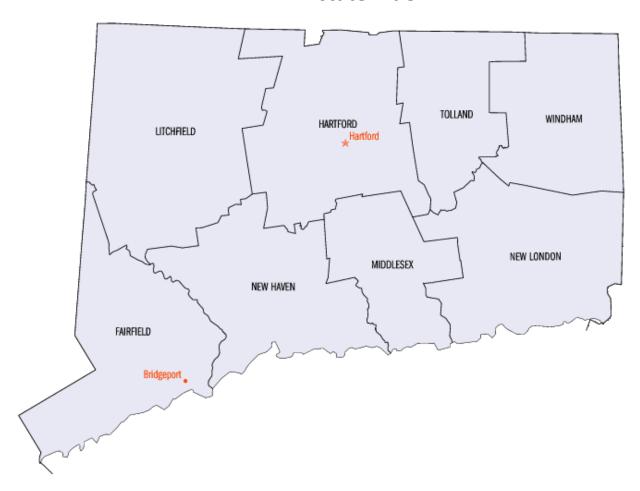
# aetna



### Geography

Geography Network Deductible and coinsurance benefits Pediatric vision Pediatric dental Pharmacy

#### statewide



#### Network



#### **Product name:**

Aetna Gold \$10 Copay OAMC PD
Aetna Silver \$10 Copay OAMC PD
Aetna Bronze \$15 Copay OAMC PD
Aetna Bronze Deductible Only HSA Eligible OAMC PD

#### **Network within CT:**

Number of providers: [Enter info]

Major hospitals: [Enter info]

Reciprocity: In state only (change from

2015)

On	Off	Product structure	Product	PCP / referral	Network used	Service area
N	Υ	1 Tier + OON	OAMC	Encouraged/ No	Aetna broad	Statewide

#### Network



#### **Product name:**

Aetna Whole Health Gold \$5 Copay PD Aetna Whole Health Silver \$10 Copay PD Aetna Whole Health Bronze \$35 Copay PD

#### **Network within CT:**

Number of providers: [Enter info]

Major hospitals: [Enter info]

Reciprocity: In state only

On	Off	Product structure	Product	PCP / referral	Network used	Service area
N	Υ	2 Tier + OON	OAMC	Encouraged/ No	ACO Broad Network	Statewide

### Deductible coinsurance

	1 7 1				12			- 3	W <sub>A</sub>	
Geography	Deductible and coinsurance		Member benefits			Pediatric Pediatric vision dental		Pharmacy		
		CT Aet	na Whole Health E	Bronze \$35 Copay PD		CT Aetna Bro Only HSA Eli	CT Aetna Bronze \$15 Copay OAMC PD			
		In netv	vork you pay	Non-designated you p	ay	In network you pay			In network you pay	
Deductible individue family¹ (applies to out-of-pocket max	5,750/\$11,500		\$6,750/\$13,500		\$6,450/\$12,900		\$6,	,850/\$13,700		
Member coinsuran	0%		0%		0%		0%			
Out-of-pocket maxi individual/family <sup>1</sup> (maximum you wil covered services)		\$6,85	0/\$13,700	\$6,850/\$13,700		\$6,450/\$1	2,900	\$6	,850/\$13,700	

<sup>1</sup> The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit.

### Deductible coinsurance

Geography	Geography Network Deductible and coinsurance benefits Pediatric vision		Pediatric Pharmacy dental					
		CT Aetna Whole He	ealth Silver \$	CT Aetna Silver \$10 Copay OAMC PD				
		In network you pay		Non-de	esignated you pay	In network you pay		
Deductible individu family¹ (applies to out-of-pocket max		\$3,750/\$7,500		\$5,750/\$11,500		\$4,000/\$8,000		
Member coinsuran	ce	20%		40%		30%		
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)		5,500/\$11,000		\$6,500	0/\$13,000	\$6,500/\$13,000		

<sup>1</sup> The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit.

#### Deductible coinsurance

Geography	Network	Deductible and coinsurance			Pediatric dental	Pharmacy		
		CT Aetna Whole Ho	ealth Gold \$5	CT Aetna Gold \$10 Copay OAMC PD				
		In network you pay		Non-de	esignated you pay	In network you pay		
Deductible individual/ family¹ (applies to out-of-pocket maximum)		\$1,250/\$2,500		\$3,500/\$7,000		\$1,400/\$2,800		
Member coinsurand	ce	20%		40%		20%		
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)		\$4,500/\$9,000		\$6,000/\$12,000		\$5,200/\$10,400		

<sup>1</sup> The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit.

				PATRICE N			T-W <sub>2</sub>
Geography	Network	Deductible and coinsurance	Member benefits	Pediatric vision	Pedia dent		Pharmacy
		CT Aetna Whole Health	Bronze \$35 Copay PD	CT Aetna Bronz Deductible Onl Eligible OAMC	y HSA	CT Aetna Bronze \$15 Copay OAMC PD	
		In network you pay	Non-designated you pay	In network you	pay	In network you pay	
Primary care office	visit	\$35 copay; ded waived	\$40 copay after ded	Covered in full after ded		\$15 copay; ded waived	
Specialist office visi	t	\$50 copay after ded	\$50 copay after ded	Covered in full	after ded	Covered	in full after ded
Hospital stay		\$250 copay per admission after ded	\$500 copay per admission after ded	Covered in full after ded		Covered	in full after ded
Outpatient surgery (Ambulatory Surgi Center/Hospital)	cal	\$250 copay after ded	\$500 copay after ded	Covered in full	after ded	Covered	in full after ded
Emergency room (copay waived if admitted)		\$200 copay after ded	Paid at the designated level	Covered in full after ded		Covered in full after ded	
Urgent care		\$60 copay after ded	\$75 copay after ded	Covered in full	after ded	\$75 cop	ay; ded waived

**Specialist office visit** 

**Outpatient surgery** 

(Ambulatory Surgical Center/Hospital)

Emergency room (copay waived

**Hospital stay** 

if admitted)

Geography	Network	coinsurance	benefits	dental	Pharmacy		
		CT Aetna Whol	e Health Silver \$10	Copay PD	CT Aetna Silv \$10 Copay O		
		In network you	pay N	Non-designated you pay	In network y	ou pay	
Primary care office	visit	\$10 copay; ded	waived \$	\$10 copay; d	\$10 copay; ded waived		

#### **Urgent care** \$75 copay; ded waived

20% after ded 40% after ded \$200 copay after ded

\$50 copay after ded

40% after ded

40% after ded

30% after ded Paid at the designated level \$200 copay after ded

\$50 copay; ded waived

\$75 copay; ded waived

30% after ded

All percentages shown are what member pays. PD: includes pediatric dental.

\$50 copay; ded waived

20% after ded

Network

Geography

Emergency room (copay waived

if admitted)

**Urgent care** 

Deductible and

coinsurance

\$200 copay after ded

\$75 copay; ded waived

	CT Aetna Whole Health Gold \$5	CT Aetna Gold \$10 Copay OAMC PD	
	In network you pay	Non-designated you pay	In network you pay
Primary care office visit	\$5 copay; ded waived	\$30 copay; ded waived	\$10 copay; ded waived
Specialist office visit	\$40 copay; ded waived	\$50 copay after ded	\$40 copay; ded waived
Hospital stay	20% after ded	20% after ded	20% after ded
Outpatient surgery (Ambulatory Surgical Center/Hospital)	20% after ded	20% after ded	20% after ded

Member

benefits

Pediatric

vision

Paid at the designated level

\$75 copay; ded waived

Pediatric

dental

\$200 copay after ded

\$75 copay; ded waived

Geography	Geography Network			ember enefits	Pediati visior	_	Pediatric dental		Pharmacy
	CT Aetna Bronze CT Aetna Whole Health Bronze \$35 Copay PD  Eligible OAMC PD					tible Only HSA	CT Aetna Bronze \$15 Copay OAMC PE		
		In network you pay	,	Non-design	ated you pay	In netv	vork you pay	In r	network you pay
Preventive care/scre (age and frequence	Covered in full; ded waived		Covered in waived	full; ded	Covere waived	d in full; ded		vered in full; ded ved	
Annual routine GYN (annual pap/mamr		Covered in full; dec	j	Covered in waived	full; ded	Covere	d in full; ded		vered in full; ded ved
Diagnostic lab		Covered in full afte	r ded	Paid at the level	designated	Covere	d in full after ded	Cov	vered in full after
Diagnostic X-ray		Covered in full afte	r ded	\$25 copay	after ded	Covere	d in full after ded	Cov	vered in full after
Imaging (CT/PET s	cans, MRIs)	\$75 copay after de	d	\$75 copay a	after ded	Covere	d in full after ded	Cov	vered in full after

(zeogranny Network			urance	benefits	vision	dental Pharmacy		
			CT Aetna	Whole Health Silver \$		CT Aetna Silver \$10 Copay OAMC PD		
			In networ	k you pay	Non-designated you pa	In network	you pay	
Preventive care/screening/immunization (age and frequency limits apply)			Covered in full; ded waived waived			Covered in t	full; ded waived	
Annual routine GYI (annual pap/mam			Covered in	n full; ded waived	Covered in full; ded waived	Covered in 1	full; ded waived	
Diagnostic lab			20% after	ded	Paid at the designated level	30% after d	ed	
Diagnostic X-ray			20% after	ded	40% after ded	30% after d	ed	

20% after ded

40% after ded

30% after ded

Member

Imaging (CT/PET scans, MRIs)

Geography	Network Deductible and coinsurance benefits Pediatric F					ediatric Pharmacy dental			
			CT Aetna	Whole Health Gold \$	CT Aetna Gold \$10 Copay OAMC PD				
			In networ	k you pay	Non-designated yo	ou pay	In network you pay		
Preventive care/scr (age and frequence	eening/immunization by limits apply)	n	Covered i	n full; ded waived	Covered in full; de waived	Covered in full; ded waived		ull; ded waived	
Annual routine GYN (annual pap/mamr			Covered in	n full; ded waived	Covered in full; de waived	Covered in full; ded waived		ull; ded waived	
Diagnostic lab			20% after	ded	Paid at the designate level	Paid at the designated level		ed	
Diagnostic X-ray			20% after	ded	40% after ded	40% after ded		ed	
Imaging (CT/PET s	scans, MRIs)		20% after	ded	40% after ded		20% after ded		

### Pediatric vision

				126			3	44	
Geography	Network				diatric Pediatrio ision dental			Pharmacy	
		CT Aetna Whole Health	PD	CT Aetna B Deductible Eligible OA	Only HSA	CT Aetna Bronze \$15 Copay OAMC PD			
		In network you pay	Non-designated	Non-designated you pay		In network you pay		In network you pay	
Pediatric eye exam (1 visit per year)		Covered in full; ded waived	Paid at the design level	Paid at the designated level		full; ded	Cove	red in full; ded ed	
Pediatric glasses/contacts (Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)		Covered in full; ded waived	Paid at the design level	nated	Covered in	full after ded	Cove	red in full; ded ed	

### Pediatric vision

						N-W				
Geography	Network		ductible and oinsurance	Member benefits		Pediatric vision		diatric ental	Pharmacy	
			CT Aetna Who	ole Health Silver \$2	10 Copay PD			CT Aetna Silver \$10 Copay OAMC PD		
			In network you pay			n-designated you pa	ıy	In network you pay		
Pediatric eye exam (1 visit per year)			Covered in full; ded waived			l at the designated	level	Covered in full; ded waived		
Pediatric glasses/contacts (Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)			Covered in full; ded waived			Paid at the designated level			ı full; ded waived	

### Pediatric vision

					- 5	A ALAS N		4	C AR
Geography	Network		ductible and oinsurance	Member benefits				diatric ental	Pharmacy
			CT Aetna Who	ole Health Gold \$5		CT Aetna Gold \$10 Copay OAMC PD			
		In network you pay			n-designated you pa	У	In network you pay		
Pediatric eye exam (1 visit per year)			Covered in full; ded waived			d at the designated	level	Covered in full; ded waived	
Pediatric glasses/contacts (Coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)			Covered in full; ded waived		Paid at the designated level			Covered in	full; ded waived

### Pediatric dental

				1294	4 6 5		A CAR			
Geography	Network	Deductible and coinsurance		1ember enefits		atric ion	Pediatric dental	Pharmacy		
		CT Aetna Whole Health Bronze \$35 Copay PD					Bronze lle Only HSA DAMC PD	CT Aetna Bronze \$15 Copay OAMC PD		
		In network you pay  Non-designar pay			ated you	In netwo	rk you pay	In network you pay		
Dental check-up/preventive dental care (2 visits per year)		Covered in full; ded waived		Paid at the designated level		Covered in full after ded		Covered in full; ded waived		
Basic dental care	Basic dental care			Paid at the designated level		Covered in full after ded		Covered in full after ded		
Major dental care		50% after ded		Paid at the designated level		ed Covered in full after ded		Covered in full after ded		
Orthodontia (medically necessa	ary only)	50% after ded		Paid at the designated level				Covered in full after ded		Covered in full after ded

### Pediatric dental

Geography	Network	Deductible and coinsurance	Member benefits	Pediatric vision		ediatric dental	Pharmacy	
		CT Aetna Whole	e Health Silver \$10	Copay PD		CT Aetna Silver \$10 Copay OAMC PD		
		In network you	pay	lon-designated you pay		In network you pay		
Dental check-up/pr dental care (2 visits per year) <sup>2</sup>		Covered in full;	ded waived F	aid at the designated le	vel	Covered in full; ded waived		
Basic dental care		30% after ded	F	aid at the designated le	vel	30% after ded		
Major dental care		50% after ded	F	aid at the designated le	vel	50% after ded		
Orthodontia (medically necessary only)		50% after ded	F	aid at the designated le	vel	50% after ded		

### Pediatric dental

Geography	Network	Deductible and coinsurance	Member benefits	Pediatric vision			ediatric dental	Pharmacy	
		CT Aetna Whole	e Health Gold \$5 (	Copay PD			CT Aetna Gold \$10 Copay OAMC PD		
		In network you p	pay	Non-designated you pay			In network you pay		
Dental check-up/pr dental care (2 visits per year) <sup>2</sup>		Covered in full;	ded waived	Paid at the designated level			Covered in full; ded waived		
Basic dental care		30% after ded		Paid at the designated level			30% after ded		
Major dental care		50% after ded		Paid at the designated level			50% after ded		
Orthodontia (medically necessary only)		50% after ded		Paid at the designated level			50% after ded		

Geography	Network	Deductible and coinsurance	Member benefits		diatric vision	Pediatr dental	_	Pharmacy
		CT Aetna Whole Health E	Bronze \$35 Copay PD		CT Aetna Br Deductible Eligible OAI	Only HSA	CT Aetna Bronze \$15 Copay OAMC PD	
		In network you pay	Non-designated pay	l you	In network y	you pay	In network you pay	
Pharmacy deductible		Integrated with medical dec	Integrated with r	nedical	Integrated with medical ded		Integrated with medical ded	
Preferred generic drugs		Generic: \$5 copay after ded	Generic: \$5 copa ded	y after	Generic: Cov after ded	ered in full	Generi ded	c: Covered in full after
Preferred brand dru	ıgs	\$50 copay after ded	\$50 copay after of	led	Covered in fu	ıll after ded	Covere	d in full after ded
Non-preferred drug	s	Generic & Brand: 40% after ded	0% after Generic & Brand: 40% after ded		Generic & Brand: Covered in full after ded		Generi full after d	c & Brand: Covered in
Specialty drugs		P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% after de	d	P: Covered in NP: Covered ded	full after ded in full after		ered in full after ded vered in full after ded

P=Preferred specialty drugs; NP=non-preferred specialty drugs.
All percentages shown are what member pays. PD: includes pediatric dental.

					PATRICE VE	TAMES IN THE STATE OF THE STATE				
Geography	Network	Deductible and coinsurance	Mem bene		Pediatric vision	Pediatric dental	Pharmacy			
		CT Aetna Whole	Health Silve	er \$10 Cop	oay PD	CT Aetna Silver \$10 Copay OAMC PD				
		In network you p	pay	Non-desi	gnated you pay	In network you pay				
Pharmacy deductib	le	\$500 per member	\$500 per member \$500 per member			\$500 per member				
Preferred generic d	Low Cost Generic: \$3 copay; ded waived Generic: \$5 copay; ded waived  Low Cost Generic: \$3 copay; ded waived Generic: \$5 copay; ded waived									
Preferred brand dru	ugs	\$40 copay after de	\$40 copay after ded \$40 copay after			\$40 copay after ded				
Non-preferred drug	Non-preferred drugs		40% after	Generic & Brand: 40% after ded		Generic & Brand: 40% after ded				
Specialty drugs		P: 40% after ded NP: 50% after ded		P: 40% af NP: 50% a		P: 40% after ded NP: 50% after ded				

P=Preferred specialty drugs; NP=non-preferred specialty drugs. All percentages shown are what member pays. PD: includes pediatric dental.

						1	Costs,	
Geography	Network	Deductible and coinsurance	Mem bene		Pediatric vision	Pediatric dental	Pharmacy	
		CT Aetna Whole	Health Gol	ld \$5 Copa	ay PD	CT Aetna Gold \$10 Copay OAMC I	CT Aetna Gold \$10 Copay OAMC PD	
		In network you p	рау	Non-des	ignated you pay	In network you pay		
Pharmacy deductib	le	\$0 per member		\$0 per m	nember	\$250 per member		
Preferred generic d	rugs	Low Cost Generi Generic: \$5 copa			t Generic: \$3 copay \$5 copay	Low Cost Generic: \$3 copay; ded waived Generic: \$5 copay; ded waived		
Preferred brand dru	erred brand drugs \$30 copay \$30 copay \$40 copay after		\$40 copay after de	d				
Non-preferred drug	Ion-preferred drugs		Generic & Brand: 30%		& Brand: 30%	Generic & Brand: 30% after ded		
Specialty drugs		P: 40% NP: 50%		P: 40% NP: 50%		P: 40% after ded NP: 50% after ded		

P=Preferred specialty drugs; NP=non-preferred specialty drugs.
All percentages shown are what member pays. PD: includes pediatric dental.

# New for 2016 Geography Network Deductible and coinsurance Deductible and coinsuran

Be a powerful force. We want you to succeed in Connecticut, so we've made some changes to make our plans more attractive and easier to sell.

#### **Topline changes for Connecticut**

- Aetna Whole Health Plans switched from "Managed Choice "to "Managed Choice Open Access", therefore PCP selection is no longer required but encouraged.
- Silver Integrated CT Aetna Silver \$10 Copay 2750 PD plan was removed.

# **Snapshot of 2016 benefit design changes in Connecticut**

- Office visit copays will include all services (ie. Lab/radiology) performed and coded in office
- Removed ER Advanced Imaging and Maternity Ultrasound as unique cost-share benefits, included in copay

#### Overview- Connecticut benefit changes from 2015-2016 (1 Tier)

#### **Notable plan changes**

- OP Hospice benefit changed to match Home Healthcare
- No age limitation on Infertility Services

#### Bronze copay plan:

- PCP copay: \$5 lower PCP copay
  - 2016: now \$15 - 2015: was \$20 • **Deductible:**
  - 2016: now \$6,850 - 2015: was \$5,750
  - Maximum out-of-pocket:
    - 2016: \$6,850 - 2015: was \$6,600

#### Pharmacy: 2016: now all tiers 100% after deductible (OAMC)

- Pharmacy Generic:
  - 2015: was \$5
- Pharmacy Brand:
- 2015: was \$40 AD
- Pharmacy Non Preferred:
  - 2015: was \$50 AD
- Pharmacy Specialty Preferred: -
  - 2015: was \$40% AD
- Pharmacy Specialty Non Preferred:
  - 2015: was 50% AD

#### Bronze HSA plan

- Deductible:
  - 2016: now \$6,450
  - 2015: was \$6,300
- Maximum out-of-pocket:
  - 2016: now \$6,450 - 2015: was \$6,300

#### Silver copay plan

- · Specialist: deductible applies
- 2016: now \$50 AD - 2015: was \$50
- Maximum out-of-pocket:
- 2016: now \$6,500 - 2015: was \$6,600
- Pharmacy Generic Low Cost:
  - 2016: now \$5 - 2015: was \$3
- Pharmacy Brand:
- 2016: now \$40 AD2015: was \$45 AD

#### Gold copay plan

- **PCP copay Tier 1:** \$5 higher PCP copay
  - 2016: now \$10
  - 2015: was \$5

#### Maximum out-of-pocket:

- 2016: now \$5,200 - 2015: was \$5,500
- **Pharmacy Brand:** 
  - 2016: now \$40 - 2015: was \$35

## Overview- Connecticut Whole Health benefit changes from 2015-2016 (2 Tiers)

#### Notable plan changes

• On Bronze plan, Tier 2 benefits greater than \$100 were updated to \$100 to account for the difference between the Deductible and the Out of Pocket Max

#### **Bronze AWH**

- PCP copay:
  - 2016: now \$35
  - 2015: was \$15
  - Specialist: deductible applies
  - 2016: now \$50 AD
  - 2015: was \$50

#### Silver AWH

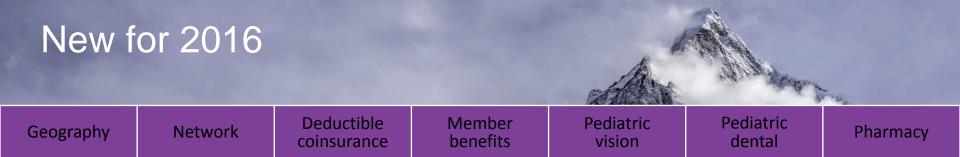
- Deductible Tier 1:
- 2016: now \$3,750
- 2015: was \$4,500
- Deductible Tier 2:
- 2016: now \$5,750
- 2015: was \$6,000
- Maximum out-of-pocket
   Tier 1:
- 2016: now \$5,500
- 2015: was \$6,600
- Maximum out-of-pocket
   Tier 2:
- 2016: now \$6,500
- 2015: was \$6,600

#### Gold AWH

- Deductible Tier 1:
- 2016: now \$5,750
- 2015: was \$5,000
- Maximum out-of-pocket Tier 1:
- 2016: now \$6,850
- 2015: was \$6,600

### Pharmacy Tier 4 Specialty Preferred:

- 2016: 40%
- 2015: 30%



#### **Quick highlights of pharmacy changes in Connecticut**

- Aetna standard network pharmacy
- Mail-order delivery with opt-out strategy
- Mail-order multiplier 2.5x for tier 1, 2 and 3 drugs