

CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS

	PPO 2500	
MEMBER BENEFITS	In-Network	Out-of-Network ⁺
Deductible		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
Coinsurance (Member's responsibility)	20% after deductible	50% after deductible
Coinsurance Maximum		
Individual	\$2,500	\$2,500
Family	\$5,000	\$5,000
Out-of-Pocket Maximum		
Individual	\$5,000	\$7,500
Family	\$10,000	\$15,000
Lifetime Maximum* per insured	\$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$25 Copay not subject to deductible	50% after deductible
Specialist Visit**	\$40 Copay not subject to deductible	50% after deductible
Hospital Admission**	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Room (after deductible)	20% after deductible	20% after deductible
Annual Routine Gyn Exam (Annual Pap/Mammogram)	\$40 Copay not subject to deductible	50% after deductible
Preventive Health (Annual Physical) (\$200 per calendar year*)	\$25 Copay not subject to deductible	50% after deductible
Lab/X-Ray	20% after deductible	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*)	20% after deductible	50% after deductible (\$600 Calendar year max.)
Home Health Care (80 visits per calendar year*)	20% after deductible	25% after deductible
Durable Medical Equipment (\$2,000 per calendar year*)	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible
PHARMACY		
Pharmacy Deductible per Individual (does not apply to generic)*	\$200 (does not apply to generic)	\$200 (does not apply to generic)
Generic (Oral Contraceptives Included)	\$15 Copay not subject to deductible	50% not subject to deductible
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	\$25/\$40 Copay after deductible	50% after 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.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna Advantage Plans for individuals and families are offered by Aetna Life Insurance Company through an out-of-state blanket trust.

For Local experienced assistance call 1-866-508-0618

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