#### Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services LYNDEN INCORPORATED AND PARTICIPATING EMPLOYERS : Aetna Choice® POS II - HDHP \$2000

Coverage for: EE Only; EE+ Family | Plan Type: POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-888-982-3862. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-982-3862 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> Designated: EE Only \$2,000; EE+ Family \$4,000. Out-of-Network: EE Only \$2,000; EE+ Family \$4,000.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. In- <u>network preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> Designated: EE Only \$4,000; EE+ Family \$9,450. Out-of-Network: EE Only \$5,000; EE+ Family \$12,500.	The <u>out–of–pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out–of–pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	<u>Premium</u> s, <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover & penalties for failure to obtain <u>pre-authorization</u> for services.	Even though you pay these expenses, they don't count toward the <u>out–of–pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-888- 982-3862 for a list of In- <u>Network</u> Designated <u>provider</u> s.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All **<u>copayment</u>** and **<u>coinsurance</u>** costs shown in this chart are after your **<u>deductible</u>** has been met, if a **<u>deductible</u>** applies.

	What You Will Pay			
Common Medical Event	Services You May Need	In-Network Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	None
lf you visit a health	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% coinsurance	None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your	Generic drugs	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription: 20% (retail)	Covers 30 day supply (retail), 31-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-
illness or condition	Preferred brand drugs	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription: 20% (retail)	approved women's contraceptives in- <u>network</u> . Review your <u>formulary</u> for prescriptions requiring precertification for coverage. Your cost will be higher for choosing Brand over Generics unless
about <u>prescription</u> <u>drug coverage</u> is available at www.aetnapharmac y.com/standard	Non-preferred brand drugs	20% <u>coinsurance</u> (retail & mail order)	20% <u>coinsurance</u> after <u>copay</u> /prescription: 20% (retail)	prescribed Dispense as Written. Maintenance drugs- no refill restrictions or penalties apply. Members save with lower <u>copay</u> s at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy. <u>Deductible</u> doesn't apply to certain preventive medications.
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> .
If you have	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None

		What You In-Network	u Will Pay	
Common Medical Event	Services You May Need	Designated Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
lf you need	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
immediate medical attention	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> .
	<u>Urgent care</u>	20% coinsurance	30% <u>coinsurance</u>	None
If you have a	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
hospital stay	Physician/surgeon fees	20% coinsurance	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or	Outpatient services	Office & other outpatient services: 20% <u>coinsurance</u>	Office & other outpatient services: 30% <u>coinsurance</u>	None
substance abuse services	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> <u>authorization</u> for out-of-network care.
	Office visits	No charge	30% <u>coinsurance</u>	Cost sharing does not apply for preventive
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	services. Maternity care may include tests and
lf you are pregnant	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Home health care	20% <u>coinsurance</u>	30% <u>coinsurance</u>	130 visits/calendar year combined with private- duty nursing. Penalty of \$400 for failure to obtain pre-authorization for out-of-network care.
If you need help recovering or have other special health needs	Rehabilitation services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	45 visits/calendar year for Physical, Occupational & Speech Therapy combined.
	Habilitation services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Skilled nursing care	20% coinsurance	30% coinsurance	60 days/calendar year. Penalty of \$400 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Durable medical equipment	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You In-Network Designated Provider (You will pay the least)	u Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Penalty of \$400 for failure to obtain <u>pre-</u> authorization for out-of-network care.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
dental of eye cale	Children's dental check-up	Not covered	Not covered	Not covered.

# **Excluded Services & Other Covered Services:**

over (Check your policy or <u>plan</u> document for more info	ormation and a list of any other <u>excluded services</u> .)
<ul> <li>Hearing aids</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul> <li>Routine eye care (Adult &amp; Child)</li> <li>Routine foot care</li> <li>Weight loss programs - Except for required <u>preventive</u> <u>services</u>.</li> </ul>
	<ul> <li>Hearing aids</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside</li> </ul>

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)

Acupuncture - 12 visits/calendar year for	Chiropractic care - 12 visits/calendar year.	• Private-duty nursing - Included as part of home health care.
<ul> <li>disease, injury &amp; chronic pain.</li> <li>Bariatric surgery - Limited to Institutes of Quality contracted facility only.</li> </ul>	<ul> <li>Infertility treatment - Limited to the diagnosis &amp; treatment of underlying medical condition.</li> </ul>	

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the <u>plan</u> at 1-888-982-3862.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="http://www.dol/gov/ebsa/healthreform">http://www.dol/gov/ebsa/healthreform</a>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should

contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your plan documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-888-982-3862. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>http://www.dol/gov/ebsa/healthreform</u>
- For non-federal governmental group health <u>plans</u>, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.
- Additionally, a consumer assistance program can help you file your <u>appeal</u>. Contact information is at: <u>http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html</u>.

## Does this plan provide Minimum Essential Coverage? Yes.

<u>Minimum Essential Coverage</u> generally includes <u>plans</u>, <u>health insurance</u> available through the <u>Marketplace</u> or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the <u>premium tax credit</u>.

## Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section

# About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a
hospital delivery)

The plan's overall <u>deductible</u>	\$2,000
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Specialist</u> office visits (*prenatal care*) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (*ultrasounds and blood work*) <u>Specialist</u> visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<u>Cost Sharing</u>	
Deductibles	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,900
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,960

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a wellcontrolled condition)

The <u>plan's</u> overall <u>deductible</u>	\$2,000
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (including disease education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Diabetic supplies</u> (glucose meter)

Total Example Cost	\$5,600
In this example, Joe would pay:	
<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,720

Mia's Simple Fracture (in-network emergency room visit and follow up care)

The plan's overall <u>deductible</u>	\$2,000
Specialist coinsurance	20%
Hospital (facility) <u>coinsurance</u>	20%
Other coinsurance	20%

#### This EXAMPLE event includes services like:

Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therapy)

Total Example Cost	\$2,800		
In this example, Mia would pay:			
<u>Cost Sharing</u>			
Deductibles	\$2,000		
<u>Copayments</u>	\$0		
<u>Coinsurance</u>	\$200		
What isn't covered			
Limits or exclusions	\$0		
The total Mia would pay is	\$2,200		

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#### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

# **Smartphone or Tablet**

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

## **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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# TTY: 711

# Language Assistance:

To access language services at no cost to you, call 1-888-982-3862.

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Armenian -Utių duup įtequlujuub dumujuupijni tubityligo qurulitijni. huutuup quibquuhupitip 1-888-982-3862 hitmuljunuuhuutuupinųl:Bahasa Indonesia -Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-888-982-3862 tanpa dikenakan biaya.Bantu-Kirundi -Kugira uronke serivisi zindimi atakiguzi, hamagara 1-888-982-3862.Bengali-Bangala -আপনাকে বিনাহুকথে ভাষা পৰিকাষ্ পশকে হকৰ এই নগকি পেৰমক ান come: 1-888-982-3861Bisayan-Visayan -Ngadto maakses ang mga serbisyo sa pinulongan alang libre, tawagan sa 1-888-982-3862.Burmese -ឯბე: დიფიცდიე: ფიөυდითი: რე өөөндө თითითითი დიფილის დიფილ	Amharic -	የቋንቋ አንልግሎቶችን ያለክፍያ ለማግኘት፣ በ ι-888-982-3862 ይደውሉ።
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Persian -	بر ای دسترسی به خدمات زبان به طور رایگان، با شماره 3862-982-888-1 تماس بگیرید
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862.

Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-888-982-3862 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Romanian -	Pentru a accesa gratuit serviciile de limbă, apelați 1-888-982-3862.
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-888-982-3862.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-888-982-3862.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862.
Sudanic-Fulfude -	Heeba a nasta jangirde djey wolde wola chede bo apelou lamba 1-888-982-3862.
Swahili -	Kupata huduma za lugha bila malipo kwako, piga 1-888-982-3862.
Syriac -	:مةبقه، ما بحته، ما بخيخه، ما بخيخه، ما بخيخه، ما بحنه، من الحقيقة، من الحقيقة، من الحقيقة، من الحقيقة، من
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862.
Telugu -	మీరు భాష సేవలను ఉచితంగా అందుకునందుకు, 1-888-982-3862 కు కాల్ చేయండి.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-888-982-3862.
Tongan -	Kapau 'oku ke fiema'u ta'etōtōngi 'a e ngaahi sēvesi kotoa pē he ngaahi lea kotoa, telefoni ki he 1-888-982-3862.
Trukese -	Ren omw kopwe angei aninisin eman chon awewei (ese kamo), kopwe kori 1-888-982-3862.
Turkish -	Sizin için ücretsiz dil hizmetlerine erişebilmek için, 1-888-982-3862 numarayı arayın.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-888-982-3862.
Urdu -	بالقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، 3862-982-888-1 پر بات کریں۔
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862
Yiddish -	צו צוטריט שפרַאך בַאדינונגען אין קיין פרייַז צו איר, רופן 1-888-982-3862
Yoruba -	Lati wọnú awọn ise èdè l'ofe fun o, pe 1-888-982-3862.