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	**2024 In-Network**	**2024 Out-of-Network**	**2024 Comments**
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	

Active Employees	Anthem Blue Cross Basic CDHP*		
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Plan Changes are in Orange	**2024 In-Network**	**2024 Out-of-Network**	**Comments**
General Information			
Lifetime Maximum Benefit	Unlimited	Unlimited	
Annual Maximum Benefit	Unlimited	Unlimited	
Coinsurance Percentage	70%	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)	No	No	
Health Reimbursement Account (HRA)	No	No	
R & C	N/A	Applies to Non-Contracted Providers	
Deductibles			
Individual Annual Deductible	$3,000 (Does not apply to Out-of-Network)	$6,000 applies to In-Network	
Family Annual Deductible	$6,000 (Does not apply to Out-of-Network)	$12,000 applies to In-Network	**embedded; in-network dedeductible is embedded at $3,200 per individual**
Deductible applies to Out-of-Pocket Maximu	Yes	Yes	
Prescription benefits are covered under med	No	No	
Out-of-Pocket Mx per Plan Year			
Individual Out-of-Pocket Maximum Per Year	$5,000 (Out of Pocket amounts accumulate separately for In and Out of Network)	$10,000 (Out of Pocket amounts accumulate separately for In and Out of	
Family Out-of-Pocket Maximum Per Year	$10,000 (Out of Pocket amounts accumulate separately for In and Out of	$20,000 (Out of Pocket amounts accumulate separately for In and Out of	embedded
Outpatient Services			
Primary Care Physician Visits	70%	50%	
Specialist Visit	70%	50%	
Lab tests and X-ray	70%	50%	
Specialized Imaging	70%	50%	
Outpatient Surgery	70%	50%	
Allergy Testing	70%	50%	
Allergy Injections	70%	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	
Hospital Services	70% - Pre-authorization required for all inpatient admissions.	50% - Pre-authorization required for all inpatient admissions.	
Physicians and Surgeons' Services	70%	50%	
Emergency Services			
Emergency Room Treatment	70%	70%	
Non-emergency or non-urgent use of ER	70%	50%	
Ambulance	70%	70% Emergencies Only	
Urgent Care Facility Services	70%	50%	
Physician Office Visit	70%	50%	
After Hours	70%	50%	
Maternity Care			
Physician Office Visit	70%	50%	
Maternity Care - Inpatient Delivery	70%	50%	
Midwife delivery services	70%	50%	
Mental Health			
Deductible per Confinement	N/A	N/A	
Copay per Day	N/A	N/A	
Mental Health Inpatient	70% - 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	70%	50%	
Mental Health - Group Therapy	70%	50%	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness	70%	50%	
Substance Abuse			
Deductible per Confinement	N/A	N/A	
Copay per Day	N/A	N/A	
Detoxification	70%	50%	
Substance Abuse - Inpatient Treatment	70% - 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	70%	50%	
Substance Abuse-Outpatient Plan Maximum	None	None	

Active Employees	Anthem Blue Cross Basic CDHP*		
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Plan Changes are in Orange	**2024 In-Network**	**2024 Out-of-Network**	**Comments**
Rehabilitation Therapy			
Inpatient Rehabilitation	70%	50%	
Outpatient Physical, Occupational, and Spee	70%	50%	
Alternative Care			
Chiropractic Care	70%	50%	
Acupuncture	70%	50%	
Acupressure	70%	50%	
Massage Therapy	70%	50%	
Other Services			
Private-Duty Nursing Care	Not covered	Not covered	
Durable Medical Equipment	70%	50%	
Prosthetic and Orthotic Appliances	70%	50%	
Smoking Cessation	Not covered	Not covered	
Weight control program	Not covered	Not covered	
Bariatric surgery	70% - requires utilization review; covered only at COE	Not covered	
TMJ	70%	50%	
Podiatry Services	70%	50%	
Home Health Care	70% 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	70% up to 180 visits combined in and out of network	50% up to 180 visits combined in and out of network	
Hospice Care	70%, deductible does not apply	50%	
Hearing Aids	70% (Limit of one every 3 years)	50%	
Family Planning			
Tubal ligation	70%	50%	
Vasectomy	70%	50%	
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A	
Contraceptive Devices	70%	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	70% Covered after cataract surgery	50% Covered after cataract surgery	
Frames	70% Covered after cataract surgery	50% Covered after cataract surgery	
Contact lenses- necessary	70% 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	70%	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 - Individual	$3,0000 (integrated with medical)	N/A	
Annual Prescription Deductible - Family	$6,000 (integrated with medical)	N/A	**embedded; in-network dedeductible is embedded at $3,200 per individual**
Out-of-Pocket Maximums - Individual	$5,000 (integrated with medical)	N/A	
Out-of-Pocket Maximums - Family	$10,000 (integrated with medical)	N/A	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	30% $30 min/ $60 max	Not Covered	
Retail - Brand Non-Formulary	50% $60 min/ $120 max	Not Covered	
Single Source Brand	ct to applicable formulary* or non-formulary	Not Covered	
Multi Source Brand	ct to applicable formulary* or non-formulary	Not Covered	
Injectable Medications	20% up $100 copay maximum	Not Covered	
Prescription Drug Mail Order			
Mail-Order - Generic	$20 copay	Not Covered	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Formulary	30% $60 min/ $120 max	Not Covered	Also, applies for Smart90 (CVS and Walgreens)
Mail-Order - Brand Non-Formulary	50% $120 min/ $240 max	Not Covered	Also, applies for Smart90 (CVS and Walgreens)
Single Source Brand	Subject to applicable formulary* or non-formulary copay	Not Covered	