

## CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS

	PPO 500	
MEMBER BENEFITS	In-Network	Out-of-Network*
Deductible		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
Coinsurance (Member's responsibility)	20% after deductible	50% after deductible
Coinsurance Maximum		
Individual	\$1,500	\$1,500
Family	\$3,000	\$3,000
Out-of-Pocket Maximum		
Individual	\$2,000	\$2,500
Family	\$4,000	\$5,000
Lifetime Maximum* per insured	\$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$20 Copay not subject to deductible	50% after deductible
Specialist Visit**	\$35 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)	\$35 Copay not subject to deductible	50% after deductible
Preventive Health (Annual Physical) (\$200 per calendar year*)	\$20 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
<b>PHARMACY</b>		
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.

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

Creative Healthcare Benefits, Manchester, Conn.

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