

## 2018 Anthem EPO - Non-California

Active Employees and Pre-65 Retirees (Non-Medicare)	Anthem EPO - Non-California*	
<i>*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.</i>		
Plan changes are in orange.	2018 In-Network	Comments
<b>General Information</b>		
Lifetime Maximum Benefit	N/A	
Annual Maximum Benefit	N/A	
Coinsurance Percentage	100.00%	
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	
<b>Deductibles</b>		
Individual Annual Deductible	N/A	
Family Annual Deductible	N/A	
Applies to Out-of-Pocket Maximum	N/A	
Prescription benefits are covered under medical	N/A	
<b>Out-of-Pocket Mx per Plan Year</b>		
Individual Out-of-Pocket Maximum Per Year	\$3,000.00	
Family Out-of-Pocket Maximum Per Year	\$6,000.00	
<b>Outpatient Services</b>		
Primary Care Physician Visits	\$20 copay	
Specialist Visit	\$35 copay	
Lab tests and X-ray	100.00%	
Specialized Imaging	\$100 copay	
Outpatient Surgery	100.00%	
Allergy Testing	100.00%	
Allergy Injections	100.00%	
<b>Preventive Care</b>		
Well Child Care Office Visit	100.00%	
Well Child Age limit	through age 18	
Adult Routine Physical Exams	100.00%	
Adult Immunizations	100.00%	
Routine Mammogram	100.00%	
Pap Smear	100.00%	
Prostate Screening (PSA)	100.00%	
Colon Cancer Screenings	100.00%	
Cardiovascular screenings	100.00%	
Hearing Evaluations	100.00%	

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<b>Inpatient Hospital</b>		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Hospital Services	<b>\$250 Copay</b>	
Physicians and Surgeons' Services	100.00%	
<b>Emergency Services</b>		
Emergency Room Treatment	<b>\$150 copay</b>	
Non-emergency or non-urgent use of ER	<b>\$150 copay</b>	
Ambulance	100.00%	
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	
<b>Maternity Care</b>		
Physician Office Visit	\$20 copay Copayment applies to initial office visit ONLY.	
Maternity Care - Inpatient Delivery	<b>\$250 Copay</b>	
Midwife delivery services	100.00%	
<b>Mental Health</b>		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Mental Health Inpatient	<b>\$250 Copay</b>	
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%	
<b>Substance Abuse</b>		
Deductible per Confinement	N/A	
Deductible per Day	N/A	
Detoxification	100.00%	
Substance Abuse - Inpatient Treatment	<b>\$250 Copay</b>	
Substance Abuse-Inpatient Plan Maximums	N/A	
Substance Abuse-Outpatient	\$20 copay	
Substance Abuse-Outpatient Plan Maximums	N/A	
<b>Rehabilitation Therapy</b>		
Inpatient Rehabilitation	<b>\$250 Copay</b>	
Outpatient Physical, Occupational, and Speech Therapy	100% 60 visits per calendar year combined for Physical Therapy, Occupational Therapy, Chiropractic and Acupuncture)	

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<b>Alternative Care</b>		
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	
<b>Other Services</b>		
Private-Duty Nursing Care	Not covered	
Durable Medical Equipment	100.00%	
Prosthetic and Orthotic Appliances	100.00%	
Smoking Cessation	Not covered	
Weight control program	Not covered	
Bariatric surgery	100.00%	
TMJ	100.00%	
Podiatry Services	\$20 PCP copay \$35 SPC copay	
Home Health Care	100.00%	
Skilled Nursing Facility Care	100% up to 100 days per calendar year	
Hospice Care	100.00%	
Hearing Aids	100% limited to one hearing aid per ear every three years; up to a maximum of \$3000 limit per ear.	
<b>Family Planning</b>		
Tubal ligation	\$0 copay	
Vasectomy	\$50 copay	
Contraceptive Drugs	Covered under pharmacy benefit	
Contraceptive Devices	100.00%	
Infertility Testing	50.00%	
Infertility Treatments - Office Visit	50.00%	
Infertility Treatments - Surgery	Not covered	
In Vitro Fertilization	Not covered	
Infertility Treatments - Lifetime Maximum	Not covered	
<b>Vision Care</b>		
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	
<b>Organ and Tissue Transplants</b>		
Organ Transplant -Inpatient	\$250 Copay	
Organs covered	100.00%	
Transplant Travel	100% subject to limitations	

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<b>Transplant donor expenses</b>		
Lifetime Maximum	N/A	
<b>Prescription Drug Coverage</b>		
Annual Prescription Deductible - Family	N/A	
Annual Prescription Deductible - Individual	N/A	
Out-of-Pocket Maximums - Individual	\$3,600.00	
Out-of-Pocket Maximums - Family	\$7,200.00	
Annual Maximum Benefit	N/A	
Lifetime Maximum Benefit	N/A	
Generic Substitution	N/A	
Retail Refill Penalty	N/A	
<b>Prescription Drug Retail</b>		
Retail - Generic	\$10 copay	
Retail - Brand Formulary	\$30 copay	
Retail - Brand Non-Formulary	\$60 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	<b>20% up \$100 copay maximum for All Specialty</b>	
<b>Prescription Drug Mail Order</b>		
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	<b>20% up \$100 copay maximum for All Specialty</b>	
Day Supply	Non-Specialty - 90 Day; Specialty - 30 Day	
<b>Other Services - Prescription Drugs</b>		
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.	