SOVOS BRANDS INTERMEDIATE, INC.
Effective Date: 01-01-2024
Open Access® Elect Choice® - Colorado

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

| PLAN FEATURES | IN-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) | $3,000 per Individual<br>$6,000 per Family |
| 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 do not 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** | You pay 20% |
| Applies to all expenses except as noted. | |
| **Out-of-pocket limit** (per calendar year) | $6,000 per Individual<br>$12,000 per Family |
| 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>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** | |
| Unlimited except where otherwise indicated. | |
| **Primary care physician selection** | Encouraged |
| **Referral requirement** | Not required |
| **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 |
|---|---|
| **Routine adult physical exams/ immunizations** | Covered 100%; no deductible |
| 1 exam every 12 months until age 65, then 1 exam every 12 months age 65 and older | |
| **Routine well child exams/immunizations** | Covered 100%; no deductible |
| • 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 | |
| **Routine gynecological care exams** | Covered 100%; no deductible |
| 1 exam and pap smear per year, including related fees | |
| **Virtual primary care (VPC) preventive care consultations** | Covered 100%; no deductible |
| Includes screening and counseling services for members age 18 and older | |
| **Routine mammogram** | Covered 100%; no deductible |
| Recommended: One per year for members age 40 and over | |

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

| | |
|---|---|
| **Women's health** | Covered 100%; no 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>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. | |
| **Pre-natal maternity** | Covered 100%; no deductible |
| **Routine digital rectal exam** | Covered 100%; no deductible |
| Recommended: For members age 40 and over | |
| **Prostate-specific antigen test** | Covered 100%; no deductible |
| Recommended: For members age 40 and over | |
| **Colorectal cancer screening** | Covered 100%; no deductible |
| Recommended: For members age 45 and over | |
| **Routine eye exams** | Covered 100%; no deductible |
| 1 routine exam per 24 months. | |
| **Routine hearing screening** | Covered 100%; no deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** |
| **Office visits to primary care physician (PCP)** | $25 office visit copay; no deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | |
| **Virtual primary care (VPC) consultations** | Covered 100%; no deductible |
| Includes basic medical service consultations for members age 18 and older | |
| **Telehealth consultation with non-specialist** | $25 office visit copay; no deductible |
| **Specialist office visits** | $50 office visit copay; no deductible |
| **Telehealth consultation with specialist** | $50 office visit copay; no deductible |
| **Hearing exams** | Covered 100%; no deductible |
| 1 routine exam per 24 months. | |
| **Walk-in clinics** | Covered 100%; no deductible |
| 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. | |
| **Allergy testing** | 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. |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK** |
| **Diagnostic X-ray** (Other than complex imaging services) | 20%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | |
| **Diagnostic laboratory** | 20%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | |
| **Diagnostic complex imaging** | 20%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | |

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

| EMERGENCY MEDICAL CARE | IN-NETWORK |
|---|---|
| **Urgent care provider** | $75 copay; no deductible |
| **Non-urgent use of urgent care provider** | Not Covered |
| **Emergency room** | 20%; after deductible |
| **Non-emergency care in an emergency room** | Not Covered |
| **Emergency use of ambulance** | 20%; after deductible |
| **Non-emergency use of ambulance** | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** |
| **Inpatient coverage** | 20%; 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 |
| 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 |
| 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 |
| 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 |
| 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** |
| **Inpatient** | 20%; 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** | $50 copay; no deductible |
| **Mental health telehealth consultations** | $50 office visit copay; no deductible |
| **Other mental health services** | 20%; 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** |
| **Inpatient** | 20%; 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 |
| 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** | $50 copay; no deductible |
| **Substance abuse telehealth consultations** | $50 office visit copay; no deductible |
| **Other substance abuse services** | 20%; 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. | |

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

| THERAPY SERVICES | IN-NETWORK |
|---|---|
| **Spinal manipulation therapy**<br>Limited to 20 visits per year | $50 copay; no deductible |
| **Outpatient short-term rehabilitation**<br>Limited to 30 visits per year<br>Includes physical, occupational, and speech therapies. | $25 copay; no deductible |
| **Outpatient rehabilitative speech therapy** | $50 copay |
| **Habilitative physical therapy** | 20%; after deductible |
| **Habilitative occupational therapy** | 20%; after deductible |
| **Habilitative speech therapy** | 20%; after deductible |
| **Autism related physical therapy** | 20%; after deductible |
| **Autism related occupational therapy** | 20%; after deductible |
| **Autism related speech therapy**<br>These benefits are combined with outpatient mental health visits | 20%; after deductible |
| **Autism behavioral therapy** | $50 copay |
| **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 |
| **OTHER SERVICES** | **IN-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 |
| **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 |
| **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 |
| **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 |
| **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 |
| **Durable medical equipment** | 20%; after deductible |
| **Prosthetics** | 20%; no deductible |
| **Diabetic supplies** -- (if not covered under the prescription drug benefit) | Covered same as any other medical expense.<br><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. |
| **Infusion therapy - home/office** | $50 copay; no deductible |
| **Infusion therapy - outpatient hospital/freestanding facility** | 20%; after deductible |
| **Hearing aids**<br>1 hearing aid per ear every 60 months for child to age 18 | 20%; no deductible |

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

| | |
|---|---|
| **Transplants** | 20%; after deductible<br>In-network coverage is only available at Institutes of Excellence (IOE) contracted 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 |
| **Acupuncture**<br>Limited to 20 visits per year | $25 copay; no deductible |
| **FAMILY PLANNING** | **IN-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. |
| **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. |
| **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. |
| **Vasectomy** | Your cost sharing amount depends on the type of service and where you receive it. |
| **Tubal ligation** | Covered 100%; no deductible |
| **PHARMACY** | **IN-NETWORK** |
| **Pharmacy plan type** | Advanced Control Plan - Aetna |
| **Prescription drug out-of-pocket limit** | Prescription drug expenses apply to your medical out-of-pocket limit. |
| **Preferred generic drugs** | |
| **Retail** | $15 copay |
| **Mail order** | $37.50 copay |
| **Preferred brand-name drugs** | |
| **Retail** | $50 copay |
| **Mail order** | $125 copay |
| **Non-preferred generic and brand-name drugs** | |
| **Retail** | $90 copay |
| **Mail order** | $225 copay |
| **Specialty drugs** | |
| **Preferred specialty** | 30%<br>Maximum $250 |
| **Non-preferred specialty** | 30%<br>Maximum $250 |

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

| | |
|---|---|
| **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 |

**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**

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

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.

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

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 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.**

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

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.

© 2021 Aetna Inc.