

CONNECTICUT AETNA ADVANTAGE PLAN OPTIONS

	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
Member Coinsurance	20%	50%	20%	50%	20%	50%
Out-of-Pocket Maximum Individual/Family (Includes deductible)	\$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*	\$5,000,000 per member lifetime		\$5,000,000 per member lifetime		\$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$20 Copay (deductible waived)	50%	\$20 Copay (deductible waived)	50%	\$25 Copay (deductible waived)	50%
Specialist Visit**	\$35 Copay (deductible waived)	50%	\$35 Copay (deductible waived)	50%	\$40 Copay (deductible waived)	50%
Hospital Admission**	20%	50%	20%	50%	20%	50%
Outpatient Surgery	20%	50%	20%	50%	20%	50%
Emergency Room	20%	20%	20%	20%	20%	20%
Annual Routine Gyn Exam (Annual Pap/Mammogram)	\$35 Copay (deductible waived)	50%	\$35 Copay (deductible waived)	50%	\$40 Copay (deductible waived)	50%
Preventive Health (Annual Physical) (\$200 max per calendar year*)	\$20 Copay (deductible waived)	50%	\$20 Copay (deductible waived)	50%	\$25 Copay (deductible waived)	50%
Lab/X-Ray	20%	50%	20%	50%	20%	50%
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20%	50%	20%	50%	20%	50%
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*) (\$600 calendar year maximum)	20%	50%	20%	50%	20%	50%
Home Health Care (80 visits per calendar year*)	20%	25%	20%	25%	20%	25%
Durable Medical Equipment (\$2,000 per calendar year*)	20%	50%	20%	50%	20%	50%
Urgent Care	20%	50%	20%	50%	20%	50%
PHARMACY BENEFITS						
Prescription Drugs (Generic formulary and non-formulary/brand formulary/brand non-formulary) Retail: per 30-day supply	\$15/\$25/\$40 Copay	50%	\$15/\$25/\$40 Copay	50%	\$15/\$25/\$40 Copay	50%
Mail Order: (31- to 60-day supply available)	2x retail copay	Not Covered	2x retail copay	Not Covered	2x retail copay	Not Covered
Calendar Year Deductible per Individual (does not apply to generic)	\$200	\$200	\$200	\$200	\$200	\$200
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.

For a full list of benefit coverage and exclusions refer to the plan documents.

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	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
Member Coinsurance	20%	50%	20%	50%	0%	0%
Out-of-Pocket Maximum Individual/Family (Includes deductible)	\$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*	\$5,000,000 per member lifetime		\$5,000,000 per member lifetime		\$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$25 Copay (deductible waived)	50%	\$20 Copay	50%	0%	0%
Specialist Visit**	\$40 Copay (deductible waived)	50%	\$35 Copay	50%	0%	0%
Hospital Admission**	20%	50%	20%	50%	0%	0%
Outpatient Surgery	20%	50%	20%	50%	0%	0%
Emergency Room	20%	20%	20%	20%	0%	0%
Annual Routine Gyn Exam (Annual Pap/Mammogram)	\$40 Copay (deductible waived)	50%	\$35 Copay Not subject to deductible	50%	0%	0%
Preventive Health (Annual Physical) (\$200 max per calendar year*)	\$40 Copay (deductible waived)	50%	\$20 Copay Not subject to deductible	50%	\$25 Copay Not subject to deductible	0%
Lab/X-Ray	20%	50%	20%	50%	0%	0%
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20%	50%	20%	50%	0%	0%
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*) (\$600 calendar year maximum)	20%	50%	20%	50%	0%	0%
Home Health Care (80 visits per calendar year*)	20%	25%	20%	25%	0%	0%
Durable Medical Equipment (\$2,000 per calendar year*)	20%	50%	20%	50%	0%	0%
Urgent Care	20%	50%	20%	50%	0%	0%
PHARMACY BENEFITS						
Prescription Drugs (Generic formulary and non-formulary/brand formulary/brand non-formulary) Retail: per 30-day supply	\$15/\$25/\$40 Copay	50%	\$15/\$25/\$40 Copay	50%	0%	0%
Mail Order: (31- to 60-day supply available)	2x retail copay	Not Covered	2x retail copay	Not Covered	0%	Not Covered
Calendar Year Deductible per Individual (does not apply to generic)	\$200	\$200	Integrated Medical/Rx Deductible		Integrated 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.

For a full list of benefit coverage and exclusions refer to the plan documents.

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INDIVIDUAL DENTAL PPO MAX		
MEMBER BENEFITS	PREFERRED	NONPREFERRED
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	\$25; \$75 family maximum	\$25; \$75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral Exams		
Periodic oral exam	100%	50%
Comprehensive oral exam	100%	50%
Problem-focused oral exam	100%	50%
X-rays		
Bitewing — single film	100%	50%
Complete series	100%	50%
PREVENTIVE SERVICES		
Adult cleaning	100%	50%
Child cleaning	100%	50%
Sealants — per tooth	Discount	Not Covered
Fluoride application — with cleaning	100%	50%
Space maintainers		
BASIC SERVICES		
Amalgam filling — 2 surfaces	100%	50%
Resin filling — 2 surfaces anterior	Discount	Not Covered
Oral Surgery		
Extraction – exposed root or erupted tooth	Discount	Not Covered
Extraction of impacted tooth —soft tissue	Discount	Not Covered
MAJOR SERVICES		
Complete upper denture	Discount	Not Covered
Partial upper denture (resin base)	Discount	Not Covered
Crown — Porcelain with noble metal	Discount	Not Covered
Pontic — Porcelain with noble metal	Discount	Not Covered
Inlay — Metallic (3 or more surfaces)	Discount	Not Covered
Oral Surgery		
Removal of impacted tooth — partially bony	Discount	Not Covered
Endodontic Services		
Bicuspid root canal therapy	Discount	Not Covered
Molar root canal therapy	Discount	Not Covered
Periodontic Services		
Scaling & root planing — per quadrant	Discount	Not Covered
Osseous surgery — per quadrant	Discount	Not Covered
ORTHODONTIC SERVICES	Discount	Not Covered

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

Access to negotiated discounts: members are eligible to receive noncovered services at the PPO negotiated rate when visiting a participating PPO dentist at any time.

Above list of covered services is representative. Full list with limitations as determined by Aetna appears on the plan booklet/certificate.

All products not available in all counties. Please refer to the state map located on page 2 of the Aetna Advantage Brochure.

Age and frequency limits may apply to some preventive services.