Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at *Benefits Outlook* at www.aldinebenefits.org or by calling 1-866-284-2473.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For each Calendar Year, Individual $2,000 / Family $3,750. Does not apply to preventive care in-network.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Yes, $75 per individual for prescription drug expenses. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: Individual $5,000 / Family $9,500.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and penalties for failure to obtain pre-authorization for service.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.aldinebenefits.org or call 1-866-284-2473.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan has in-network benefits only. It features a very limited network of designated specialists and only allows use of Memorial Hermann hospitals for in and outpatient hospital care. A designated provider is an in-network provider who meets additional criteria and is identified with an icon in the provider directory.
- Designated specialties are: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	20% coinsurance	Not covered	See above where designated specialties are listed.
	Other practitioner office visit	20% coinsurance	Not covered	Chiropractic care is limited to 20 visits per calendar year.
	Preventive care /screening /immunization	No charge	Not covered	Age and frequency schedules may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	Freestanding facilities and Memorial Herman Hospitals.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	Freestanding facilities and Memorial Herman Hospitals. Precertification applies.

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If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	$15 retail/ $37.50 mail order	Not covered	Covers up to a 30-day supply (retail prescription); 84-90 day supply maintenance medications available via an Express Scripts Smart90 retail pharmacy or through Express Scripts' Home Delivery service.
	Preferred brand drugs	$35 retail/ $87.50 mail order	Not covered	
	Non-preferred brand drugs	$55 retail/ $137.50 mail order	Not covered	
	Specialty drugs Tier II (Generic/preferred)	$75 Mail Order There is limited retail access for a small subset of specialty medications.	Not covered	Prescriptions are limited to a 30-day supply. Most specialty medications are only available via Mail Order through Express Scripts specialty pharmacy, Accredo.
	Specialty drugs Tier III (Non-preferred)	$150 Mail Order There is limited retail access for a small subset of specialty medications.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Freestanding facilities and Memorial Herman Hospitals.
	Physician/surgeon fees	20% coinsurance	Not covered	Refer to page 2 for list of 12 designated specialists.
If you need immediate medical attention	Emergency room services	20% coinsurance after $150 copay per visit	20% coinsurance after $150 copay per visit	40% coinsurance for non-emergency use. Copay is waived if confined to the hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency condition not covered.
	Urgent care	20% coinsurance	Not covered	20% coinsurance for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Memorial Hermann Hospitals only.
	Physician/surgeon fee	20% coinsurance	Not covered	———— None ————
If you have mental health, behavioral	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	Coverage is limited to 60 visits per calendar year combined with substance abuse.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	Coverage is limited to 45 visits per calendar year combined with substance abuse.

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health, or substance abuse needs	Substance use disorder outpatient services	20% coinsurance	Not covered	Coverage is limited to 60 visits per calendar year combined with mental disorder.
	Substance use disorder inpatient services	20% coinsurance	Not covered	Coverage is limited to 45 visits per calendar year combined with mental disorder.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	Refer to page 2 for list of 12 designated specialists.
	Delivery and all inpatient services	20% coinsurance	Not covered	Memorial Hermann Hospitals only.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not covered	Coverage is limited to 60 visits per calendar year for Physical, Occupational, Speech Therapy and Autism Spectrum combined.
	Habilitation services	20% coinsurance	Not covered	See above rehabilitation services limits.
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance	Not covered	Diabetic Supplies not covered, except for monitors, pumps and support equipment.
	Hospice service	20% coinsurance	Not covered	———————— None ————————
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental Care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult & Child)
- Routine foot care
- Private duty nursing
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery – Coverage is limited to Institutes of Quality facilities only, 20% coinsurance, $12,000 lifetime maximum
- Chiropractic care – 20 visits per calendar year
- Infertility treatment – Coverage is limited to the diagnosis and treatment of underlying medical condition.
- Prescription drugs

Your Rights to Continue Coverage:

Questions: Call 1-866-284-2473 or visit us at www.aldinebenefits.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary at www.HealthReformPlanSBC.com.

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-982-3862. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

- If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice or assistance, you can contact us by calling the toll free number on your Medical ID Card. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Additionally, a consumer assistance program can help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Provide Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-284-2473.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-284-2473.

如果需要中文的帮助，请拨打这个号码 1-866-284-2473.

Para obtener asistencia en Español, llame al 1-866-284-2473.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,320
- **Patient pays:** $3,220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,000
Copays	$20
Coinsurance	$1,050
Limits or exclusions	$150
Total	**$3,220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $2,570
- **Patient pays:** $2,830

Sample care costs:

Prescriptions	$2,900
Medical equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventative	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,070
Copays	$600
Coinsurance	$80
Limits or exclusions	$80
Total	**$2,830**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.