SOVOS BRANDS INTERMEDIATE, INC.
Effective Date: 01-01-2024
Open Access® Managed Choice® POS - Colorado
Qualified High Deductible Health Plan

**PLAN DESIGN & BENEFITS**
**MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY**

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Benefit limitations** - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more. | | |
| **Deductible** (per calendar year) | $3,200 per Individual<br>$6,000 per Family | $3,200 per Individual<br>$6,000 per Family |
| Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible.<br>You must first meet the deductible before the plan begins paying benefits, unless otherwise noted.<br>The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs count toward the deductible. Refer to your plan documents for details.<br>Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible. | | |
| **Member coinsurance**<br>Applies to all expenses except as noted. | You pay 20% | You pay 40% |
| **Out-of-pocket limit** (per calendar year) | $6,000 per Individual<br>$12,000 per Family | $9,000 per Individual<br>$18,000 per Family |
| Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit.<br>Some of your cost sharing may not count toward the out-of-pocket limit.<br>Your pharmacy expenses count toward your out-of-pocket limit.<br>In-network expenses include coinsurance/copays and deductibles.<br>Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply.<br>Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount. | | |
| **Lifetime maximum**<br>Unlimited except where otherwise indicated. | | |
| **Payment for out-of-network care**** | Does not apply | Professional: 150% of Medicare<br>Facility: 150% of Medicare |
| **Primary care physician selection** | Encouraged | Does not apply |
| **Precertification requirements -**<br>Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $400. Refer to your plan documents for a full list of services that need this approval. | | |
| **Referral requirement** | Not required | None |
| **Telehealth consultations** - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts. | | |
| **PREVENTIVE CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Routine adult physical exams/ immunizations**<br>1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older | Covered 100%; no deductible | 40%; after deductible |
| **Routine well child exams/immunizations**<br>• 7 exams in the first 12 months<br>• 3 exams from age 13 through 24 months<br>• 3 exams from age 25 through 36 months<br>• 1 exam every 12 months from age 3 until age 22 years | Covered 100%; no deductible | 40%; after deductible |
| **Routine gynecological care exams**<br>1 exam and pap smear per year, including related fees | Covered 100%; no deductible | 40%; after deductible |

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| **Routine mammogram**<br>Recommended: One per year for members age 40 and over | Covered 100%; no deductible | 40%; after deductible |
| **Women's health**<br>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>Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply. | Covered 100%; no deductible | 40%; after deductible |
| **Pre-natal maternity** | Covered 100%; no deductible | 40%; after deductible |
| **Routine digital rectal exam**<br>Recommended: For members age 40 and over | Covered 100%; no deductible | 40%; after deductible |
| **Prostate-specific antigen test**<br>Recommended: For members age 40 and over | Covered 100%; no deductible | 40%; after deductible |
| **Colorectal cancer screening**<br>Recommended: For members age 45 and over | Covered 100%; no deductible | 40%; after deductible |
| **Routine eye exams**<br>1 routine exam per 24 months. | Covered 100%; no deductible | 40%; after deductible |
| **Routine hearing screening** | Covered 100%; no deductible | 40%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office visits to primary care physician (PCP)**<br>Includes services of an internist, general physician, family practitioner or pediatrician. | 20%; after deductible | 40%; after deductible |
| **Telehealth consultation with non-specialist** | 20%; after deductible | 40%; after deductible |
| **Specialist office visits** | 20%; after deductible | 40%; after deductible |
| **Telehealth consultation with specialist** | 20%; after deductible | 40%; after deductible |
| **Hearing exams**<br>1 routine exam per 24 months. | 20%; after deductible | 40%; after deductible |
| **Walk-in clinics**<br>Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services.<br>Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices. | Covered 100%; after deductible | 40%; after deductible |
| **Allergy testing** | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| **Allergy injections** | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Diagnostic X-ray** (Other than complex imaging services)<br>When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | 20%; after deductible | 40%; after deductible |
| **Diagnostic laboratory**<br>When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | 20%; after deductible | 40%; after deductible |
| **Diagnostic complex imaging**<br>When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | 20%; after deductible | 40%; after deductible |

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| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Urgent care provider** | 20%; after deductible | 40%; 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 |
| **Non-emergency use of ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient coverage** | 20%; after deductible | 40%; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Inpatient maternity coverage** (includes delivery and postpartum care) | 20%; after deductible | 40%; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Outpatient hospital** | 20%; after deductible | 40%; after deductible |
| When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **Outpatient surgery - hospital** | 20%; after deductible | 40%; after deductible |
| When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **Outpatient surgery - freestanding facility** | 20%; after deductible | 40%; after deductible |
| When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 20%; after deductible | 40%; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Mental health office visits** | 20%; after deductible | 40%; after deductible |
| **Mental health telehealth consultations** | 20%; after deductible | 40%; after deductible |
| **Other mental health services** | 20%; after deductible | 40%; after deductible |
| When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **SUBSTANCE ABUSE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient** | 20%; after deductible | 40%; after deductible |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Residential treatment facility** | 20%; after deductible | 40%; after deductible |
| When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Substance abuse office visits** | 20%; after deductible | 40%; after deductible |
| **Substance abuse telehealth consultations** | 20%; after deductible | 40%; after deductible |

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| **Other substance abuse services** | 20%; after deductible | 40%; after deductible |
| When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | | |
| **THERAPY SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Spinal manipulation therapy**<br>Limited to 20 visits per year | 20%; after deductible | 40%; after deductible |
| **Outpatient short-term rehabilitation**<br>Limited to 30 visits per year<br>Includes physical, occupational, and speech therapies. | 20%; after deductible | 40%; after deductible |
| **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 related physical therapy** | 20%; after deductible | 40%; after deductible |
| **Autism related occupational therapy** | 20%; after deductible | 40%; after deductible |
| **Autism related speech therapy** | 20%; after deductible | 40%; after deductible |
| **Autism related behavioral therapy**<br>These benefits are combined with outpatient mental health visits | 20%; after deductible | 40%; after deductible |
| **Autism applied behavior analysis** | 20%; after deductible | 40%; after deductible |
| **Autism related applied behavior analysis**<br>Your benefits for these services are the same as any other outpatient mental health other services benefit | 20%; after deductible | 40%; after deductible |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled nursing facility**<br>Limited to 60 days per year<br>When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | 20%; after deductible | 40%; after deductible |
| **Home health care**<br>Limited to 60 visits per year<br>Home health care services include private duty nursing<br>Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less. | 20%; after deductible | 40%; after deductible |
| **Hospice care - inpatient**<br>When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | 20%; after deductible | 40%; after deductible |
| **Hospice care - outpatient**<br>When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. | 20%; after deductible | 40%; after deductible |
| **Private duty nursing**<br>We count each period of up to 8 hours as one private duty nursing shift. | Covered as part of home health care | Covered as part of home health care |
| **Durable medical equipment** | 20%; after deductible | 40%; after deductible |
| **Prosthetics** | 20%; after deductible | 40%; after deductible |
| **Diabetic supplies** -- (if not covered under the prescription drug benefit) | Covered same as any other medical expense.<br>You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount. | Covered same as any other medical expense.<br>You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount. |

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| **Infusion therapy - home/office** | 20%; after deductible | 40%; after deductible |
| **Infusion therapy - outpatient hospital/freestanding facility** | 20%; after deductible | 40%; after deductible |
| **Hearing aids**<br>1 hearing aid per ear every 60 months for child to age 18 | 20%; after deductible | 40%; after deductible |
| **Transplants** | 20%; after deductible<br>In-network coverage is only available at Institutes of Excellence (IOE) contracted facility. | 40%; after deductible<br>Out-of-network coverage applies when you use a non-IOE facility. You will pay more out of pocket when using a non-IOE facility. |
| **Bariatric surgery**<br>When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | 20%; after deductible | 40%; after deductible |
| **Acupuncture**<br>Limited to 20 visits per year | 20%; after deductible | 40%; after deductible |
| **FAMILY PLANNING** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Infertility treatment**<br>You have coverage for the diagnosis and treatment of the underlying cause of infertility. | Your cost sharing amount depends on the type of service and where you receive it. | Your cost sharing amount depends on the type of service and where you receive it. |
| **Comprehensive infertility services**<br>Coverage includes artificial insemination and ovulation induction limited to six courses of treatment per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law. | Your cost sharing amount depends on the type of service and where you receive it. | Applicable cost sharing based on the type of service performed and place of service where rendered |
| **Advanced Reproductive Technology (ART)**<br>Limited to 3 oocyte retrievals per lifetime. Unlimited embryo transfers. Includes coverage for cryopreservation and storage only for iatrogenic infertility. Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment.<br>ART coverage includes Invitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and cryopreservation, unlimited storage. | Your cost sharing amount depends on the type of service and where you receive it. | Applicable cost sharing based on the type of service performed and place of service where rendered |
| **Vasectomy** | Your cost sharing amount depends on the type of service and where you receive it. | 40%; after deductible |
| **Tubal ligation** | Covered 100%; no deductible | 40%; after deductible |

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| 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** | Advanced Control Plan - Aetna | |
| **Prescription drug deductible** | Prescription drug expenses apply to your medical deductible. | |
| **Prescription drug out-of-pocket limit** | Prescription drug expenses apply to your medical out-of-pocket limit. | |
| **Preferred generic drugs** | | |
| **Retail** | $15 copay | 40% of submitted cost |
| **Mail order** | $37.50 copay | Not Applicable |
| **Preferred brand-name drugs** | | |
| **Retail** | $50 copay | 40% of submitted cost |
| **Mail order** | $125 copay | Not Applicable |
| **Non-preferred generic and brand-name drugs** | | |
| **Retail** | $90 copay | 40% of submitted cost |
| **Mail order** | $225 copay | Not Applicable |
| **Specialty drugs** | | |
| **Preferred specialty** | 30%<br>Maximum $250 | Not Covered |
| **Non-preferred specialty** | 30%<br>Maximum $250 | Not Covered |
| **Pharmacy day supply and requirements** | | |
| **Retail** | You can get up to a 30-day supply from Aetna National Network | |
| **Mandatory maintenance choice** | Maintenance drugs are prescriptions commonly used to treat conditions that require regular, daily use of medicines.<br>If you take a maintenance drug, you can get two retail fills.<br>Then you must fill a 31-90-day supply of the maintenance drug at CVS Caremark® Mail Service Pharmacy or a CVS Pharmacy®.<br>If you do not, you will need to pay 100% of the drug cost. | |
| **Opt Out** | You must notify us if you want to continue to fill the medicine at a network retail pharmacy. Just call the number on the member ID card. | |
| **Specialty** | You can get up to a 30-day supply of specialty drugs<br>You must fill all specialty drugs through our preferred specialty pharmacy network.<br>Advanced Control Formulary Aetna Insured List | |

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**Your prescription drug plan also includes:**
• Diabetic supplies
• Insulin; your payment maximum for any rolling 30-day period is $100.
• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction
• A limited list of over-the-counter medications when filled with a prescription

**Family planning**
• Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
• Contraceptives covered up to a 12-month supply. Contraceptive copay strategy applies.

**The following are covered 100% in-network:**
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

**Precertification requirements**
Some covered prescription drugs need approval from us before we will cover the drug.
Some covered prescription drugs require step therapy before we cover them. With step therapy, you must first try one or more drugs before we will pay for drugs that require step therapy.
To get the most up-to-date precertification requirements and a list of drugs that require step therapy, see your plan documents or go online to your member website.

**Choose generics** - Sometimes you or your provider may ask for a brand-name prescription drug when a generic is available. If so, you will pay the brand-name copay plus the difference between the generic price and the brand-name price.

## GENERAL PROVISIONS

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| **Dependents who are eligible to be on your plan** | Spouse, children from birth to age 26. Student status of children does not matter. |

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. 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.

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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 this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.