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.	**2019 In-Network**	**2019 Out-of-Network**	**Comments**
General Information			
Lifetime Maximum Benefit	Unlimited	Unlimited	
Annual Maximum Benefit	Unlimited	Unlimited	
Coinsurance Percentage	80.00%	50.00%	
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	50.00%	
Specialist Visit	$35 copay	50.00%	
Lab tests and X-ray	80.00%	50.00%	
Specialized Imaging	80.00%	50.00%	
Outpatient Surgery	80.00%	50.00%	
Allergy Testing	80.00%	50.00%	
Allergy Injections	80.00%	50.00%	
Preventive Care			
Well Child Care Office Visit	100.00%	50.00%	
Well Child Age limit	to age 19	to age 19	
Adult Routine Physical Exams	100.00%	50.00%	
Adult Immunizations	100.00%	50.00%	
Routine Mammogram	100.00%	50.00%	
Pap Smear	100.00%	50.00%	
Prostate Screening (PSA)	100.00%	50.00%	
Colon Cancer Screenings	100.00%	50.00%	
Cardiovascular screenings	100.00%	50.00%	
Hearing Evaluations	100.00%	50.00%	
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	80.00%	50.00%	
Emergency Services			
Emergency Room Treatment	$150, Waived if admitted	$150, Waived if admitted	
Non-emergency or non-urgent use of ER	80.00%	50.00%	
Ambulance	80.00%	80% Emergencies Only	
Urgent Care Facility Services	$20 copay	50.00%	
Physician Office Visit	$20 copay	50.00%	
After Hours	$20 copay	50.00%	
Maternity Care			
Physician Office Visit	$20 copay Copayment applies to initial office visit ONLY.	50.00%	
Maternity Care - Inpatient Delivery	80.00%	50.00%	
Midwife delivery services	80.00%	50.00%	

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Mental Health			
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Mental Health Inpatient	80% - Pre-authorization required for all inpatient admissions	50% - Pre-authorization required for all inpatient admissions	
Mental Health-Inpatient Plan Maximums	None	None	
Mental Health Outpatient	$20 copay	50.00%	
Mental Health - Group Therapy	$20 copay	50.00%	
Mental Health-Outpatient Plan Maximums	None	None	
Severe Mental Illness	80.00%	50.00%	
Substance Abuse	80.00%	50.00%	
Deductible per Confinement	N/A	N/A	
Deductible per Day	N/A	N/A	
Detoxification	80.00%	50.00%	
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	50.00%	
Substance Abuse-Outpatient Plan Maximums	None	None	
Rehabilitation Therapy			
Inpatient Rehabilitation	80.00%	50.00%	
Outpatient Physical, Occupational, and Speech Therapy	80.00%	50.00%	
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	80.00%	50.00%	
Prosthetic and Orthotic Appliances	80.00%	50.00%	
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	80.00%	50.00%	
Podiatry Services	80.00%	50.00%	
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	50.00%	
Hearing Aids	80% (Limit of one every 3 years)	50% (Limited of one every 3 years)	
Family Planning			
Tubal ligation	100% no deductible	50.00%	
Vasectomy	80.00%	50.00%	
Contraceptive Drugs	Not covered unless prescription is covered under the pharmacy formulary.	N/A	
Contraceptive Devices	100% no deductible	50.00%	
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	

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Vision Care			
Eye Examination	Not covered	Not covered	
Lenses	80.00% Covered after cataract surgery	50.00% Covered after cataract surgery	
Frames	80.00% Covered after cataract surgery	50.00% Covered after cataract surgery	
Contact lenses- necessary	80.00% Covered after cataract surgery	50.00% 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	80.00%	Not covered	
Organs covered	80.00%	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.	
Details			