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

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross PPO - 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.		
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 inpatient admissions	50% - Pre-authorization required for all inpatient admissions
Mental Health-Inpatient Plan Maximums	None	None
Mental Health Outpatient	$20 copay	50%
Mental Health - Group Therapy	$20 copay	50%
Mental Health-Outpatient Plan Maximums	None	None
Severe Mental Illness	80%	50%
Substance Abuse	80%	50%
Deductible per Confinement	N/A	N/A
Deductible per Day	N/A	N/A
Detoxification	80%	50%
Substance Abuse - Inpatient Treatment;	80% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions
Substance Abuse-Inpatient Plan Maximums	None	None
Substance Abuse-Outpatient	$20 copay	50%
Substance Abuse-Outpatient Plan Maximums	None	None
Rehabilitation Therapy		
Inpatient Rehabilitation	80%	50%
Outpatient Physical, Occupational, and Speech Therapy	80%	50%
Alternative Care		
Chiropractic Care	80% up to 24 visits per calendar year. Visit max combined for Physical Therapy, Occupational Therapy, Acupuncture	50% up to 24 visits per calendar year. Visit max combined for Physical Therapy, Occupational Therapy, Acupuncture
Acupuncture	80% Combined max with Chiropractic Care, Physical Therapy, Occupational Therapy. Additional 10 visits allowed	50% Combined max with Chiropractic Care, Physical Therapy, Occupational Therapy. Additional 10 visits allowed
Acupressure	Not covered	Not covered
Massage Therapy	Covered only as part of office visit to a licensed chiropractor or physical therapist .	Covered only as part of office visit to a licensed chiropractor or physical therapist .
Other Services		
Private-Duty Nursing Care	Not covered	Not covered
Durable Medical Equipment	80%	50%
Prosthetic and Orthotic Appliances	80%	50%
Smoking Cessation	Not covered	Not covered
Weight control program	Not covered	Not covered
Bariatric surgery	80% - requires utilization review; covered only at COE	Not covered
TMJ	80%	50%
Podiatry Services	80%	50%
Home Health Care	100% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network
Skilled Nursing Facility Care	80% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network
Hospice Care	100%, deductible does not apply	50%
Hearing Aids	80% (Limit of one every 3 years)	50% (Limited of one every 3 years)
Family Planning		
Tubal ligation	100% no deductible	50%
Vasectomy	80%	50%
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A
Contraceptive Devices	100% no deductible	50%
Infertility Testing	Not covered	Not covered
Infertility Treatments - Office Visit	Not covered	Not covered
Infertility Treatments - Surgery	Not covered	Not covered
In Vitro Fertilization	Not covered	Not covered
Infertility Treatments - Lifetime Maximum	N/A	N/A
Vision Care		
Eye Examination	Not covered	Not covered
Lenses	80% Covered after cataract surgery	50% Covered after cataract surgery
Frames	80% Covered after cataract surgery	50% Covered after cataract surgery
Contact lenses- necessary	80% Covered after cataract surgery	50% Covered after cataract surgery
Contact lenses-elective	Not covered	Not covered
Lasik Eye Surgery	Not covered	Not covered

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross PPO - 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.		
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 performed at a designated COE facility: benefit limitations may apply	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply
Transplant donor expenses	Covered; subject to plan limitations	Covered; subject to plan limitations
Lifetime Maximum	N/A	N/A
Prescription Drug Coverage		
Annual Prescription Deductible - Family	N/A	N/A
Annual Prescription Deductible - Individual	$200 Brand Name Drugs Only	$200 Brand Name Drugs Only
Out-of-Pocket Maximums - Individual	$3,600, combined for in and out of network	$3,600, combined for in and out of network
Out-of-Pocket Maximums - Family	$7,200, combined for in and out of network	$7,200, combined for in and out of network
Annual Maximum Benefit	N/A	N/A
Lifetime Maximum Benefit	N/A	N/A
Generic Substitution	N/A	N/A
Retail Refill Penalty	N/A	N/A
Prescription Drug Retail		
Retail - Generic	$5 copay	$5 copay, then 50% of the cost of the medication
Retail - Brand Formulary	$30 copay, after $200 brand deductible	$30 copay, then 50% of the cost of the medication after $200 brand deductible
Retail - Brand Non-Formulary	$60 copay, after $200 brand deductible	$60 copay, then 50% of the cost of the medication after $200 brand deductible
Single Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Subject to applicable formulary/non-formulary copay after brand deductible
Multi Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Subject to applicable formulary/non-formulary copay after brand deductible
Injectable Medications	20% up $100 copay maximum for Self-Injectable Specialty medications only	20% up $100 copay maximum for Self-Injectable Specialty medications only
Prescription Drug Mail Order		
Mail-Order - Generic	$10 copay	Not covered
Mail-Order - Brand Formulary	$60 copay, after $200 brand deductible	Not covered
Mail-Order - Brand Non-Formulary	$120 copay, after $200 brand deductible	Not covered
Single Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Not covered
Multi Source Brand	Subject to applicable formulary/non-formulary copay after brand deductible	Not covered
Injectable Medications	20% up $100 copay maximum	Not covered
Day Supply	Non-Specialty - 90 Day; Specialty - 30 Day	Not covered
Other Services - Prescription Drugs		
Over the Counter	Not covered	Not covered
Prenatal Vitamins	Rx Only	Rx Only
Diabetic Supplies	$0 copay for preferred strips; regular copay for supplies	Regular copays plus 50% of the maximum allowed amount plus any costs over the allowed amount
Lifestyle Drugs	Regular copays; may be subject to prior authorization	Regular copays plus 50% of the maximum allowed amount plus any costs over the allowed amount
Contraceptives - Injectable	$0 copay per ACA guidelines	Not covered
Fertility Drugs	Not covered	Not covered
Smoking Cessation	$0 copay per ACA guidelines	Not covered
Cosmetic Medications	Not covered	Not covered
Nutritional Supplements	Metabolic Infant Formula only.	Metabolic Infant Formula only.

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross EPO - Non-California*
***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**
General Information	
Lifetime Maximum Benefit	N/A
Annual Maximum Benefit	N/A
Coinsurance Percentage	100%
Precertification Requirements	Precertification is required for certain 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 medical deductible	N/A
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%
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	
Deductible per Confinement	N/A
Deductible per Day	N/A
Hospital Services	100%
Physicians and Surgeons' Services	100%
Emergency Services	
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*
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**
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 Maximums	N/A
Rehabilitation Therapy	
Inpatient Rehabilitation	100%
Outpatient Physical, Occupational, and Speech Therapy	100% 60 visits per calendar year combined 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*
*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**
Other Services	
Private-Duty Nursing Care	Not covered
Durable Medical Equipment	100%
Prosthetic and Orthotic Appliances	100%
Smoking Cessation	Not covered
Weight control program	Not covered
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	
Organ Transplant -Inpatient	100%
Organs covered	100%
Transplant Travel	100% subject to limitations
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
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-formularycopay
Multi Source Brand	Subject to applicable formulary* or non-formulary copay

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross EPO - Non-California*
***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**
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-formulary copay
Multi Source Brand	Subject to applicable formulary* or non-formulary copay
Specialty Injectable Medications	20% up $100 copay maximum for Self-Injectable Specialty medications only
Day Supply	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 (Non-Medicare Only)	Anthem Blue Cross HMO - California*	
***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 Comments**
General Information		
Lifetime Maximum Benefit	N/A	
Annual Maximum Benefit	N/A	
Coinsurance Percentage	100%	
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 medical deductible	N/A	
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%	
Specialized Imaging	$100 copay	
Outpatient Surgery	100%	
Allergy Testing	100% (If billed for an office visit; an applicable copayment will apply.)	
Allergy Injections	100% (Serum is covered at 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		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Hospital Services	100%	
Physicians and Surgeons' Services	100%	

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross HMO - California*	
***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 Comments**
Emergency Services		
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	
Maternity Care		
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-Outpatient	$20 copay	
Substance Abuse-Outpatient Plan Maximums	N/A	
Rehabilitation Therapy		
Inpatient Rehabilitation	100%	
Outpatient Physical, Occupational, and Speech Therapy	100% limited to a 60-day period of care 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.
Prosthetic and Orthotic Appliances	100%	
Smoking Cessation	Not covered	
Weight control program	Not covered	
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%	(Inpatient or outpatient services for members; family bereavement services)
Hearing Aids	100% limited to one hearing aid per ear every three years	

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross HMO - California*	
***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 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 Maximum	Medical care that is covered, when provided 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 Maximum	Medical care that is covered, when provided 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	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
Vision Care		
Eye Examination	$20 copay PCP/ $35 Specialist	(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%	
Transplant Travel	100% subject to limitations	
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	
Retail Refill Penalty	N/A	

Active Employees and Pre-65 Retirees (Non-Medicare Only)	Anthem Blue Cross HMO - California*	
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 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.	

Active Employees	Anthem Blue Cross CDHP*		
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**	**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 precertification obtained where required	Covered benefits reduced by 30% if no precertification obtained where required	
Health Savings Account (HSA)	Yes	Yes	Health Savings Account (HSA) Employer Contribution: $750 Individual / $1,500 Family
Health Reimbursement Account (HRA)	No	No	
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 Maximum	Yes	Yes	
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 seperately for In and Out of Network)	$18,000 (Out of Pocket amounts 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*		
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**	**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%	

Active Employees	Anthem Blue Cross CDHP*		
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**	**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	
Weight control program	Not covered	Not covered	
Bariatric surgery	80% - requires utilization review; covered only at COE	Not covered	
TMJ	80%	50%	
Podiatry Services	80%	50%	
Home Health Care	80% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network	
Skilled Nursing Facility Care	80% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network	
Hospice Care	80%, deductible does not apply	50%	
Hearing Aids	80% (Limit of one every 3 years)	50%	
Family Planning			
Tubal ligation	80%	50%	
Vasectomy	80%	50%	
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A	
Contraceptive Devices	80%	50%	
Infertility Testing	Not covered	Not covered	
Infertility Treatments - Office Visit	Not covered	Not covered	
Infertility Treatments - Surgery	Not covered	Not covered	
In Vitro Fertilization	Not covered	Not covered	
Infertility Treatments - Lifetime Maximum	N/A	N/A	
Vision Care			
Eye Examination	Not covered	Not covered	
Lenses	80% Covered after cataract surgery	50% Covered after cataract surgery	
Frames	80% Covered after cataract surgery	50% Covered after cataract surgery	
Contact lenses- necessary	80% Covered after cataract surgery	50% Covered after cataract surgery	
Contact lenses-elective	Not covered	Not covered	
Lasik Eye Surgery	Not covered	Not covered	
Organ and Tissue Transplants			
Organ Transplant -Inpatient	80%	Not covered	
Transplant Travel	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply	Covered benefit for specialized transplants performed at a designated COE facility: benefit limitations may apply	
Transplant donor expenses	Covered; subject to plan limitations	Covered; subject to plan limitations	
Lifetime Maximum	N/A	N/A	

Active Employees	Anthem Blue Cross CDHP*		
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**	**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*		
***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**	**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 medical deductible	No	No	
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	
Family Out-of-Pocket Maximum Per Year	N/A	N/A	
Outpatient Services			
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 visit $0 copay for each Medicare-covered clinical/diagnostic lab test	$20 copay for each Medicare-covered x-ray 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 to 1 exam and a $70 maximum benefit every 12 months combined INN & OON	$0 copay for routine hearing exams limited 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	

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.**			
Plan Changes are in Orange	**2021 In-Network**	**2021 Out-of-Network**	**2021 Comments**
Emergency Services			
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	Covered based on Medicare guidelines	Covered based on Medicare guidelines	
Substance Abuse	$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	
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Detoxification	Covered based on Medicare guidelines	Covered based on Medicare guidelines	
Substance Abuse - Inpatient Treatment	$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.
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	

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.			
Plan Changes are in Orange	**2021 In-Network**	**2021 Out-of-Network**	**2021 Comments**
Alternative Care			
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 any hospital or SNF for 60 days in a row.
Hospice Care	$0 copay for the one time only hospice consultation	$0 copay for the one time only hospice consultation	(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	Not covered	Not covered	
Contraceptive Drugs	Not covered, unless prescription is covered under the pharmacy formulary	Not covered, unless prescription is covered 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	Not covered	Not covered	
Vision Care			
Eye Examination	$0 copay for routine vision exams limited to 1 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 diseases of the eye	$0 copay for routine vision exams limited to 1 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 diseases of the eye	
Lenses	Not covered except after cataract surgery Medicare guidelines apply	Not covered except after cataract surgery 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	

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.**			
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.			
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	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 governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.		
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 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		
Individual Annual Deductible	$0	
Family Annual Deductible	N/A	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical deductible	No	
Out-of-Pocket Mx per Plan Year		
Individual 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	
Lab 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	
Allergy Injections	$10 copay per visit including the office visit	
Preventive Care		
Well Child Care Office Visit	N/A	
Well Child Age limit	N/A	
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	
Inpatient 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	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 governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits Department.**		
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 is limited to what is allowed under the Medicare fee schedule for the services performed/received in the United States	Prudent layperson applies
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 hospitalization	
Mental Health - Group Therapy	$10 copay for each Medicare-covered professional individual therapy, group therapy or partial hospitalization visit	
Mental Health-Outpatient Plan Maximums	None	
Severe Mental Illness	Covered based on Medicare guidelines	
Substance Abuse		
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 Maximums	None	
Rehabilitation Therapy		
Inpatient Rehabilitation	$0 copay per admission	
Outpatient Physical, Occupational, and Speech Therapy	$10 copay for Medicare-covered visits	

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 governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits 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 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	

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 governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits 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 for progressive lenses limited to 1 pair every 24 months	Lens: every 24 months: Standard single vision lenses one (1) pair. Standard bifocal 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	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 governed by the master insurance contract and membership agreements on file in the Aerospace Employee Benefits 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 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	$20 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	$40 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	
Multi Source Brand	Applicable copays apply	
Injectable Medications	Applicable copays apply	
Prescription Drug Mail Order		
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	
Nutritional Supplements	Not covered	

Active Employees	Anthem Dental Net*	
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 Comments**
Plan Information		
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 will not be payable under this plan.
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. *	(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 Dental Net*	
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 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 quadrant during any 12-month period.	(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.

Active Employees	Anthem Dental Net*	
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 Comments**
Major Services		
Pretreatment 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 will not be payable under this plan.
Extractions	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.
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 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.

Active Employees	Anthem Dental Net*	
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 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		
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.