ENDEAVOR PARENT, LLC DBS WME IMG HOLDINGS, LLC
Effective Date: 01-01-2024
Aetna Choice® POS II -- ASC
Choice POS II 90/80

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

| 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) | $1,000 per Individual<br>$2,000 per Family | $1,000 per Individual<br>$2,000 per Family |
| Covered expenses add up toward both your in-network and out-of-network deductible at the same time.<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 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**<br>Applies to all expenses except as noted. | You pay 10% | You pay 20% |
| **Out-of-pocket limit** (per calendar year) | $2,000 per Individual<br>$4,000 per Family | $3,000 per Individual<br>$6,000 per Family |
| Covered expenses add up toward both your in-network and out-of-network out-of-pocket limit at the same time.<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: 105% of Medicare<br>Facility: 140% 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 $0. 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 | 20%; 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 | 20%; after deductible |
| **Routine gynecological care exams**<br>1 exam and pap smear per calendar year, includes related fees. | Covered 100%; no deductible | 20%; after deductible |

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|---|---|---|
| **Routine mammogram** | Covered 100%; no deductible | 20%; after deductible |
| **Women's health** | Covered 100%; no deductible | 20%; 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>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 | 20%; after deductible |
| **Routine digital rectal exam** | Covered 100%; no deductible | 20%; after deductible |
| Recommended: For members age 40 and over | | |
| **Prostate-specific antigen test** | Covered 100%; no deductible | 20%; after deductible |
| Recommended: For members age 40 and over | | |
| **Colorectal cancer screening** | Covered 100%; no deductible | 20%; after deductible |
| Recommended: For members age 45 and over | | |
| **Routine eye exams** | Not Covered | Not Covered |
| **Routine hearing screening** | Covered 100%; no deductible | 20%; after deductible |
| **PHYSICIAN SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Office visits to primary care physician (PCP)** | $25 office visit copay; no deductible | 20%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| **Telemedicine consultation with non-specialist** | $25 office visit copay; no deductible | 20%; after deductible |
| **Specialist office visits** | $30 office visit copay; no deductible | 20%; after deductible |
| **Telemedicine consultation with specialist** | $30 office visit copay; no deductible | 20%; after deductible |
| **Hearing exams**<br>1 routine exam per 24 months. | $30 copay; no deductible | 20%; after deductible |
| **Office Based Surgery** | 10%; after deductible | 20%; after deductible |
| **Walk-in clinics** | $25 copay; no deductible<br>**Designated Walk-in clinics**<br>Covered 100%; no deductible | 20%; after 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. | 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) | 10%; after deductible | 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** | 10%; after deductible | 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** | 10%; after deductible | 20%; after deductible |
| When your physician performs and bills for this service at their office, you pay your office visit cost share amount. | | |

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| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| **Urgent care provider** | $25 office visit copay; no deductible | $25 per visit deductible; no plan deductible |
| **Non-urgent use of urgent care provider** | Not Covered | Not Covered |
| **Emergency room**<br>Copay waived if admitted | $200 copay; no deductible | Same as in-network care |
| **Non-emergency care in an emergency room** | Not Covered | Not Covered |
| **Emergency use of ambulance** | $200 copay; no deductible | Same as in-network care |
| **Non-emergency use of ambulance** | Not Covered | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Inpatient coverage** | 10%; after deductible | 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) | 10%; after deductible | 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** | 10%; after deductible | 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** | 10%; after deductible | 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** | 10%; after deductible | 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** | **OUT-OF-NETWORK** |
| **Inpatient** | 10%; after deductible | 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** | $30 copay; no deductible | 20%; after deductible |
| **Mental health telemedicine consultations** | $30 office visit copay; no deductible | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other mental health services** | 10%; after deductible | 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** | **OUT-OF-NETWORK** |
| **Inpatient** | 10%; after deductible | 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** | 10%; after deductible | 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. | | |

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| **Substance abuse office visits** | $30 copay; no deductible | 20%; after deductible |
| **Substance abuse telemedicine consultations** | $30 office visit copay; no deductible | 20%; after deductible |
| Your cost sharing applies to all covered benefits incurred during your outpatient visit. | | |
| **Other substance abuse services** | 10%; after deductible | 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. | | |
| **THERAPY SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Spinal manipulation therapy** | $30 copay; no deductible | 20%; after deductible |
| Unlimited visits | | |
| **Outpatient physical therapy** | $30 copay; no deductible | 20%; after deductible |
| Unlimited visits | | |
| **Outpatient speech and occupational therapy** | 10%; after deductible | 20%; after deductible |
| Unlimited visits | | |
| **Habilitative physical therapy** | 10%; after deductible | 20%; after deductible |
| **Habilitative occupational therapy** | 10%; after deductible | 20%; after deductible |
| **Habilitative speech therapy** | 10%; after deductible | 20%; after deductible |
| **Autism related physical therapy** | 10%; after deductible | 20%; after deductible |
| **Autism related occupational therapy** | 10%; after deductible | 20%; after deductible |
| **Autism related speech therapy** | 10%; after deductible | 20%; after deductible |
| **Autism related behavioral therapy** | $30 copay; no deductible | 20%; after deductible |
| These benefits are combined with outpatient mental health visits | | |
| **Autism related applied behavior analysis** | 10%; after deductible | 20%; after deductible |
| Your benefits for these services are the same as any other outpatient mental health other services benefit | | |
| **OTHER SERVICES** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Skilled nursing facility** | 10%; after deductible | 20%; after deductible |
| Limited to 100 days per year | | |
| When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Home health care** | Covered 100%; after deductible | Covered 100%; after deductible |
| Unlimited visits | | |
| Home health care services include private duty nursing | | |
| Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less. | | |
| **Hospice care - inpatient** | Covered 100%; after deductible | Covered 100%; 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. | | |
| **Hospice care - outpatient** | Covered 100%; after deductible | Covered 100%; 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. | | |
| **Private duty nursing** | Covered as part of home health care | Covered as part of home health care |
| We count each period of up to 8 hours as one private duty nursing shift. | | |
| **Durable medical equipment** | 10%; after deductible | 20%; after deductible |
| **Hearing Aids** | 10%; after deductible | 20%; after deductible |
| Limited to $5,000 lifetime max | | |
| **Orthotics** | 10%; after deductible | 20%; after deductible |

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| **Prosthetics** | 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. |
| **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. |
| **Infusion therapy - home/office** | $30 copay; no deductible | 20%; after deductible |
| **Infusion therapy - outpatient hospital/freestanding facility** | 10%; after deductible | 20%; after deductible |
| **Gene-based, Cellular, and other Innovative Therapies (GCIT™)** | Your cost sharing amount depends on the type of service and where you receive it.<br>$50 copay: no deductible for gene therapy drugs, if applicable<br>In-network coverage is provided at GCIT™ designated facilities only. | Not Covered |
| **Mouth, Jaws and Teeth** (oral surgery procedures, whether medical or dental in nature)<br>Includes surgical and non-surgical | 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. |
| **Transplants** | 10%; after deductible<br>In-network coverage is only available at Institutes of Excellence (IOE) contracted facility. | Not Covered |
| **Bariatric surgery** | 10%; after deductible | Not Covered |
| When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive. | | |
| **Acupuncture**<br>Unlimited visits | 10%; no deductible | 10%; no deductible |
| **FAMILY PLANNING** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Infertility treatment** | 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. |
| You have coverage for the diagnosis and treatment of the underlying cause of infertility. | | |
| **Comprehensive infertility services** | 10%; after deductible | 20%; after deductible |
| Coverage includes artificial insemination and ovulation induction limited to a lifetime limit of $50,000 combined with ART. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law. | | |
| **Advanced Reproductive Technology (ART)** | 10%; after deductible | 20%; after deductible |
| Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law. Limited to a lifetime limit of $50,000 combined with Comprehensive Infertility. Maximum applies to all procedures covered by any of our plans except where prohibited by law. | | |
| **Vasectomy** | Your cost sharing amount depends on the type of service and where you receive it. | 20%; after deductible |
| **Tubal ligation** | Covered 100%; no deductible | 20%; after deductible |

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| **Abortion (Voluntary)** | 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. |
| **PHARMACY** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| **Pharmacy plan type** | Aetna Standard Open Formulary | |
| **Prescription drug out-of-pocket limit** | Prescription drug expenses apply to your medical out-of-pocket limit. | |
| **Generic drugs** | | |
| **Retail** | $20 copay | 50% of submitted cost; after applicable in-network cost share |
| **Mail order** | $40 copay | Not Applicable |
| **Preferred brand-name drugs** | | |
| **Retail** | $30 copay | 50% of submitted cost; after applicable in-network cost share |
| **Mail order** | $60 copay | Not Applicable |
| **Non-preferred brand-name drugs** | | |
| **Retail** | $40 copay | 50% of submitted cost; after applicable in-network cost share |
| **Mail order** | $80 copay | Not Applicable |
| **Pharmacy day supply and requirements** | | |
| **Retail** | You can get up to a 30-day supply from Aetna National Network<br>3x copay 61-90 day supply from Aetna National Network | |
| **Mail order** | You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.<br>You must fill all specialty drugs through our preferred specialty pharmacy network.<br>Aetna Specialty Network Drug List | |

**Your prescription drug plan also includes:**
• Diabetic supplies and blood glucose monitors
• Prescription weight loss drugs
• Sexual dysfunction drugs, including daily dose, additional 6 tablets a month for erectile dysfunction

**Family planning**
• Oral fertility drugs included.

**The following are covered 100% in-network:**
• 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.
To get the most up-to-date precertification requirements, see your plan documents or go online to your member website.

**Choose generics with dispense as written (DAW) override** - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

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| **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. |

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**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.

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.