PERNOD RICARD USA, LLC
Effective Date: 01-01-2023
Aetna Choice® POS II -- ASC
Qualified High Deductible Health Plan

**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) | $2,500 Individual<br>$5,000 Family | $2,500 Individual<br>$5,000 Family |
| All covered expenses accumulate simultaneously toward both the in-network and out-of-network Deductible.<br>Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses apply towards the Deductible.<br>Once Family Deductible is met, all family members will be considered as having met their Deductible. There is no Individual Deductible to satisfy within the Family Deductible. | | |
| **Member Coinsurance** | 20% | 40% |
| Applies to all expenses unless otherwise stated. | | |
| **Payment Limit** (per calendar year) | $5,000 Individual<br>$10,000 Family | $10,000 Individual<br>$20,000 Family |
| All covered expenses accumulate simultaneously toward both the in-network and out-of-network Payment Limit.<br>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.<br>Pharmacy expenses apply towards the Payment Limit.<br>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** | Covered 100%; deductible waived | 40%; after deductible |
| 1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older | | |
| **Routine Well Child Exams/Immunizations** | Covered 100%; deductible waived | 40%; after deductible |
| 7 exams first 12 months, 3 exams 13-24 months, 3 exams 25-36 months, 1 exam per calendar year thereafter to age 22. | | |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived | 40%; after deductible |
| 1 exam and pap smear per calendar year, includes related fees. | | |
| **Routine Mammograms** | Covered 100%; deductible waived | 40%; after deductible |
| For females age 35 and older, 1 service maximum per year. | | |

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| **Women's Health** | Covered 100%; deductible waived | 40%; 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.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | | |
| **Routine Digital Rectal Exam** | Covered 100%; deductible waived | 40%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Prostate-specific Antigen Test** | Covered 100%; deductible waived | 40%; after deductible |
| Recommended: For covered males age 40 and over. | | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived | 40%; after deductible |
| Recommended: For all members age 45 and over. | | |
| **Routine Eye Exams** | Covered 100%; deductible waived | 40%; after deductible |
| 1 routine exam per calendar year. | | |
| **Routine Hearing Screening** | Covered 100%; deductible waived | 40%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office Visits to Primary Care Physician (PCP)** | 20%; after deductible | 40%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Specialist Office Visits** | 20%; after deductible | 40%; after deductible |
| **Hearing Exams** | Covered 100%; deductible waived | 40%; after deductible |
| 1 routine exam per 24 months. | | |
| **Pre-Natal Maternity** | Covered 100%; deductible waived | 40%; after deductible |
| **Walk-in Clinics** | 20%; after deductible<br>**Designated Walk-in Clinics**<br>Covered 100%; after deductible | 40%; 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** | 20%; after deductible | 40%; after deductible |
| **Allergy Injections** | 20%; after deductible | 40%; after deductible |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic X-ray** | 20%; after deductible | 40%; after deductible |
| (other than Complex Imaging Services)<br>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. | | |
| **Diagnostic Laboratory** | 20%; after deductible | 40%; after deductible |
| 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. | | |
| **Diagnostic Complex Imaging** | 20%; after deductible | 40%; after deductible |
| 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. | | |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Urgent Care Provider** | 20%; after deductible | 20%; after deductible |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered | Not Covered |
| **Emergency Room** | 20%; after deductible | Same as in-network care |
| **Non-Emergency Care in an Emergency Room** | Not Covered | Not Covered |
| **Emergency Use of Ambulance** | 20%; after deductible | Same as in-network care |

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| **Non-Emergency Use of Ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient Coverage** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care) | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Outpatient Hospital Expenses** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Hospital** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Outpatient Surgery - Freestanding Facility** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Mental Health Office Visits** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Mental Health Services** | 20%; after deductible | 40%; after deductible |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Residential Treatment Facility** | 20%; after deductible | 40%; after deductible |
| **Substance Abuse Office Visits** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other Substance Abuse Services** | 20%; after deductible | 40%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled Nursing Facility** | 20%; after deductible | 40%; after deductible |
| Limited to 60 days per year | | |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Home Health Care** | 20%; after deductible | 40%; after deductible |
| 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. | | |
| **Hospice Care - Inpatient** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your inpatient stay. | | |
| **Hospice Care - Outpatient** | 20%; after deductible | 40%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Private Duty Nursing** | 20%; after deductible | 40%; after deductible |
| 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. | | |
| **Spinal Manipulation Therapy** | 20%; after deductible | 40%; after deductible |
| Limited to 20 visits per year | | |
| **Outpatient Short-Term Rehabilitation** | 20%; after deductible | 40%; after deductible |
| Includes speech, physical, occupational therapy; limited to 60 visits per year | | |

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|---|---|---|
| **Habilitative Physical Therapy** | 20%; after deductible | 40%; after deductible |
| **Habilitative Occupational Therapy** | 20%; after deductible | 40%; after deductible |
| **Habilitative Speech Therapy** | 20%; after deductible | 40%; after deductible |
| **Autism Behavioral Therapy**<br>Combined with outpatient mental health visits | Refer to MBH Outpatient Mental Health | Refer to MBH Outpatient Mental Health |
| **Autism Applied Behavior Analysis**<br>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** | 20%; after deductible | 40%; after deductible |
| **Autism Occupational Therapy** | 20%; after deductible | 40%; after deductible |
| **Autism Speech Therapy** | 20%; after deductible | 40%; after deductible |
| **Durable Medical Equipment** | 20%; after deductible | 40%; 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. |
| **Infusion Therapy**<br>Administered in the home or physician's office | 20%; after deductible | 40%; after deductible |
| **Infusion Therapy**<br>Administered in an outpatient hospital department or freestanding facility | 20%; after deductible | 40%; after deductible |
| **Acupuncture**<br>Limited to 20 visits per year | 20%; after deductible | 40%; 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<br>20%: after deductible for gene therapy drugs, if applicable<br>In-network coverage is provided at GCIT™ designated facilities only. | Not Covered |
| **Vision Eyewear** | Not Covered | Not Covered |
| **Transplants** | 20%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. | 40%; after deductible |
| **Bariatric Surgery**<br>Limited to $15,000 per lifetime<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 50%; after deductible | 50%; after deductible |

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| 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** | 20%; after deductible | 40%; 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)** | 20%; 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 | 40%; after deductible |
| **Tubal Ligation** | Covered 100%; deductible waived | 40%; after deductible |
| **PHARMACY** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan. | | |
| **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<br>Aetna Specialty Performance Network Drug List | |

**Preventive Medications** - Deductible is waived for certain preventive medications. A full list of these drugs is available on your secure member site or from your employer.

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**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.

**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.

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.

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• 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.**

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.