IN/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						
	IN/A	IV/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-	Subject to applicable formulary/non-						
Matti Oassa Barad	formulary copay after brand deductible	formulary copay after brand deductible						
Multi Source Brand	Subject to applicable formulary/non-	Subject to applicable formulary/non-						
	formulary copay after brand deductible	formulary copay after brand deductible						
Injectable Medications	20% up \$100 copay maximum for Self-	20% up \$100 copay maximum for Self-						
	Injectable Specialty medications only	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-	Not covered						
	formulary copay after brand deductible	•						
Multi Source Brand	Subject to applicable formulary/non-	Not covered						
	formulary copay after brand deductible							
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	Regular copays plus 50% of the maximum						
	for supplies	allowed amount plus any costs over the allowed amount						
Lifestyle Drugs	Regular copays; may be subject to prior	Regular copays plus 50% of the maximum						
Listino Drugo	authorization	allowed amount plus any costs over the						
	authorization							
Octobranding Library III	#0	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						
No delle con la Communicación	NASABARA LAGARA FARRALLA A	** * * * * * * * * * * * * * * * * * * *						

Metabolic Infant Formula only.

Metabolic Infant Formula only.

Nutritional Supplements

Active Employees and Pre-65 Retirees (Non-Medicare Only)

### Anthem Blue Cross EPO - Non-California\*

contract and membership agreements on file in the Aerospace Employee Benefits Department.			
Plan Changes are in Orange	2021 In-Network		
General Information			
Lifetime Maximum Benefit	N/A		
Annual Maximum Benefit	N/A		
Coinsurance Percentage	100%		
Precertification Requirements	Precertification is required for certain		
. reconing and recognition	services.		
Precertification Penalty	No Penalty		
Health Savings Account (HSA)	N/A		
Health Reimbursement Account (HRA)	N/A		
R & C	N/A		
Deductibles			
Individual Annual Deductible	N/A		
Family Annual Deductible	N/A		
Applies to Out-of-Pocket Maximum	N/A		
Prescription benefits are covered under	N/A		
medical deductible	IN/A		
Out-of-Pocket Mx per Plan Year			
Individual Out-of-Pocket Maximum Per Year	\$2,000		
individual Out-of-Pocket Maximum Per Year	\$3,000		
Family Out-of-Pocket Maximum Per Year	\$6,000		
Outpatient Services			
Primary Care Physician Visits	\$20 copay		
Specialist Visit	\$35 copay		
Lab tests and X-ray	100%		
Specialized Imaging	\$100 copay		
Outpatient Surgery	100%		
Allergy Testing	100%		
Allergy Injections	100%		
Preventive Care			
Well Child Care Office Visit	100%		
Well Child Age limit	through age 18		
Adult Routine Physical Exams	100%		
Adult Immunizations	100%		
Routine Mammogram	100%		
Pap Smear	100%		
Prostate Screening (PSA)	100%		
Colon Cancer Screenings	100%		
Cardiovascular screenings	100%		
Hearing Evaluations	100%		
Inpatient Hospital	10070		
Deductible per Confinement	NI/A		
	N/A		
Deductible per Day	N/A 100%		
Hospital Services	100%		
Physicians and Surgeons' Services	100%		
Emergency Services	Φ7F		
Emergency Room Treatment	\$75 copay		
Non-emergency or non-urgent use of ER	\$75 copay		
Ambulance	100%		
Urgent Care Facility Services	\$20 copay if services billed as office visit. If		
	facility located and billed by a hospital, then		
	ER copay applies.		
Physician Office Visit	\$20 copay		
After Hours	\$20 copay		

# Active Employees and Pre-65 Retirees (Non-Medicare Only)

### Anthem Blue Cross EPO - Non-California\*

Department.		
Plan Changes are in Orange	2021 In-Network	
Maternity Care		
Physician Office Visit	\$20 copay Copayment applies to initial	
	office visit ONLY.	
Maternity Care - Inpatient Delivery	100%	
Midwife delivery services	100%	
Mental Health		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Mental Health Inpatient	100%	
Mental Health-Inpatient Plan Maximums	N/A	
Mental Health Outpatient	\$20 copay	
Mental Health - Group Therapy	\$20 copay	
Mental Health-Outpatient Plan Maximums	N/A	
Severe Mental Illness	\$20 copay applies for professional office	
	visits; outpatient paid at 100%	
Substance Abuse		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Detoxification	100%	
Substance Abuse - Inpatient Treatment	100%	
Substance Abuse-Inpatient Plan Maximums	N/A	
Substance Abuse-Outpatient	\$20 copay	
Substance Abuse-Outpatient Plan	N/A	
Maximums		
Rehabilitation Therapy		
Inpatient Rehabilitation	100%	
Outpatient Physical, Occupational, and	100% 60 visits per calendar year combined	
Speech Therapy	for Physical Therpay, Occupational Therpay,	
	Chiropractic and Acupunture)	
Alternative Care		
Chiropractic Care	\$20 copay 60 visits per calendar year	
	combined for Physical Therpay,	
	Occupational Therpay, Chiropractic and	
	Acupunture)	
Acupuncture	\$20 copay 60 visits per calendar year	
	combined for Physical Therpay,	
	Occupational Therpay, Chiropractic and	
	Acupunture)	
Acupressure	Not covered	
Massage Therapy	Not Covered	

Active Employees and Pre-65 Retirees
(Non-Medicare Only)

### Anthem Blue Cross EPO - Non-California\*

contract and membership agreements on tile in the Aerospace Employee Benefits Department.		
Plan Changes are in Orange	2021 In-Network	
Other Services	ZOZ I III-NCLWOIR	
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	100%	
Prosthetic and Orthotic Appliances	100%	
Smoking Cessation	Not covered	
-	Not covered	
Weight control program		
Bariatric surgery	100%	
TMJ	100%	
Podiatry Services	\$20 PCP copay \$35 SPC copay	
Home Health Care	100%	
Skilled Nursing Facility Care	100% up to 100 days per calendar year	
Hospice Care	100%	
Hearing Aids	100% limited to one hearing aid per ear	
	every three years; up to a maximum of	
	\$3000 limit per ear.	
Family Planning		
Tubal ligation	\$0 copay	
Vasectomy	\$50 copay	
Contraceptive Drugs	Covered under pharmacy benefit	
Contraceptive Devices	100%	
Infertility Testing	50%	
Infertility Treatments - Office Visit	50%	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
Vision Care		
Eye Examination	\$35 copay	
Lenses	Not covered	
Frames	Not covered	
Contact lenses- necessary	Not covered	
Contact lenses-elective	Not covered	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants	1401 0040100	
Organ Transplant -Inpatient	100%	
Organs covered	100%	
Organs covered Transplant Travel		
	100% subject to limitations	
Transplant donor expenses	N1/A	
Lifetime Maximum	N/A	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	N/A	
Annual Prescription Deductible - Individual	N/A	
Out-of-Pocket Maximums - Individual	\$3,600	
Out-of-Pocket Maximums - Family	\$7,200	
Annual Maximum Benefit	N/A	
Lifetime Maximum Benefit	N/A	
Generic Substitution	N/A	
Retail Refill Penalty	N/A	
Prescription Drug Retail		
Retail - Generic	\$10 copay	
Retail - Brand Formulary	\$30 copay	
Retail - Brand Non-Formulary	\$60 copay	
Single Source Brand	Subject to applicable formulary* or non-	
Sg. S Source Brains	formularycopay	
Multi Source Brand	Subject to applicable formulary* or non-	
Mail Couloc Bland	formulary copay	
	ioinidiary copay	

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross EPO - Non- California*
*Displainer. This comparison portains the property factures of the plane board or	

Department.			
Plan Changes are in Orange	2021 In-Network		
Specialty Injectable Medications	20% up \$100 copay maximum for Self-		
	Injectable Specialty medications only		
Prescription Drug Mail Order			
Mail-Order - Generic	\$20 copay		
Mail-Order - Brand Formulary	\$60 copay		
Mail-Order - Brand Non-Formulary	\$120 copay		
Single Source Brand	Subject to applicable formulary* or non-		
Multi Source Brand	formulary copay		
Multi Source Brand	Subject to applicable formulary* or non- formulary copay		
Specialty Injectable Medications	20% up \$100 copay maximum for Self-		
Specially injectable inedications	Injectable Specialty medications only		
Day Supply	Non-Specialty - 90 Day: Specialty - 30 Day		
Бау Зирріу	Non-Specialty - 90 Day; Specialty - 30 Day		
Other Services - Prescription Drugs			
Over the Counter	Exclusion		
Prenatal Vitamins	Subject to applicable formulary* or non-		
	formulary copays		
Diabetic Supplies	\$0 copay for preferred strips; regular copay		
	for supplies		
Lifestyle Drugs	Subject to applicable formulary* or non-		
	formulary copays; may be subject to prior		
	authorization		
Contraceptives - Injectable	\$0 copay per ACA guidelines		
Fertility Drugs	Exclusion		
Smoking Cessation	\$0 copay per ACA guidelines		
Cosmetic Medications	Exclusion		
Nutritional Supplements	Metabolic Infant Formula only.		

### Active Employees and Pre-65 Retirees Anthem Blue Cross HMO - California\* (Non-Medicare Only) \*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits <u>Department.</u> Plan Changes are in Orange 2021 In-Network 2021 Comments **General Information** Lifetime Maximum Benefit N/A N/A Annual Maximum Benefit 100% Coinsurance Percentage Precertification Requirements Pre-certification is required for certain services. However, this is an HMO Plan and the member must be referred by Primary Care Physicians for all services or those services will not be covered. Precertification Penalty Services will be denied if pre-certification is not obtained, unless services are related to emergency. Health Savings Account (HSA) N/A Health Reimbursement Account (HRA) N/A R&C N/A **Deductibles** Individual Annual Deductible N/A Family Annual Deductible N/A Applies to Out-of-Pocket Maximum N/A Prescription benefits are covered under N/A medical deductible Out-of-Pocket Mx per Plan Year Individual Out-of-Pocket Maximum Per Year \$3.000 Family Out-of-Pocket Maximum Per Year \$6,000 **Outpatient Services** Primary Care Physician Visits \$20 copay Specialist Visit \$35 copay Lab tests and X-ray 100% \$100 copay Specialized Imaging **Outpatient Surgery** 100% Allergy Testing 100% (If billed for an office visit; an applicable copayment will apply.) 100% (Serum is covered at 100%) Allergy Injections **Preventive Care** Well Child Care Office Visit 100% through age 18 Well Child Age limit Adult Routine Physical Exams 100% Adult Immunizations 100% Routine Mammogram 100% Pap Smear 100% Prostate Screening (PSA) 100% Colon Cancer Screenings 100% Cardiovascular screenings 100% Hearing Evaluations 100% Inpatient Hospital Deductible per Confinement N/A Deductible per Day N/A

100%

100%

Hospital Services

Physicians and Surgeons' Services

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross HMO - California*		
	e general features of the plans based on o	ur knowledge at the time of this printing	
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outlined in detail in the certificates issue	to you by the respective carriers. Final inte	erpretation of any provision of the plan i	
overned by the master insurance contra	ct and membership agreements on file in t	the Aerospace Employee Benefits	
Department.			
Plan Changes are in Orange	2021 In-Network	2021 Comments	
Emergency Services			
Emergency Room Treatment	\$75 copay		
Non-emergency or non-urgent use of ER	\$75 copay		
Ambulance	100%		
Jrgent Care Facility Services	\$20 copay if services billed as office visit. If		
orgent date racinty dervices	facility located and billed by a hospital, then		
	ER copay applies.		
Physician Office Visit	\$20 copay		
After Hours	\$20 copay		
	<del>\$20 сорау</del>		
Maternity Care	400		
Physician Office Visit	\$20 copay		
Maternity Care - Inpatient Delivery	100%		
Midwife delivery services	100%		
Mental Health			
Deductible per Confinement	N/A		
Deductible per Day	N/A		
Mental Health Inpatient	100%		
Mental Health-Inpatient Plan Maximums	N/A		
Mental Health Outpatient	\$20 copay		
Mental Health - Group Therapy	\$20 copay		
Mental Health-Outpatient Plan Maximums	N/A		
Severe Mental Illness	\$20 copay applies for professional office		
	visits; outpatient paid at 100%		
Substance Abuse			
Deductible per Confinement	N/A		
Deductible per Day	N/A		
Detoxification	100%		
Substance Abuse - Inpatient Treatment	100%		
Substance Abuse-Inpatient Plan Maximums	N/A		
Substance Abuse-inpatient Flan Maximums	IN/A		
Substance Abuse-Outpatient	\$20 aanay		
	\$20 copay		
Substance Abuse-Outpatient Plan	N/A		
Maximums			
Rehabilitation Therapy			
npatient Rehabilitation	100%		
Outpatient Physical, Occupational, and	100% limited to a 60-day period of care		
Speech Therapy	after an illness or injury; additional visits		
	available if approved by medical group		
Alternative Care			
Chiropractic Care	\$20 copay - must be ordered by Primary		
	Care Physician and approved by Medical		
	Group		
Acupuncture	\$20 copay; PCP referral required		
Acupressure	Not covered		
Massage Therapy	Not Covered		
Other Services			
Private-Duty Nursing Care	Not covered		
Durable Medical Equipment	100%	No calendar year maximum.	
		ino calendar year maximum.	
Prosthetic and Orthotic Appliances	100%		
Smoking Cessation	Not covered		
Weight control program	Not covered		
Bariatric surgery	100%		
ΓMJ	100%		
Podiatry Services	\$20 PCP copay \$35 SPC copay		
Home Health Care	100%		
Skilled Nursing Facility Care	100% up to 100 days per calendar year		
Hospice Care	100%	(Inpatient or outpatient services for members; family bereavement services)	
Joaring Aido	100% limited to one hearing aid per ear	<u> </u>	
Hearing Aids	10070 littlica to one nearing dia per car		

Active Employees and Pre-65 Retirees Anthem Blue Cross HMO - California\* (Non-Medicare Only) \*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Plan Changes are in Orange 2021 In-Network 2021 Comments Family Planning Tubal ligation No copayment Vasectomy \$50 copay Contraceptive Drugs Covered under pharmacy benefit Contraceptive Devices 100% Infertility Testing 50% does not apply to the Out of Pocket Medical care that is covered, when provided Maximum for the diagnosis and treatment of infertility, shall be those services and supplies specified in the Evidence of Coverage (EOC) as covered for the treatment of illness generally. The member must be under the direct care and treatment of a physician for infertility. Benefits are NOT payable for laboratory medical procedures involving the actual in vitro fertilization process. Infertility Treatments - Office Visit 50% does not apply to the Out of Pocket Medical care that is covered, when provided Maximum for the diagnosis and treatment of infertility, shall be those services and supplies specified in the Evidence of Coverage (EOC) as covered for the treatment of illness generally. The member must be under the direct care and treatment of a physician for infertility. Benefits are NOT payable for laboratory medical procedures involving the actual in vitro fertilization process Infertility Treatments - Surgery Not covered Not covered In Vitro Fertilization Infertility Treatments - Lifetime Maximum Not covered **Vision Care** \$20 copay PCP/ \$35 Specialist Eye Examination (vision screening from primary care physician covers evaluation only; diagnostic & treatment programs, including refraction, from an optometrist or ophthalmologist must be authorized by primary care physician) Lenses Not covered (eyeglasses and contact lenses needed after cataract surgery are covered) Frames Not covered (eyeglasses and contact lenses needed after cataract surgery are covered) Contact lenses- necessary 100% (eyeglasses and contact lenses needed after cataract surgery are covered) Contact lenses-elective Not covered Lasik Eye Surgery Not covered **Organ and Tissue Transplants** Organ Transplant -Inpatient 100% Organs covered 100% 100% subject to limitations Transplant Travel Transplant donor expenses Lifetime Maximum N/A **Prescription Drug Coverage** Annual Prescription Deductible - Family N/A Annual Prescription Deductible - Individual N/A Out-of-Pocket Maximums - Individual \$3,600 Out-of-Pocket Maximums - Family \$7,200 Annual Maximum Benefit N/A Lifetime Maximum Benefit N/A Generic Substitution N/A

N/A

Retail Refill Penalty

Active Employees and Pre-65 Retirees	Anthem Blue Cross HMO - California*			
(Non-Medicare Only)				
*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing				
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outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan i				
governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits				
Department.				
Plan Changes are in Orange	2021 In-Network	2021 Comments		
Prescription Drug Retail				
Retail - Generic	\$10 copay			
Retail - Brand Formulary	\$30 copay			
Retail - Brand Non-Formulary	\$60 copay			
Single Source Brand	Subject to applicable formulary copay			
Multi Source Brand	Subject to applicable formulary copay			
Injectable Medications	20% up \$100 copay maximum			
Prescription Drug Mail Order				
Mail-Order - Generic	\$20 copay			
Mail-Order - Brand Formulary	\$60 copay			
Mail-Order - Brand Non-Formulary	\$120 copay			
Single Source Brand	Copay determined by formulary			
Multi Source Brand	Copay determined by formulary			
Injectable Medications	20% up \$100 copay maximum			
Day Supply	90 Day			
Other Services - Prescription Drugs				
Over the Counter	Exclusion			
Prenatal Vitamins	Rx Only			
Diabetic Supplies	Regular copays			
Lifestyle Drugs	Regular copays			
Contraceptives - Injectable	Exclusion			
Fertility Drugs	Exclusion			
Smoking Cessation	Exclusion			
Cosmetic Medications	Exclusion			
Nutritional Supplements	Metabolic Infant Formula only.			

Department. Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	Comments
General Information			
Lifetime Maximum Benefit	Unlimited	Unlimited	
Annual Maximum Benefit	Unlimited	Unlimited	
Coinsurance Percentage	80%	50%	
Precertification Penalty	Covered benefits reduced by 30% if no	Covered benefits reduced by 30% if no	
Health Savings Account (HSA)	precertification obtained where required  Yes	precertification obtained where required  Yes	Health Savings Account (HSA) Employer
risaan sannigs risseam (risri)	, 55	. 33	Contribution: \$750 Individual / \$1,500 Family
Health Reimbursement Account (HRA)	No	No	. army
R & C	N/A	Applies to Non-Contracted Providers	
Deductibles			
Individual Annual Deductible	\$1,500 (Does not apply to Out-of-Network)	\$3,000 applies to In-Network	
Family Annual Deductible	\$3,000 (Does not apply to Out-of-Network)	\$6,000 applies to In-Network	
Deductible applies to Out-of-Pocket	Yes	Yes	
Maximum			
Prescription benefits are covered under medical deductible	No	No	
Out-of-Pocket Mx per Plan Year			
Individual Out-of-Pocket Maximum Per Year	\$3,300 (Out of Pocket amounts accumulate seperately for In and Out of Network)	\$9,000 (Out of Pocket amounts accumulate seperately for In and Out of Network)	
Family Out-of-Pocket Maximum Per Year	\$6,600 (Out of Pocket amounts accumulate	\$18,000 (Out of Pocket amounts	
ramin, caron rouse maninam rouse	seperately for In and Out of Network)	accumulate seperately for In and Out of  Network)	
Outpatient Services			
Primary Care Physician Visits	80%	50%	
Specialist Visit	80%	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	
Copay per Day	N/A	N/A	

Active Employees	Anthem Blue Cross CDHP*
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Department.			
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	Comments
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	80%	80%	
Non-emergency or non-urgent use of ER	80%	50%	
Ambulance	80%	80% Emergencies Only	
Urgent Care Facility Services	80%	50%	
Physician Office Visit	80%	50%	
After Hours	80%	50%	
Maternity Care			
Physician Office Visit	80%	50%	
Maternity Care - Inpatient Delivery	80%	50%	
Midwife delivery services	80%	50%	
Mental Health			
Deductible per Confinement	N/A	N/A	
Copay 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	80%	50%	
Mental Health - Group Therapy	80%	50%	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness	80%	50%	
Substance Abuse			
Deductible per Confinement	N/A	N/A	
Copay 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	80%	50%	
Substance Abuse-Outpatient Plan Maximums	None	None	
Rehabilitation Therapy			
Inpatient Rehabilitation	80%	50%	
Outpatient Physical, Occupational, and Speech Therapy	80%	50%	

Department. Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	Comments
Alternative Care			
Chiropractic Care	80%	50%	
Acupuncture	80%	50%	
Acupressure	80%	50%	
Massage Therapy	80%	50%	
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	
Veight control program	Not covered	Not covered	
Bariatric surgery	80% - requires utilization review; covered	Not covered	
	only at COE 80%	50%	
Podiatry Services	80%	50%	
Home Health Care	80% up to 180 visits combined in and out of	50% up to 180 visits combined in and out of	
Skilled Nursing Facility Care	network  80% up to 180 visits combined in and out of	network 50% up to 180 visits combined in and out of	
Hospice Care	network 80%, deductible does not apply	network 50%	
· Hearing Aids	80% (Limit of one every 3 years)	50%	
amily Planning			
ubal ligation	80%	50%	
/asectomy	80%	50%	
Contraceptive Drugs	Not covered unless prescription is covered	N/A	
Contraceptive Devices	under the pharmacy formulary.  80%	50%	
nfertility Testing	Not covered	Not covered	
	Not covered  Not covered		
nfertility Treatments - Office Visit		Not covered	
nfertility Treatments - Surgery	Not covered	Not covered	
n Vitro Fertilization	Not covered	Not covered	
nfertility Treatments - Lifetime Maximum	N/A	N/A	
/ision Care			
Eye Examination	Not covered	Not covered	
enses	80% Covered after cataract surgery	50% Covered after cataract surgery	
rames	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	
asik Eye Surgery	Not covered	Not covered	
Organ and Tissue Transplants			
Organ Transplant -Inpatient	80%	Not covered	
ransplant 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	
Fransplant donor expenses	Covered; subject to plan limitations	Covered; subject to plan limitations	
Lifetime Maximum	N/A	N/A	

Active Employees	Anthem Blue Cross CDHP*

Department.			
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	Comments
Prescription Drug Coverage			
Annual Prescription Deductible - Family	\$3,000 (integrated with medical)	N/A	non-embedded
Annual Prescription Deductible - Individual	\$1,500 (integrated with medical)	N/A	non-embedded
Out-of-Pocket Maximums - Individual	\$3,300 (integrated with medical)	N/A	non-embedded
Out-of-Pocket Maximums - Family	\$6,600 (integrated with medical)	N/A	non-embedded
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	\$10 copay	Not Covered	
Retail - Brand Formulary	20%, \$30 min/ \$60 max	Not Covered	
Retail - Brand Non-Formulary	50%, \$60 min/ \$120 max	Not Covered	
Single Source Brand	Subject to applicable formulary* or non- formulary copay	Not Covered	
Multi Source Brand	Subject to applicable formulary* or non- formulary copay	Not Covered	
Injectable Medications	20% up \$100 copay maximum	Not Covered	
Prescription Drug Mail Order			
Mail-Order - Generic	\$20 copay	Not Covered	
Mail-Order - Brand Formulary	20%, \$60 min/ \$120 max	Not Covered	
Mail-Order - Brand Non-Formulary	50%, \$120 min/ \$240 max	Not Covered	
Single Source Brand	Subject to applicable formulary* or non- formulary copay	Not Covered	
Multi Source Brand	Subject to applicable formulary* or non- formulary copay	Not Covered	
Injectable Medications	20% up \$100 copay maximum for All Specialty	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	Not Covered	
Diabetic Supplies	\$0 copay for preferred strips; regular copay for supplies	Not Covered	
Lifestyle Drugs	Regular copays; may be subject to prior authorization	Not Covered	
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.	Not Covered	

Medicare Eligible / Over 65 Only

Anthem Medicare Preferred (PPO) with Senior Rx Plus - Nationwide\*

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Department.			
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	2021 Comments
General Information			
Lifetime Maximum Benefit	None	None	
Annual Maximum Benefit	None	None	
Coinsurance Percentage	N/A	N/A	
Precertification Requirements			
Precertification Penalty	Prior authorization is required/requested for select services - refer to the Benefit Chart/EOC	Prior authorization is required/requested for select services - refer to the Benefit Chart/EOC	Each time you are admitted to a hospital without properly obtaining certification, benefits are reduced by 30%. This penalty will be deducted from covered expense after the deductible has been satisfied.
Health Savings Account (HSA)	N/A	N/A	
Health Reimbursement Account (HRA)	N/A	N/A	
R&C	N/A	N/A	
Deductibles			
Individual Annual Deductible	\$0	\$0	
Family Annual Deductible	N/A	N/A	
Applies to Out-of-Pocket Maximum	N/A	N/A	
Prescription benefits are covered under	No	No	
medical deductible	110	110	
Out-of-Pocket Mx per Plan Year	\$2,500 combined INN & OON	\$2,500 combined INN & OON	
Individual Out-of-Pocket Maximum Per Year	\$2,500 combined INN & OON	\$2,500 combined INN & OON	
marriada out of 1 ookot waximam 1 of 1 oal	\$2,000 combined into a cont	\$2,000 combined in a Con	
Family Out-of-Pocket Maximum Per Year	N/A	N/A	
Outpatient Services	1377	1303	
Primary Care Physician Visits	\$5 copay	\$5 copay	
Specialist Visit	\$20 copay	\$20 copay	
Lab tests and X-ray	\$20 copay for each Medicare-covered x-ray	\$20 copay for each Medicare-covered x-ray	
Lab lests and A-ray	visit \$0 copay for each Medicare-covered clinical/diagnostic lab test	visit \$0 copay for each Medicare-covered clinical/diagnostic lab test	
Specialized Imaging	\$50 copay for Medicare-covered complex diagnostic test/radiology visit	\$50 copay for Medicare-covered complex diagnostic test/radiology visit	
Outpatient Surgery	\$50 copay	\$50 copay	
Allergy Testing	\$0 copay	\$0 copay	
Allergy Injections	\$0 copay	\$0 copay	
Preventive Care			
Well Child Care Office Visit	N/A	N/A	
Well Child Age limit	N/A	N/A	
Adult Routine Physical Exams	\$0 copay	\$0 copay	
Adult Immunizations	\$0 copay	\$0 copay	
Routine Mammogram	\$0 copay	\$0 copay	
Pap Smear	\$0 copay	\$0 copay	
Prostate Screening (PSA)	\$0 copay	\$0 copay	
Colon Cancer Screenings	\$0 copay	\$0 copay	
Cardiovascular screenings	\$0 copay	\$0 copay	
Hearing Evaluations	\$0 copay for routine hearing exams limited	\$0 copay for routine hearing exams limited	
<b>3</b>	to 1 exam and a \$70 maximum benefit every 12 months combined INN & OON	to 1 exam and a \$70 maximum benefit every 12 months combined INN & OON	
Inpatient Hospital			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Hospital Services	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	Pre-Authorization is required for all inpatient admissions.
Physicians and Surgeons' Services	\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	\$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	

Department.			
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	2021 Comments
Emergency Services	050	050	
Emergency Room Treatment	\$50 copay for each Medicare-covered emergency room visit Copay is waived if admitted within 72 hours for the same condition	\$50 copay for each Medicare-covered emergency room visit Copay is waived if admitted within 72 hours for the same condition	
Non-emergency or non-urgent use of ER	Emergency care coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States	Emergency care coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States	
Ambulance	\$50 copay for Medicare-covered ambulance services per one-way trip	\$50 copay for Medicare-covered ambulance services per one-way trip	
Urgent Care Facility Services	\$10 copay for each Medicare-covered urgently needed care visit Copay is waived if admitted within 72 hours for the same condition	\$10 copay for each Medicare-covered urgently needed care visit Copay is waived if admitted within 72 hours for the same condition	
Physician Office Visit	\$5 copay primary care physician \$20 copay specialist	\$5 copay primary care physician \$20 copay specialist	
After Hours	\$5 copay primary care physician \$20 copay specialist	\$5 copay primary care physician \$20 copay specialist	
Maternity Care			
Physician Office Visit	\$5 copay primary care physician \$20 copay specialist	\$5 copay primary care physician \$20 copay specialist	
Maternity Care - Inpatient Delivery	Benefits depend upon the type of Medicare- covered services rendered	Benefits depend upon the type of Medicare- covered services rendered	
Midwife delivery services	Benefits depend upon the type of Medicare- covered services rendered	Benefits depend upon the type of Medicare- covered services rendered	
Mental Health			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Mental Health Inpatient	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient hospital care combined INN & OON	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient hospital care combined INN & OON	Pre-Authorization is required for all inpatient admissions.
Mental Health-Inpatient Plan Maximums	None	None	Pre-Authorization is required for all inpatient admissions.
Mental Health Outpatient	\$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	\$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	
Mental Health - Group Therapy	\$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	\$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness Substance Abuse	Covered based on Medicare guidelines \$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	Covered based on Medicare guidelines \$20 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Detoxification Substance Abuse - Inpatient Treatment	Covered based on Medicare guidelines \$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	Covered based on Medicare guidelines \$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	Pre-Authorization is required for all inpatient admissions.
Substance Abuse-Inpatient Plan Maximums	None	None	Pre-Authorization is required for all inpatient admissions.
Substance Abuse-Outpatient	\$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	\$0 copay for each Medicare-covered outpatient hospital facility visit for individual therapy, group therapy or partial hospitalization	
Substance Abuse-Outpatient Plan Maximums	None	None	
Rehabilitation Therapy			
Inpatient Rehabilitation	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	
Outpatient Physical, Occupational, and Speech Therapy	\$10 copay for Medicare-covered visits	\$10 copay for Medicare-covered visits	

Department.			
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	2021 Comments
Alternative Care	COO carrou for each Madisons sourced visit	COO construction and Madisons covered visit	
Chiropractic Care	\$20 copay for each Medicare-covered visit	\$20 copay for each Medicare-covered visit	
Acupuncture	Not covered	Not covered	
Acupressure	Not covered	Not covered	
Massage Therapy	Not covered	Not covered	Massage Therapy is covered only if done by a licensed chiropractor or physical therapist as part of their office visit.
Other Services			
Private-Duty Nursing Care	Not covered	Not covered	
Durable Medical Equipment	10% coinsurance on all Medicare-covered DME	10% coinsurance on all Medicare-covered DME	
Prosthetic and Orthotic Appliances	10% coinsurance on all Medicare-covered prosthetics and orthotics	10% coinsurance on all Medicare-covered prosthetics and orthotics	
Smoking Cessation	\$0 copay for each Medicare-covered counseling quit attempt	\$0 copay for each Medicare-covered counseling quit attempt	
Weight control program	Not covered	Not covered	
Bariatric surgery	Covered based on Medicare guidelines	Covered based on Medicare guidelines	(Utilization review required; bariatric surgery covered only when performed at COE facility)
TMJ	Covered based on Medicare guidelines	Covered based on Medicare guidelines	
Podiatry Services	\$20 copay for each Medicare-covered visit Supplemental Benefit: \$5 copay for primary care physician visits and \$20 copay for specialist visits for routine foot care Routine foot care is limited to 4 visits per year combined INN & OON	\$20 copay for each Medicare-covered visit Supplemental Benefit: \$5 copay for primary care physician visits and \$20 copay for specialist visits for routine foot care Routine foot care is limited to 4 visits per year combined INN & OON	
Home Health Care	\$0 copay	\$0 copay	Part-time or intermittent skilled nursing and
			home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
Skilled Nursing Facility Care	\$10 copay per day for 1-100 days and \$0 copay for days 101-180 per benefit period.	\$10 copay per day for 1-100 days and \$0 copay for days 101-180 per benefit period.	Inpatient skilled nursing facility (SNF) coverage is limited to 180 days each benefit period. A "benefit period" begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at
Hospice Care	\$0 copay for the one time only hospice consultation	\$0 copay for the one time only hospice consultation	any hospital or SNF for 60 days in a row.  (inpatient or outpatient services; family bereavement services)
Hearing Aids	\$0 copay limited to a \$1,500 maximum benefit every 36 months combined INN & OON	\$0 copay limited to a \$1,500 maximum benefit every 36 months combined INN & OON	,
Family Planning			
Tubal ligation	Not covered	Not covered	
Vasectomy Contraceptive Drugs	Not covered  Not covered, unless prescription is covered	Not covered  Not covered, unless prescription is covered	
OSTATAGOPATO DI UGO	under the pharmacy formulary	under the pharmacy formulary	
Contraceptive Devices	Covered under Part D	Covered under Part D	
Infertility Testing	Covered based on Medicare guidelines to determine a diagnosis of infertility	Covered based on Medicare guidelines to determine a diagnosis of infertility	
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  Vision Care	Not covered	Not covered	
Eye Examination	\$0 copay for routine vision exams limited to	\$0 copay for routine vision exams limited to	
Lyo Ladiiii ddoi	visit and a \$50 maximum benefit per year combined INN & OON \$5 copay for primary care physician visits and \$20 copay for specialist visits to diagnose and treat	visit and a \$50 maximum benefit per year combined INN & OON \$5 copay for primary care physician visits and \$20 copay for specialist visits to diagnose and treat	
Lenses	diseases of the eye  Not covered except after cataract surgery	diseases of the eye  Not covered except after cataract surgery	
	Medicare guidelines apply	Medicare guidelines apply	
Frames	Not covered except after cataract surgery Medicare guidelines apply	Not covered except after cataract surgery  Medicare guidelines apply	
Contact lenses- necessary	Not covered except after cataract surgery  Medicare guidelines apply	Not covered except after cataract surgery Medicare guidelines apply	
Contact lenses-elective	Not covered	Not covered	
Lasik Eye Surgery	Not covered	Not covered	

Department.	Department.			
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	2021 Comments	
Organ and Tissue Transplants				
Organ Transplant -Inpatient	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	\$100 copay per admission \$300 inpatient out-of-pocket maximum per year combined with inpatient mental health combined INN & OON	(Utilization review required, transplants covered only when performed at COE facilities	
Organs covered	Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intenstinal/multivisceral.	Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell and intenstinal/multivisceral.	(Utilization review required, transplants covered only when performed at COE facilities	
Transplant Travel	Covered based on Medicare guidelines	Covered based on Medicare guidelines	Covered benefit for for specialized transplants performed at a designated COE facility, benefit limitations may apply.	
Transplant donor expenses	Covered based on Medicare guidelines	Covered based on Medicare guidelines		
Lifetime Maximum	None	None		
Prescription Drug Coverage				
Annual Prescription Deductible - Family	N/A	N/A		
Annual Prescription Deductible - Individual	\$100	\$100		
Out-of-Pocket Maximums - Individual	\$5,100	\$5,100		
Out-of-Pocket Maximums - Family	N/A	N/A		
Annual Maximum Benefit	None	None		
Lifetime Maximum Benefit	None	None		
Generic Substitution	N/A	N/A		
Retail Refill Penalty	N/A	N/A		
Prescription Drug Retail Retail - Generic	\$10 copay Deductible waived	\$10 copay Deductible waived	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.	
Retail - Brand Formulary	\$30 copay	\$30 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.	
Retail - Brand Non-Formulary	\$60 copay	\$60 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.	
Single Source Brand	Applicable copays apply	Applicable copays apply	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.	

Medicare Eligible / Over 65 Only

Anthem Medicare Preferred (PPO) with Senior Rx Plus - Nationwide\*

\*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits

Department.	in is governed by the master insurance con		
Plan Changes are in Orange	2021 In-Network	2021 Out-of-Network	2021 Comments
Multi Source Brand	Applicable copays apply	Applicable copays apply	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Injectable Medications	20% coinsurance with a maximum copay of \$100 for Specialty Drugs (Generic and Brand)	20% coinsurance with a maximum copay of \$100 for Specialty Drugs (Generic and Brand)	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Prescription Drug Mail Order			
Mail-Order - Generic	\$20 copay Deductible waived	\$20 copay Deductible waived	
Mail-Order - Brand Formulary	\$60 copay	\$60 copay	
Mail-Order - Brand Non-Formulary	\$120 copay	\$120 copay	
Single Source Brand	Applicable copays apply	Applicable copays apply	
Multi Source Brand	Applicable copays apply	Applicable copays apply	
Injectable Medications	20% coinsurance with a maximum copay of \$100 for Specialty Drugs (Generic and Brand)	20% coinsurance with a maximum copay of \$100 for Specialty Drugs (Generic and Brand)	Generally you must fill prescriptions at a network pharmacy to receive benefits under this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Day Supply	90-day	90-day	
Other Services - Prescription Drugs			
Over the Counter	Not covered	Not covered	
Prenatal Vitamins	Covered	Covered	
Diabetic Supplies	Covered under Part B medical plan	Covered under Part B medical plan	
Lifestyle Drugs	Covered	Covered	
Contraceptives - Injectable	Not covered Contraceptive devices are covered	Not covered Contraceptive devices are covered	
Fertility Drugs	Not covered	Not covered	
Smoking Cessation	Covered	Covered	
Cosmetic Medications	Not covered	Not covered	
Nutritional Supplements	Not covered	Not covered	

### Medicare Eligible / Over 65 Only

Department.	ct and membership agreements on file in t	ne Aerospace Employee Bellents
Plan Changes are in Orange	2021 Current Benefits	2021 Comments
General Information		
Lifetime Maximum Benefit	None	
Annual Maximum Benefit	None	
Coinsurance Percentage	N/A	
Precertification Requirements	Prior authorization is required for select	
10001tilloation (toquilomorite	services. Services must be coordinated by	
	your primary care physician. (Refer to the	
	Benefit Chart/EOC)	
Precertification Penalty	N/A	
Health Savings Account (HSA)	N/A	
Health Reimbursement Account (HRA)	N/A	
R & C	N/A	
Deductibles	IV/A	
	Φ0	
ndividual Annual Deductible	\$0 N/A	
Family Annual Deductible	N/A	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under	No	
medical deductible		
Out-of-Pocket Mx per Plan Year	00.155	
ndividual Out-of-Pocket Maximum Per Year	\$3,400	
Family Out-of-Pocket Maximum Per Year	N/A	
Outpatient Services		
Primary Care Physician Visits	\$10 copay	
Specialist Visit	\$10 copay	
_ab tests and X-ray	\$0 copay for each Medicare-covered x-ray	
	visit \$0 copay for each Medicare-covered	
	clinical/diagnostic lab test	
Specialized Imaging	\$0 copay for Medicare-covered complex	
	diagnostic test/radiology visit	
Outpatient Surgery	\$0 copay	
Allergy Testing	\$10 copay per visit including the office visit	
<i>.</i>		
Allergy Injections	\$10 copay per visit including the office visit	
Preventive Care		
	N/A	
Vell Child Care Office Visit		
Well Child Age limit	N/A	Modiooro quidalinas analis
Adult Routine Physical Exams	\$0 copay	Medicare guidelines apply
Adult Immunizations	\$0 copay	Medicare guidelines apply
Routine Mammogram	\$0 copay	Medicare guidelines apply
Pap Smear	\$0 copay	Medicare guidelines apply
Prostate Screening (PSA)	\$0 copay	Medicare guidelines apply
Colon Cancer Screenings	\$0 copay	Medicare guidelines apply
Cardiovascular screenings	\$0 copay	Medicare guidelines apply
Hearing Evaluations	\$0 copay for routine hearing exams limited	
	to 1 exam and a \$70 maximum benefit	
	every 12 months	
npatient Hospital		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Hospital Services	\$0 copay per admission	
Physicians and Surgeons' Services	\$0 copay for Medicare-covered physician	
	services received while an inpatient during	
	a Medicare-covered hospital stay	

### Medicare Eligible / Over 65 Only

Medicare Eligible / Over 65 Only

Anthem Blue Cross Senior Secure HMO - Southern CA\*

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Department.	ct and membership agreements on file in t	TO ASTOSPACO Employee Dellents
Plan Changes are in Orange	2021 Current Benefits	2021 Comments
Emergency Services		
Emergency Room Treatment	\$20 copay for each Medicare-covered	
	emergency room visit Copay is waived if	
	admitted within 72 hours for the same	
	condition	
Non-emergency or non-urgent use of ER	Emergency care coverage is worldwide and	Prudent layperson applies
	is limited to what is allowed under the	,
	Medicare fee schedule for the services	
	performed/received in the United States	
Ambulance	\$0 copay for Medicare-covered ambulance	
	services per one-way trip	
Urgent Care Facility Services	\$10 copay for each Medicare-covered	
	urgently needed care visit Copay is waived	
	if admitted within 72 hours for the same	
	condition	
Physician Office Visit	\$10 copay primary care physician \$10	
	copay specialist	
After Hours	\$10 copay primary care physician \$10	
	copay specialist	
Maternity Care		
Physician Office Visit	\$10 copay primary care physician \$10	
	copay specialist	
Maternity Care - Inpatient Delivery	Benefits depend upon the type of Medicare-	
	covered services rendered	
Midwife delivery services	Benefits depend upon the type of Medicare-	
	covered services rendered	
Mental Health		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Mental Health Inpatient	\$0 copay per admission	
Mental Health-Inpatient Plan Maximums	None	
Mental Health Outpatient	\$0 copay for each Medicare-covered	
	outpatient hospital facility visit for individual	
	therapy, group therapy or partial	
Maratal Hardin Community	hospitalization	
Mental Health - Group Therapy	\$10 copay for each Medicare-covered	
	professional individual therapy, group therapy or partial hospitalization visit	
Montal Health Outrationt Plan Maximuma		
Mental Health-Outpatient Plan Maximums Severe Mental Illness	None Covered based on Medicare guidelines	
Substance Abuse	Covered based on Medicare guidelines	
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Detoxification	Covered based on Medicare guidelines	
Substance Abuse - Inpatient Treatment	\$0 copay per admission	
Substance Abuse-Inpatient Plan Maximums	None	
Substance Abuse-Outpatient	\$0 copay for each Medicare-covered	
	outpatient hospital facility visit for individual	
	therapy, group therapy or partial	
	hospitalization	
Substance Abuse-Outpatient Plan	None	
Maximums		
Rehabilitation Therapy		
Inpatient Rehabilitation	\$0 copay per admission	
Outpatient Physical, Occupational, and	\$10 copay for Medicare-covered visits	
Speech Therapy		

Department.		
Plan Changes are in Orange	2021 Current Benefits	2021 Comments
Alternative Care		
Chiropractic Care	\$10 copay for each Medicare-covered visit	
·	Supplemental Benefit: \$5 copay per visit	
	limited to 20 visits per year \$5 copay for x-	
	rays and lab tests \$0 copay for appliances	
	limited to a benefit maximum of \$50 per	
	year	
Acupuncture	Not covered	
Acupressure	Not covered	
Massage Therapy	Not covered	
Other Services		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	\$0 copay on all Medicare-covered DME	
Prosthetic and Orthotic Appliances	\$0 copay on all Medicare-covered	
	prosthetics and orthotics	
Smoking Cessation	\$0 copay for each Medicare-covered	
, , , , , , , , , , , , , , , , , , ,	counseling quit attempt	
Weight control program	Not covered	
Bariatric surgery	Covered based on Medicare guidelines	
TMJ	Covered based on Medicare guidelines	
Podiatry Services	\$10 copay for each Medicare-covered visit	
,	Supplemental Benefit: \$10 copay for	
	primary care physician visits and \$10 copay	
	for specialist visits for routine foot care	
	Routine foot care is limited to 12 visits per	
	year	
Home Health Care	\$0 copay	
Skilled Nursing Facility Care	\$0 copay per admission limited to 100 days	
ğ ,	each benefit period 3 day minimum prior	
	inpatient hospital stay for related illness	
	required	
Hospice Care	\$10 copay for the one time only hospice	
•	consultation	
Hearing Aids	\$0 copay limited to a \$500 maximum	
	benefit every 12 months	
Family Planning		
Tubal ligation	Not covered	
Vasectomy	Not covered	
Contraceptive Drugs	Not covered, unless prescription is covered	
	under the pharmacy formulary	
Contraceptive Devices	Covered under Part D	
Infertility Testing	Covered based on Medicare guidelines to	
	determine a diagnosis of infertility	
Infertility Treatments - Office Visit	Not covered	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	

Department.		
Plan Changes are in Orange	2021 Current Benefits	2021 Comments
Vision Care		
Eye Examination	\$13 copay for routine vision exams limited	
	to 1 visit every 12 months \$10 copay for	
	primary care physician visits and \$10 copay	
	for specialist visits to diagnose and treat	
	diseases of the eye	
Lenses	\$0 copay for eyeglass lenses or \$65 copay	Lens: every 24 months: Standard single
	for progressive lenses limited to 1 pair	vision lenses one (1) pair. Standard bifocal
	every 24 months	lenses one (1) pair. Standard trifocal lenses
		one (1) pair.
Frames	\$75 allowance towards the purchase of	
	frames limited to 1 every 24 months	
Contact lenses- necessary	\$0 copay for glasses/contacts following	
	Medicare-covered cataract surgery	
	Medicare guidelines apply	
Contact lenses-elective	\$95 allowance towards the purchase of	
	elective contact lenses (in lieu of glasses)	
	limited to 1 every 24 months	
Lasik Eye Surgery	Not covered	
Organ and Tissue Transplants		
Organ Transplant -Inpatient	\$0 copay per admission	
Organs covered	Under certain conditions, the following types	
	of transplants are covered: corneal, kidney,	
	kidney-pancreatic, heart, liver, lung,	
	heart/lung, bone marrow, stem cell and	
	intenstinal/multivisceral.	
Transplant Travel	Covered based on Medicare guidelines	
Transplant donor expenses	Covered based on Medicare guidelines	
Lifetime Maximum	None	
Prescription Drug Coverage		
Annual Prescription Deductible - Family	N/A	
Annual Prescription Deductible - Individual	\$0	
Out-of-Pocket Maximums - Individual	\$5,100	
Out-of-Pocket Maximums - Family	N/A	
Annual Maximum Benefit	None	
Lifetime Maximum Benefit	None	
Generic Substitution	N/A	Medicare does not permit mandatory generic
Retail Refill Penalty	N/A	

## Medicare Eligible / Over 65 Only

Medicare Eligible / Over 65 Only

Anthem Blue Cross Senior Secure HMO - Southern CA\*

\*Disclaimer: This comparison contains the general features of the plans based on our knowledge at the time of this printing and is not intended to replace the legal documents that contain the complete provisions of each plan. Contract terms are outlined in detail in the certificates issue to you by the respective carriers. Final interpretation of any provision of the plan is

Department.		
Plan Changes are in Orange	2021 Current Benefits	2021 Comments
Prescription Drug Retail		
Retail - Generic	\$10 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits unde this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Retail - Brand Formulary	\$20 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits unde this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Retail - Brand Non-Formulary	\$40 copay	Generally you must fill prescriptions at a network pharmacy to receive benefits unde this Plan. In certain circumstances you may be reimbursed for drug costs when you must get a covered prescription filled at an out-of-network pharmacy. You will have to pay the cost of the drug and submit a claim to us. You will be responsible for all amounts over our negotiated cost, plus any deductible, copayment or coinsurance listed in the benefit chart.
Single Source Brand	Applicable copays apply	+
Multi Source Brand	Applicable copays apply	
Injectable Medications	Applicable copays apply	
Prescription Drug Mail Order	rippinoable copaly capply	
Mail-Order - Generic	\$20 copay	
Mail-Order - Brand Formulary	\$40 copay	
Mail-Order - Brand Non-Formulary	\$80 copay	
Single Source Brand	Applicable copays apply	
Multi Source Brand	Applicable copays apply	
Injectable Medications	Applicable copays apply	
Day Supply	90-day	
Other Services - Prescription Drugs		
Over the Counter	Not covered	Reference formulary for complete list of drugs covered
Prenatal Vitamins	Covered	Reference formulary for complete list of drugs covered
Diabetic Supplies	Covered under Part B medical plan	
Lifestyle Drugs	Covered	
Contraceptives - Injectable	Not covered Contraceptive devices are covered	
Fertility Drugs	Not covered	
Smoking Cessation	Covered	Reference formulary for complete list of drugs covered
Cosmetic Medications	Not covered	, , , , , , , , , , , , , , , , , , ,
	Not covered	

Active Employees	Anthem Dental Net*	
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Plan Changes are in Orange	2021 In Network	2021 Comments
Plan Information	2021 III NELWOIR	2021 Comments
Deductible - Individual	No deductible	
Deductible - Family	No deductible	
Out-of-Pocket Maximums - Family	N/A	
Out-of-Pocket Maximums - Individual	N/A	
Annual Maximum Benefit	N/A	
Lifetime Maximum	Lifetime Maximum. Orthodontic treatment is limited to one full case (up	
	to 24 months of standard orthodontic care) during your lifetime.	
R&C Percentile	N/A	
Preventive Care		
Deductible applies to Preventive Care?	No deductible	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Prophylaxis	Covered at 100%	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits
Oral Exams	Covered at 100% - Oral Exams. Oral exams are limited to two per calendar year  Pediatric Annual Maximum. Pediatric dental services are limited to \$500 per calendar year for each child. Referral to a pedodontist will be considered for children to the age of 5. Charges in excess of \$500 will be your financial responsibility. *	will not be payable under this plan.  (assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Flouride Application	Covered at 100%	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
X-rays	Covered at 100%	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Other Services	Covered at 100%	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.

Active Employees	Anthem D	Dental Net*
and is not intended to replace the le outlined in detail in the certificates is	ins the general features of the plans based on o gal documents that contain the complete provis ssue to you by the respective carriers. Final into ontract and membership agreements on file in	sions of each plan. Contract terms are erroretation of any provision of the plan is
Plan Changes are in Orange	2021 In Network	2021 Comments
Basic Services		
Space Maintainers	Fee schedule copayments will apply	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Sealants	Not covered	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Fillings	100%	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Periodontics	Periodontal Procedures. Periodontal scaling and root planing and/or gingival curettage are limited to one course of therapy per guadrant	(assigned participating dentist, participating dental office) are

of therapy per quadrant

during any 12-month period.

Fee schedule copayments will apply

Other Services

Dental Net for all the care the member

receives. If care is not authorize, benefits will not be payable under this plan.

(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member

receives. If care is not authorize, benefits will not be payable under this plan.

Active Employees	Anthem Dental Net*
Addive Employees	

governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.		
Plan Changes are in Orange	2021 In Network	2021 Comments
Major Services Pretreatment Review	Foo schodulo consuments will apply	(assigned participating dentist, participating
Frededitient Review	Fee schedule copayments will apply	(assigned participating dentist, participating dental office) are
		responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
Extractions	100%	will not be payable under this plan. (assigned participating dentist, participating
LXII actions	100%	dental office) are
		responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
Inlava Onlava and Crawna	Foo ashedula consumenta will apply	will not be payable under this plan.
Inlays, Onlays, and Crowns	Fee schedule copayments will apply	(assigned participating dentist, participating dental office) are
		responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
Dridge	Not Covered	will not be payable under this plan.
Bridges	Not Covered	(assigned participating dentist, participating dental office) are
		responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
Dentures	Fee schedule copayments will apply	(assigned participating dentist, participating
		dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
Dental Implants	Not covered	(assigned participating dentist, participating
		dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
Endodontics	Fee schedule copayments will apply	(assigned participating dentist, participating
		dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
Oral Surgery	Fee schedule copayments will apply	(assigned participating dentist, participating
		dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
General Anesthesia	Fee schedule copayments will apply	(assigned participating dentist, participating
		dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
Periodontic, Scaling and Root Planing	Fee schedule copayments will apply	(assigned participating dentist, participating
		dental office) are responsible for obtaining authorizing from
		Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
TMJ	Not covered	(assigned participating dentist, participating
		dental office) are
		responsible for obtaining authorizing from Dental Net for all the care the member
		receives. If care is not authorize, benefits
		will not be payable under this plan.
Other Services	Fee schedule copayments will apply	(assigned participating dentist, participating
		dental office) are
		responsible for obtaining authorizing from
		Dental Net for all the care the member receives. If care is not authorize, benefits
		will not be payable under this plan.
		will flot be payable under this plant.

Active Employees	Anthem [	Dental Net*
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Plan Changes are in Orange	2021 In Network	2021 Comments
Orthodontic Services		
Eligibility	Children and Adults	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Deductible	N/A	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Orthodontia	Fee schedule copayments will apply	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Orthodontic Lifetime Maximum (per person)	Member has a copayment as follows: Children up through age 17: \$1,450 Adults 18 and over: \$1,850	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Other Plan Provisions		minor so payasie ander tino pram
Emergency Dental Care	Fee schedule copayments will apply	Emergency Services: If members are temporarily MORE than 35 miles from their participating dental office and they need emergency dental care, they may obtain care from any dentist. They will have to pay for such emergency services; however, upon submission of an itemized paid receipt of the emergency services rendered, we will reimburse the member up to a maximum of \$50, less any applicable co-payments for the procedures performed. If the member presents an itemized statement from a dental office which is located within 35 miles of their participating dental office, the services will NOT be reimbursed for that expense.
Anesthesia	Local Anesthesia covered at 100%	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.
Cosmetic	Not covered	(assigned participating dentist, participating dental office) are responsible for obtaining authorizing from Dental Net for all the care the member receives. If care is not authorize, benefits will not be payable under this plan.