COMPARISON OF AETNA TO ANTHEM

		IN-NETWORK LOW DEDUCTIBLE PLAN ONLY	
SERVICE		**AETNA**	**ANTHEM**
ANNUAL DEDUCTIBLE		$500/$1,000	$450/$900
CO-INSURANCE		10%	15%
ANNUAL OUT OF POCKET MAXIMUM		$1,000/$2,000	$2,500/$5,000
REFERRAL REQUIREMENT		NONE	NONE
PRESCRIPTION DRUG ANNUAL OUT OF POCKET	IND	$6,750	ANTHEM'S $2,500/$5,000 ABOVE
	FAM	$13,500	
PREVENTIVE CARE			
ROUTINE ADULT PHYSICAL		COVERED 100%	COVERED 100%
EXAM/IMMUNIZATIONS		1 PER YEAR	DEDUCTIBLE WAIVED
		DEDUCTIBLE WAIVED	
ROUTINE WELL CHILD		COVERED 100%	COVERED 100%
EXAM/IMMUNIZATIONS		# VARIES	DEDUCTIBLE WAIVED
		DEDUCTIBLE WAIVED	
ROUTINE GYNO EXAMS/MAMMOGRAMS/WOMEN'S HEALTH		COVERED 100%	COVERED 100%
ROUTINE DIGITAL RECTAL EXAM/PROSTATE-SPECIFIC ANTIGEN TEST		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
COLORECTAL CANCER SCREENING			
ROUTINE EYE/HEARING EXAMS			
PHYSICIAN SERVICES			
OFFICE VISITS - NON SPECIALIST		$25 COPAY	$20 COPAY
		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
SPECIALIST OFFICE VISIT		$50 COPAY	$20 COPAY
		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
			IF PREVENTATIVE, COVERED 100%
HEARING EXAMS		NOT COVERED	$20 COPAY
PRE-NATAL MATERNITY		COVERED 100%	0% COINSURANCE
		DEDUCTIBLE WAIVED	
WALK-IN CLINICS		$25 COPAY	$20 COPAY
		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
ALLERGY TESTING		BASED ON SERVICE	$20 COPAY
ALLERGY INJECTIONS		COVERED 100%	DEDUCTIBLE PLUS 15% COINSURANCE
		DEDUCTIBLE WAIVED	
DIAGNOSTIC PROCEDURES			
DIAGNOSTIC X-RAY/LABORATORY/COMPLEX IMAGING		10% AFTER DEDUCTIBLE	15% CO INSURANCE
EMERGENCY MEDICAL CARE			
URGENT CARE PROVIDER		$50 COPAY	$20 COPAY
		DEDUCTIBLE WAIVED	
EMERGENCY ROOM		$100 COPAY	$250 COPAY
		WAIVED IF ADMITTED	THEN 15% COINSURANCE
EMERGENCY USE OF AMBULANCE		10% AFTER DEDUCTIBLE	15% COINSURANCE
HOSPITAL CARE			
INPATIENT COVERAGE/MATERNITY		10% AFTER DEDUCTIBLE	15% COINSURANCE
OUTPATIENT HOSPITAL/SURGERY			

COMPARISON OF AETNA TO ANTHEM

		IN-NETWORK LOW DEDUCTIBLE PLAN ONLY	
SERVICE		**AETNA**	**ANTHEM**
MENTAL HEALTH SERVICES			
INPATIENT		10% AFTER DEDUCTIBLE	15% COINSURANCE
MENTAL HEALTH OFFICE VISITIS		$25 COPAY	$20 COPAY
		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
OTHER MENTAL HEALTH SERVICES		10% AFTER DEDUCTIBLE	15% COINSURANCE
SUBSTANCE ABUSE			
INPATIENT		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
RESIDENTIAL TREATMENT FACILTY		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
SUBSTANCE ABUSE OFFICE SERVICES		$25 COPAY	$20 COPAY
		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
OTHER SUBSTANCE ABUSE SERVICES		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
			UNLESS OFFICE VISIT, THEN $20 COPAY
OTHER SERVICES			
SKILLED NURSING FACILITY/HOME HEALTH CARE/PRIVATE NURSING		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
HOSPICE CARE-INPATIENT		COVERED 100%	15% COINSURANCE AFTER DEDUCTIBLE
		DEDUCTIBLE WAIVED	
HOSPICE CARE-OUTPATIENT		COVERED 100%	15% COINSURANCE AFTER DEDUCTIBLE
		DEDUCTIBLE WAIVED	
SPINAL MANIPULATION THERAPY		$50 COPAY	15% coinsurance after deductible
		DEDUCTIBLE WAIVED	COVERED UP TO 60 VISITS PER YEAR
OUTPATIENT REHABILITATIVE SPEECH/PHYSICAL/OCC THERAPY		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
DURABLE MEDICAL EQUIPMENT		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
DIABETIC SUPPLIES		COVERED SAME AS	COVERED IN FULL
		ANY OTHER MEDICAL EXPENSE	
AFFORDABLE CARE ACT MANDATED		COVERED 100%	COVERED 100%
WOMEN'S CONTRACEPTIVES		DEDUCTIBLE WAIVED	UNDER PRECSCRIPTION BENEFIT
WOMEN'S CONTRACEPTIVE DRUGS		COVERED 100%	COVERED 100%
AND DEVICES NOT OBTAINABLE AT A PHARMACY		DEDUCTIBLE WAIVED	DEDUCTIBLE WAIVED
INFUSION THERAPY		10% AFTER DEDUCTIBLE	15% COINSURANCE AFTER DEDUCTIBLE
TRANSPLANTS		COVERED 100%	15% COINSURANCE AFTER DEDUCTIBLE
BARIATRIC SURGERY		NOT COVERED	COVERED UP TO $30,000
PHARMACY			
GENERIC DRUGS	RETAIL	$10	$5
	MAIL	$20	$10
PREFERRED BRAND-NAME DRUGS	RETAIL	$35	$20
	MAIL	$70	$40
NON-PREFERRED BRAND-NAME DRUGS	RETAIL	$70	$35
	MAIL	$140	$70
STANDARD SPECIALTY DRUGS			
		25%	PRUDENT RX
PREFERRED BRAND SPECIALTY		MAX $250	DISCOUNT PROGRAM
NON-PREFERRED BRAND SPECIALITY		25%	PRUDENT RX
		MAX $250	DISCOUNT PROGRAM