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, please visit *Benefits Outlook* at www.aldinebenefits.org or call 1-866-284-2473. 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 www.HealthReformPlanSBC.com or call 1-866-284-2473 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For each Calendar Year, Individual: $2,500 / Family: $5,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive Care, Primary Care Physician and Specialist Visits, Urgent Care, Mental Health/Substance Abuse Outpatient Services.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $75 Individual deductible for prescription drug coverage. 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.
What is the out-of-pocket limit for this plan?	Individual: $6,500 / Family: $13,000.	The out-of-pocket limit is the most you could pay in a year for covered services
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
Will you pay less if you use a network provider?	Yes. See www.aldinebenefits.org or call 1-866-284-2473 for a list of preferred providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$50 copayment	Not covered	Includes Internist, General Physician, Family Practitioner or Pediatrician.
	Specialist visit	$100 copayment	Not covered	———————— None ————————
	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.
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 copayment coinsurance mail order Tier III (non-preferred): $75 copayment 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.
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	———————— None ————————
If you need immediate	Emergency room care	20% coinsurance after	20% coinsurance after $250	40% coinsurance for non-emergency use.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
medical attention		$250 copayment	copayment	Copay is waived if confined to the hospital.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency condition – Not covered
	Urgent care	$75 copayment	Not covered	———————— None ————————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Memorial Hermann Hospitals only.
	Physician/surgeon fees	20% coinsurance	Not covered	———————— None ————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copayment	Not covered	———————— None ————————
	Inpatient services	20% coinsurance	Not covered	———————— None ————————
If you are pregnant	Office visits	$100 copayment	Not covered	———————— None ————————
	Childbirth/delivery professional services	20% coinsurance	Not covered	Memorial Hermann Hospitals only.
	Childbirth/delivery facility 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 rehabilitative limits above.
	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 related supplies.
	Hospice services	20% coinsurance	Not covered	———————— None ————————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- 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: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-982-3862
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-982-3862
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-888-982-3862
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-982-3862

To see examples of how this plan 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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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)

n The plan's overall deductible	$2,500
n Specialist	$100
n Hospital (facility)	20%
n Other	20%

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

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$200
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,260

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

n The plan's overall deductible	$2,500
n Specialist	$100
n Hospital (facility)	20%
n Other	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$1,500
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$3,560

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

n The plan's overall deductible	$2,500
n Specialist	$100
n Hospital (facility)	20%
n Other	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.