

CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS

Creative Healthcare Benefits, Manchester, Conn.

	HIGH DEDUCTIBLE PPO 2 (HSA COMPATIBLE)	
MEMBER BENEFITS	In-Network	Out-of-Network*
Deductible		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Coinsurance (Member's responsibility)	0%	0%
Coinsurance Maximum		
Individual	\$0	\$0
Family	\$0	\$0
Out-of-Pocket Maximum		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Lifetime Maximum* per insured	\$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	0% after deductible	0% after deductible
Specialist Visit**	0% after deductible	0% after deductible
Hospital Admission**	0% after deductible	0% after deductible
Outpatient Surgery	0% after deductible	0% after deductible
Emergency Room (after deductible)	0% after deductible	0% after deductible
Annual Routine Gyn Exam (Annual Pap/Mammogram)	0% after deductible	0% after deductible
Preventive Health (Annual Physical) (\$200 per calendar year*)	\$25 Copay not subject to deductible	0% after deductible
Lab/X-Ray	0% after deductible	0% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	0% after deductible	0% after deductible
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*)	0% after deductible	0% after deductible
Home Health Care (80 visits per calendar year*)	0% after deductible	0% after deductible
Durable Medical Equipment (\$2,000 per calendar year*)	0% after deductible	0% after deductible
Urgent Care	0% after deductible	0% after deductible
PHARMACY		
Pharmacy Deductible per Individual (does not apply to generic)*	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible
Generic (Oral Contraceptives Included)	0% after Medical/Rx Deductible	0% after Medical/Rx Deductible
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	0% after Medical/Rx Deductible	0% after Medical/Rx Deductible
Calendar Year Maximum per Individual*	\$2,500	\$2,500

* Maximum applies to combined in and out of network benefits.

** Maternity and pregnancy related expenses are not covered.

+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

A summary of exclusions is listed on page 17. For a full list of benefit coverage and exclusions refer to the plan documents.

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