PERNOD RICARD USA, LLC
Effective Date: 01-01-2023
Aetna Choice® POS II – ASC
Fort Smith

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	$350 Individual $1,050 Family	$550 Individual $1,650 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	15%	35%
Payment Limit (per calendar year)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.		
Referral Requirement	None	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older	Covered 100%; deductible waived	30%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13-24 months, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams 1 exam and pap smear per calendar year, includes related fees.	Covered 100%; deductible waived	35%; after deductible
Routine Mammograms For females age 35 and older, 1 service maximum per year.	Covered 100%; deductible waived	35%; after deductible

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Women's Health	Covered 100%; deductible waived	30%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	35%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	35%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	35%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Covered 100%; deductible waived	35%; after deductible
1 routine exam per calendar year.		
Routine Hearing Screening	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$25 office visit copay; deductible waived Copay waived for services accessed at an IMWell Health provider.	35%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$40 office visit copay; deductible waived	35%; after deductible
Hearing Exams	Covered 100%; deductible waived	35%; after deductible
1 routine exam per 24 months.		
Pre-Natal Maternity	Covered 100%; deductible waived	35%; after deductible
Walk-in Clinics	$25 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	35%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	Your cost sharing is based on the type of service and where it is performed Copay waived for services accessed at an IMWell Health provider.	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed Copay waived for services accessed at an IMWell Health provider.	Your cost sharing is based on the type of service and where it is performed

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	15%; after deductible	35%; after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	15%; after deductible	35%; after deductible
Diagnostic Complex Imaging If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	15%; after deductible	35%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$40 office visit copay; deductible waived	$40 per visit deductible; plan deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$200 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	15%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	15%; after deductible	35%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	15%; after deductible	35%; after deductible
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	15%; after deductible	35%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	15%; after deductible	35%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	15%; after deductible	35%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	15%; after deductible	35%; after deductible
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$40 copay; deductible waived Copay waived for services accessed at an IMWell Health provider.	35%; after deductible
Other Mental Health Services	15%; after deductible	35%; after deductible

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SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	15%; after deductible	35%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	15%; after deductible	35%; after deductible
Substance Abuse Office Visits	$40 copay; deductible waived Copay waived for services accessed at an IMWell Health provider.	35%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	15%; after deductible	35%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	15%; after deductible	35%; after deductible
Home Health Care Limited to 90 visits per year. Private Duty Nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	15%; after deductible	35%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	15%; after deductible	35%; after deductible
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	15%; after deductible	35%; after deductible
Private Duty Nursing Limited to 70 eight hour shifts per year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.	15%; after deductible	35%; after deductible
Spinal Manipulation Therapy Limited to 20 visits per year	$40 copay; deductible waived	35%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy; limited to 60 visits per year	$40 copay; deductible waived	35%; after deductible
Habilitative Physical Therapy	$40 copay; deductible waived	35%; after deductible
Habilitative Occupational Therapy	$40 copay; deductible waived	35%; after deductible
Habilitative Speech Therapy	$40 copay; deductible waived	35%; after deductible
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	$40 copay; deductible waived	35%; after deductible
Autism Occupational Therapy	$40 copay; deductible waived	35%; after deductible
Autism Speech Therapy	$40 copay; deductible waived	35%; after deductible
Durable Medical Equipment	15%; after deductible	35%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.

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Infusion Therapy Administered in the home or physician's office	$40 copay; deductible waived	35%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	15%; after deductible	35%; after deductible
Acupuncture Limited to 20 visits per year	$25 copay; deductible waived	35%; after deductible
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing is based on the type of service and where it is performed $50 copay: after deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Vision Eyewear	Not Covered	Not Covered
Transplants	15%; after deductible Preferred coverage is provided at an IOE contracted facility only.	35%; after deductible
Bariatric Surgery Limited to $15,000 per lifetime	50%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	15%; after deductible	35%; after deductible
Coverage includes artificial insemination and ovulation induction limited to six courses of treatment combined, per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Advanced Reproductive Technology (ART)	15%; after deductible	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	35%; after deductible
Tubal Ligation	Covered 100%; deductible waived	35%; after deductible

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Standard Open Formulary	
Generic Drugs		
Retail	$10 copay	Not Covered
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$30 copay	Not Covered
Mail Order	$60 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$50 copay	Not Covered
Mail Order	$100 copay	Not Applicable
Specialty Drugs		
Preferred Specialty	$75 copay	Not Covered
Non-Preferred Specialty	$75 copay	Not Covered
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mandatory Maintenance Choice	After two retail fills, you'll need to fill 90-day supplies with CVS Caremark Mail Service Pharmacy™ or at CVS Pharmacy stores. Otherwise, the member will be responsible for 100 percent of the cost-share.	
Opt Out	The member must notify us of whether they want to continue to fill at a network retail pharmacy by calling the number on the member ID card.	
Specialty	Up to a 30 day supply Aetna Specialty Performance Network Drug List	
Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.		
Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy. Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction. Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited). Precertification for specialty drugs included Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.		
Prescription Drug Annual Out of Pocket Maximum	$2,600 Individual $5,200 Family	
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered.

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See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.
In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.**

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Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

New York

All contract state benefits shown above will match for this ancillary state.