Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

AMERICAN AIR LIQUIDE HOLDINGS INC. : Memorial Hermann Open Access® Aetna SelectSM

Coverage for: Individual + Family | Plan Type: EPO



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 1-866-449-6495. 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 1-866-449-6495 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> limit for this <u>plan</u> ?	Memorial Hermann In- <u>Network</u> : Individual \$6,600 / Family \$13,200.	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> , they have to meet their own <u>out–of–pocket</u> <u>limits</u> until the overall family <u>out–of–pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	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 1-866- 449-6495 for a list of memorial hermann in- <u>network providers</u> .	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	ı Will Pay	
Common Medical Event	Services You May Need	Memorial Hermann In-Network Providers (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	\$15 <u>copay</u> /visit	Not covered	None
If you visit a health	<u>Specialist</u> visit	\$30 <u>copay</u> /visit	Not covered	None
care <u>provider</u> 's office or clinic	Preventive care /screening /immunization	No charge	Not covered	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)	No charge	Not covered	None
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
	Generic drugs	\$10 copay	\$10 copay	Mail Order: \$25 copay
If you need drugs to treat your illness or condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.caremark.com</u>	Preferred brand drugs	30% coinsurance (\$30 min. \$75 max. copay)	30% coinsurance (\$30 min. \$75 max. copay)	Mail Order: 30% coinsurance (\$70 min. \$175 max. copay)
	Non-preferred brand drugs	40% coinsurance (\$60 min. \$125 max. copay)	40% coinsurance (\$60 min. \$125 max. copay)	Mail Order: 40% coinsurance (\$140 min. \$295 max. copay)
	Specialty drugs	Covered at Preferred or Non- Preferred brand drug coinsurance/copays as applicable	Not covered	None
If you have	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
outpatient surgery	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	Non-emergency transport: not covered.
	Urgent care	\$50 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.
If you have a	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /stay	Not covered	None
hospital stay	Physician/surgeon fees	No charge	Not covered	None

			u Will Pay	
Common Medical Event	Services You May Need	Memorial Hermann In-Network Providers (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$15 <u>copay</u> /visit, <u>deductible</u> doesn't apply; other outpatient services: no charge	Not covered	None
	Inpatient services	\$250 <u>copay</u> /stay	Not covered	None
	Office visits	No charge	Not covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	No charge	Not covered	services. Maternity care may include tests and
n jou are prognam	Childbirth/delivery facility services	\$250 <u>copay</u> /stay	Not covered	services described elsewhere in the SBC (i.e. ultrasound.)
	Home health care	No charge	Not covered	40 visits/calendar year combined with private- duty nursing.
	Rehabilitation services	\$30 <u>copay</u> /visit	Not covered	None
If you need help recovering or have other special health needs	Habilitation services	\$30 <u>copay</u> /visit	Not covered	None
	Skilled nursing care	\$250 copay/stay	Not covered	60 days/calendar year.
	Durable medical equipment	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	No charge	Not covered	None
If your child peode	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.
	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.)

 Cosmetic surgery Dental care (Adult & Child) Glasses (Child) 	 Long-term care Non-emergency care when traveling outside the U.S. 	 Routine eye care (Adult & Child) Routine foot care Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations	may apply to these services. This isn't a complete list. Pleas	se see your <u>plan</u> document.)
Acupuncture	Chiropractic care - 60 visits/calendar year.	Infertility treatment

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 plan at 1-866-449-6495.
- 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 : <u>https://www.dol.gov/agencies/ebsa</u>
- For non-federal governmental group health plans, 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 www.cciio.cms.gov.
- If your coverage is a church <u>plan</u>, church <u>plans</u> 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 Health Insurance <u>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 <u>plan</u> documents also provide complete information 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:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-866-449-6495.
- 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 https://www.doi.gov/agencies/ebsa
- 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.

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 Minimum Value Standards? Yes.

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

-----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)

\$0 \$30

\$250

\$0

The plan's overall deductible
Specialist copayment
Hospital (facility) <u>copayment</u>
Other <u>copayment</u>

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	\$12,700
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$360

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>	\$0
Specialist copayment	\$30
Hospital (facility) <u>copayment</u>	\$250
Other <u>copayment</u>	\$0

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	\$0
Copayments	\$500
Coinsurance	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$2,360

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

The <u>plan's</u> overall <u>deductible</u>	\$0
Specialist copayment	\$30
Hospital (facility) <u>copayment</u>	\$250
Other copayment	\$0

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	\$0
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$400

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:1-866-449-6495.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-449-6495.

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 discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides 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: PO Box 24030 Fresno, CA 93779),

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705),

Email: <u>CRCoordinator@aetna.com</u>.

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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

Language Assistance:

For language assistance in your language call 1-866-449-6495 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-866-449-6495.
Amharic -	ለቋንቋ እንዛ በ አማርኛ በ 1-866-449-6495 በነጻ ይደውሉ
Arabic -	للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني ق649-449-1866
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-866-449-6495 առանց գնով։
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-866-449-6495 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-866-449-6495 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-866-449-6495-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-866-449-6495 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် ၂-866-449-6495ကို ခေါ် ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït1-866-449-6495.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-866-449-6495 sin gåstu.
Cherokee -	Օ ℴЂӮѲ ℌ℗ℎℬⅆℋ <i>⅄</i> ℎℴℨℇℙℴℨ℣ Მ℄ℸ (GWУ) ℚᲮℍℰ℩℁ 1-866-449-6495 ℧℮ℸ ℒ ⅄ℾℴℨℋⅆℇ Ⴚℙ ℋℎℙ℞Ѳ.
Chinese -	欲取得繁體中文語言協助,請撥打1-866-449-6495,無需付費。
Choctaw -	(Chahta) anumpa y <u>a</u> apela a chi I p <u>a</u> ya hinla1-866-449-6495.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-866-449-6495 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar1-866-449-6495.
French -	Pour une assistance linguistique en français appeler le 1-866-449-6495 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-866-449-6495 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-866-449-6495 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-866-449-6495 χωوίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહ્રાય માટે કોઈ પણ ખર્ચ વગર ₁₋₈₆₆₋₄₄₉₋₆₄₉₅ પર કૉલ કરો.

Hawaiian -	No ke kōkua ma ka 'ōlelo Hawai'i, e kahea aku i ka helu kelepona1-866-449-6495. Kāki 'ole 'ia kēia kōkua nei.
Hindi -	हनि्दी में भाषा सहायता के लएि, 1-866-449-6495 पर मुफ्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-866-449-6495.
bo -	Maka enyemaka asụsụ na Igbo kpọọ 1-866-449-6495 na akwụghị ụgwọ ọ bụla
locano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-866-449-6495 nga awan ti bayadanyo.
talian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente1-866-449-6495.
Japanese -	日本語で援助をご希望の方は、1-866-449-6495 まで無料でお電話ください。
Karen -	လၤတၢိမၤစၢၤတၢိကတိၤကျိဉ်အဂ်ီ၊ ကျိဉ် ကိႏ 1-866-449-6495 ၊ လၤတအိုဉ်ဒီးတၢ်လၢ၇်ဘူဉ်လၢ၇်စ္၊ဘဉ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인1-866-449-6495 번으로 전화해 주십시오.
Kru-Bassa -	Ɓε´m`ké gbo-kpá-kpá dyé pidyi dé Ɓašɔɔ́>̀wùduùň wɛ̃ɛ, dá 1-866-449-6495.
Kurdish -	بر ای ر اهنمایی به زبان فارسی با شمار ه 6495-449-1666 به خوّر ایی پهیومندی بکهن.
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ ₁₋₈₆₆₋₄₄₉₋₆₄₉ 5ດຍບໍ່ເສຍຄ່າໂທ.
Varathi -	तीलभाषा (मराठी) सहाय्यासाठी 1-866-449-6495 क्रमांकावरकोणत्याहीखर्चाशिवायकॉलकरा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-866-449-6495 ilo ejjelok wōnān.
Vicronesian- Pohnpeyan - Von-Khmer, Cambodian -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-866-449-6495 ni sohte isais. សម្ភាប់ជំនួយភាសាជា ភាសាខុមរៃ សូមទូរស័ព្ ទទ ៅកាន់លខេ 1-866-449-6495 ដហេយឥតគិតថ្លល់។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-866-449-6495.
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-866-449-6495 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-866-449-6495 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-866-449-6495 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-866-449-6495 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-866-449-6495 aa. Es Aaruf koschtet nix.
Persian - Polish -	بر ای راهنمایی به زبان فارسی با شماره 1-866-449-6495 بدون هیچ هزینه ای تماس بگیرید. انگلیسی Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-866-449-6495.

Portuguese -	Para obter assistência linguística em português ligue para o 1-866-449-6495 gratuitamente.
Romanian -	Pentru asistență lingvistică în românește telefonați la numărul gratuit 1-866-449-6495.
Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру1-866-449-6495.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-866-449-6495 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-866-449-6495.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-866-449-6495.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-866-449-6495. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-866-449-6495 bila malipo.
Syriac -	יאל אישר איג אין געוון האור שלער אימאאיר היר ליא ipper אללא אישר אין 1-866-449-6495 ישיא אי
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-866-449-6495 nang walang bayad.
Telugu -	భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 1-866-449-6495 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-866-449-6495 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 1-866-449-6495 'o 'ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-866-449-6495 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden1-866-449-6495.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером1-866-449-6495.
Urdu -	ا ری رک ل کمنت م رپ I-866-449-6495 سے <i>لیک متن و</i> اع میں اس رہی م و در
Vietnamese -	Để được hố trợ ngôn ngự băng (ngôn ngự), hấy gọi miến phi đến số 1-866-449-6495.
Yiddish -	פאר שפראך הילף אין אידיש רופט ₁₋₈₆₆₋₄₄₉₋₆₄₉₅ פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-866-449-6495 lái san owó kankan rárá.