CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS Creative Healthcare Benefits, Manchester, Conn.

	PPO 500		PPO 1500		PPO 2500	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual Family	 $500 $1,000	 $1,000 $2,000	 $1,500 $3,000	 $3,000 $6,000	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (Member's responsibility)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000	 $1,500 $3,000	 $2,500 $5,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $2,000 $4,000	 $2,500 $5,000	 $3,000 $6,000	 $4,500 $9,000	 $5,000 $10,000	 $7,500 $15,000
Lifetime Maximum* per insured	$5,000,000		$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	$20 Copay not subject to deductible	50% after deductible	$20 Copay not subject to deductible	50% after deductible	$25 Copay not subject to deductible	50% after deductible
Specialist Visit**	$35 Copay not subject to deductible	50% after deductible	$35 Copay not subject to deductible	50% after deductible	$40 Copay not subject to deductible	50% after deductible
Hospital Admission**	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room (after deductible)	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$35 Copay not subject to deductible	50% after deductible	$35 Copay not subject to deductible	50% after deductible	$40 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	$20 Copay not subject to deductible	50% after deductible	$25 Copay not subject to deductible	50% after deductible
Lab/X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*)	20% after deductible ($600 Calendar year max.)	50% after deductible	20% after deductible ($600 Calendar year max.)	50% after deductible	20% after deductible ($600 Calendar year max.)	50% after deductible
Home Health Care (80 visits per calendar year*)	20% after deductible	25% after deductible	20% after deductible	25% after deductible	20% after deductible	25% after deductible
Durable Medical Equipment ($2,000 per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible	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)	$200 (does not apply to generic)	$200 (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	$15 Copay not subject to deductible	50% not subject to deductible	$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	$25/$40 Copay after deductible	50% after deductible]	$25/$40 Copay after deductible	50% after deductible
Calendar Year Maximum per Individual*	$2,500	$2,500	$2,500	$2,500	$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.

CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS

	PPO 5000		HIGH DEDUCTIBLE PPO 1 (HSA COMPATIBLE)		HIGH DEDUCTIBLE PPO 2 (HSA COMPATIBLE)	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual Family	$5,000 $10,000	$10,000 $20,000	$2,750 $5,500	$5,500 $11,000	$5,000 $10,000	$10,000 $20,000
Coinsurance (Member's responsibility)	20% after deductible	50% after deductible	20% after deductible 0% Once out-of-pocket max is satisfied	50% after deductible	0% after deductible	0% after deductible
Coinsurance Maximum Individual Family	$2,500 $5,000	$2,500 $5,000	$2,250 $4,500	$4,500 $9,000	$0 $0	$0 $0
Out-of-Pocket Maximum Individual Family	$7,500 $15,000	$12,500 $25,000	$5,000 $10,000	$10,000 $20,000	$5,000 $10,000	$10,000 $20,000
Lifetime Maximum* per insured	$5,000,000		$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	$25 Copay not subject to deductible	50% after deductible	$20 Copay after deductible	50% Copy after deductible	0% after deductible	0% after deductible
Specialist Visit**	$40 Copay not subject to deductible	50% after deductible	$35 Copay after deductible	50% Copy after deductible	0% after deductible	0% after deductible
Hospital Admission**	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Emergency Room (after deductible)	20% after deductible	20% after deductible	20% after deductible	20% after deductible	0% after deductible	0% after deductible
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$40 Copay not subject to deductible	50% after deductible	0% not subject to deductible	50% after deductible	0% not subject to deductible	0% after deductible
Preventive Health (Annual Physical) ($200 per calendar year*)	$40 Copay not subject to deductible	50% after deductible	$20 Copay not subject to deductible	50% after deductible	$25 Copay not subject to deductible	0% after deductible
Lab/X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*)	20% after deductible ($600 Calendar year max.)	50% after deductible	20% after deductible ($600 Calendar year max.)	50% after deductible	0% after deductible ($600 Calendar year max.)	0% after deductible
Home Health Care (80 visits per calendar year*)	20% after deductible	25% after deductible	20% after deductible	25% after deductible	0% after deductible	0% after deductible
Durable Medical Equipment ($2,000 per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
Urgent Care	20% after deductible	50% after deductible	20% after deductible	50% after deductible	0% after deductible	0% after deductible
PHARMACY						
Pharmacy Deductible per Individual	$200 (does not apply to generic)	$200 (does not apply to generic)	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible	Integrated Medical/ Rx Deductible
Generic (Oral Contraceptives Included)	$15 Copay not subject to deductible	50% not subject to deductible	$15 Copay after deductible	50% after deductible	0% after Medical/Rx Deductible	0% after Medical/Rx Deductible
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	$25/$40 Copay after deductible	50% after deductible	$25/$40 Copay after deductible	50% after deductible	0% after Medical/Rx Deductible	0% after Medical/Rx Deductible
Calendar Year Maximum per Individual*	$2,500	$2,500	$2,500	$2,500	$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.

CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS

	PREVENTATIVE AND HOSPITAL CARE 1250		PREVENTATIVE AND HOSPITAL CARE 3000 (HSA COMPATIBLE)	
MEMBER BENEFITS	In-Network	Out-of-Network+	In-Network	Out-of-Network+
Deductible Individual Family	$1,250 $2,500	$2,500 $5,000	$3,000 $6,000	$6,000 $12,000
Coinsurance (Member's Responsibility)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Co-insurance Maximum Individual Family	$2,500 $5,000	$5,000 $10,000	$2,000 $4,000	$4,000 $8,000
Out of Pocket Maximum Individual Family	$3,750 $7,500	$7,500 $15,000	$5,000 $10,000	$10,000 $20,000
Lifetime Maximum* Per insured	$5,000,000		$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrican or Internist)	Not Covered	Not Covered	Not Covered	Not Covered
Specialist Visit	Not Covered	Not Covered	Not Covered	Not Covered
Hospital Admission	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room	$100 copay (waived if admitted) 20% after deductible		$100 copay (waived if admitted) 20% after deductible	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	$35 copay not subject to deductible	50% after deductible	$40 Copay not subject to deductible	50% after deductible
Maternity	Not covered	Not covered	Not covered	Not covered
Preventive Health (Physical-every 24 months*) ($ 200 per exam)	$25 copay not subject to deductible	50% after deductible	$30 copay not subject to deductible	50% after deductible
Lab/X-Ray++	Not Covered	Not Covered	Not Covered	Not Covered
Skilled Nursing (In lieu of Hospital) (30 days per calendar year*)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Physical/ Occupational Therapy & Chiropractic Care	Not Covered	Not Covered	Not covered	Not covered
Home Health Care (In lieu of Hospital) (80 visits per calendar year*)	20% after deductible	25% after deductible	20% after deductible	25% after deductible
Durable Medical Equipment**	Not Covered	Not Covered	Not covered	Not covered
PHARMACY				
Pharmacy Deductible per Individual (does not apply to generic)*	Not Applicable	Not Applicable	Not Applicable	Not Applicable
Generic (Oral Contraceptives included)	Not Covered***	Not Covered***	Not Covered***	Not Covered***
Preferred Brand Name/ Non-Preferred Brand (Oral Contractives Included)	Not Covered***	Not Covered***	Not Covered***	Not Covered***
Calendar Year Maximum per Individual*	Not Covered***	Not Covered***	Not Covered***	Not Covered***

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

** Diabetic and Ostomy supplies are covered. A Max. of $1,000 per calendar year for Ostomy supplies.

*** Aetna discount available.

\+ 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.

++ Outpatient Hospital Lab/XRays (including complex imaging) covered if such services would have been performed as an Inpatient. Aetna will $100 per occurrence. Outpatient Hospital -Any other services Aetna will provide coverage of max. of $50 paid if services rendered within 72 hours of accident.

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