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, 1-844-216-4952
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.HealthcareHighways.com or call 1-844-216-4952 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,800 Individual, $5,600 Family Out- of-Network Deductible: $5,600 Individual, $11,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventative is Covered before you meet your deductible.	This plan covers some items and services even if you haven't 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?	No	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?	For network providers: $2,800 Individual / $5,600 Family For out- of-network: $11,200 Individual, $22,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayment for certain services, premiums, balance-billing charges, preauthorization penalties and health care this plan doesn't cover.	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.HealthcareHighways.com or call 1-844-216-4952 for a list of network providers	You pay the least if you use a in network provider. 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	0% coinsurance after deductible	70% coinsurance after deductible	None
	Specialist visit	0% coinsurance after deductible	70% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge, deductible does not apply.	70% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. See Valued Based Benefits for additional Covered Diabetes and Coronary Artery Disease **Routine mammograms 2D or 3D are covered**
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	70% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	70% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CerpassRX.com	Generic drugs	0% coinsurance after deductible	N/A	Covers up to a Retail 1-34 days, Retail 35-91 days, Mail order 90-day supply
	Preferred brand drugs	0% coinsurance after deductible	N/A	
	Non-preferred brand drugs	0% coinsurance after deductible	N/A	
	Specialty drugs	0% coinsurance after deductible	N/A	Cerpass RX
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	70% coinsurance after deductible	None
	Physician/surgeon fees	0% coinsurance after deductible	70% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	0% coinsurance after deductible	If admitted, inpatient hospital expenses will apply. Non-Emergency 70% coinsurance

				after deductible
	Emergency medical transportation	0% coinsurance after deductible	70% coinsurance after deductible	Precertification is required for scheduled Air Ambulance transfers
	Urgent care	0% coinsurance after deductible	70% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	70% coinsurance after deductible	Preauthorization required
	Physician/surgeon fees	0% coinsurance after deductible	70% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	70% coinsurance after deductible	Preauthorization required – Inpatient and outpatient for services done at the facility
	Inpatient services	0% coinsurance after deductible	70% coinsurance after deductible	
If you are pregnant	Office visits	0% coinsurance after deductible	70% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization required if confinement exceeds 48 hours for normal delivery or 96 hours for c-section delivery
	Childbirth/delivery professional services	0% coinsurance after deductible	70% coinsurance after deductible	
	Childbirth/delivery facility services	0% coinsurance after deductible	70% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	0% coinsurance after deductible	70% coinsurance after deductible	30 visits per plan year
	Rehabilitation services	0% coinsurance after deductible	70% coinsurance after deductible	Preauthorization required
	Habilitation services	0% coinsurance after deductible	70% coinsurance after deductible	
	Skilled nursing care	0% coinsurance after deductible	70% coinsurance after deductible	Preauthorization required 30 visits per plan year
	Durable medical equipment	0% coinsurance after deductible	70% coinsurance after deductible	Preauthorization required if over $500 DME.
	Hospice services	0% coinsurance after deductible	70% coinsurance after deductible	Preauthorization required.

If your child needs dental or eye care	Children's eye exam	N/C	N/C	None
	Children's glasses	N/C	N/C	None
	Children's dental check-up	N/C	N/C	None

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
- Infertility Treatment (Surgery/Artificial Insemination)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care

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

- Valued Based Benefits
- Ambulance Air
- Chiropractic Care

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 plan at 1-833-841-6710, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323-x 61565 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 on how 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: Healthcare Highways Health Plan at 1-833-841-6710 or visit www.HealthcareHighways.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? **Yes**

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

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 www.HealthcareHighways.com or call 1-844-365-1645
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa www.HealthcareHighways.com or call 1-844-365-1645
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 www.HealthcareHighways.com or call 1-844-365-1645
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' www.HealthcareHighways.com or call 844-365-1645

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*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)

The plan's overall deductible	**$2800**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**0%**

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2800**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2800**
Specialist *[cost sharing]*	**0%**
Hospital (facility) *[cost sharing]*	**0%**
Other *[cost sharing]*	**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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact www.HealthcareHighways.com or call 1-844-365-1645

Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" on page 1.

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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.HealthcareHighways.com or call 1-844-216-4952 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,000 Individual, $4,000 Family Out- of-Network Deductible: $6,000 Individual, $12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventative is Covered before you meet your deductible.	This plan covers some items and services even if you haven't 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?	No	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?	For network providers: $5,000 Individual / $10,000 Family For out- of-network: $10,000 Individual, $20,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayment for certain services, premiums, balance-billing charges, preauthorization penalties and health care this plan doesn't cover.	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.HealthcareHighways.com or call 1-844-216-4952 for a list of network providers	You pay the least if you use a in network provider. 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	$35 copay/visit; deductible does not apply	50% coinsurance after deductible	Only one copay per physician visit, per day applied
	Specialist visit	$70 copay/visit; deductible does not apply	50% coinsurance after deductible	Only one copay per physician visit, per day applied
	Preventive care/screening/ immunization	No charge, deductible does not apply.	50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. See Valued Based Benefits for additional Covered Diabetes and Coronary Artery Disease **Routine mammograms 2D or 3D are covered**
If you have a test	Diagnostic test (x-ray, blood work)	No charge, deductible does not apply	50% coinsurance after deductible	No charge with office visit copay
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CerpassRX.com	Generic drugs	$10 copay	N/A	Covers up to a Retail 1-34 days, Retail 35-91 days, Mail order 90-day supply
	Preferred brand drugs	$40 copay	N/A	
	Non-preferred brand drugs	$75 copay	N/A	
	Specialty drugs	Greater of $100 or 50% coinsurance to max of $300	N/A	Cerpass RX
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Deductible waived if service performed in Gregg County
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% after $500 copay and deductible	20% after $500 copay and deductible	Copay waived for first visit per year. Emergency room copay waived if admitted. If admitted, inpatient hospital expenses will

				apply. Non-Emergency 50% coinsurance after deductible
	Emergency medical transportation	20% coinsurance after deductible	50% coinsurance after deductible	Precertification is required for scheduled Air Ambulance transfers
	Urgent care	$75 copay	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required Deductible waived if service performed in Gregg County
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required – Inpatient for services done at the facility
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	$35 copay Initial office visit only	50% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization required if confinement exceeds 48 hours for normal delivery or 96 hours for c-section delivery
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	30 visits per plan year
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required 30 visits per plan year
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required if over $500

				DME.
	Hospice services	100% after deductible	50% coinsurance after deductible	Preauthorization required
If your child needs dental or eye care	Children's eye exam	N/C	N/C	None
	Children's glasses	N/C	N/C	None
	Children's dental check-up	N/C	N/C	None

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
- Infertility Treatment (Surgery/Artificial Insemination)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care

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

- Valued Based Benefits
- Ambulance Air
- Chiropractic Care

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Does this plan meet the Minimum Value Standards? **Yes**

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[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 www. HealthcareHighways.com or call 1-844-365-1645
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' www.HealthcareHighways.com or call 844-365-1645

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

The plan's overall deductible	**$2000**
Specialist *[cost sharing]*	**$70**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$80
Coinsurance	$2,112
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,252**

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

The plan's overall deductible	**$2000**
Specialist *[cost sharing]*	**$70**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	**$2000**
Specialist *[cost sharing]*	**$70**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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:	
Cost Sharing	
Deductibles	$2,000
Copayments	$600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,640**

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact www.HealthcareHighways.com or call 1-844-365-1645

Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" on page 1.

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $2,000 Individual, $4,000 Family Out- of-Network Deductible: $6,000 Individual, $12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventative is Covered before you meet your deductible.	This plan covers some items and services even if you haven't 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?	No	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?	For network providers: $5,000 Individual / $10,000 Family For out- of-network: $15,000 Individual, $30,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Copayment for certain services, premiums, balance-billing charges, preauthorization penalties and health care this plan doesn't cover.	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.HealthcareHighways.com or call 1-844-216-4952 for a list of network providers	You pay the least if you use a in network provider. 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	20% coinsurance after deductible	50% coinsurance after deductible	None
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge, deductible does not apply.	50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. See Valued Based Benefits for additional Covered Diabetes and Coronary Artery Disease **Routine mammograms 2D or 3D are covered**
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CerpassRX.com	Generic drugs	$10 copay	N/A	Covers up to a Retail 1-34 days, Retail 35-91 days, Mail order 90-day supply
	Preferred brand drugs	$40 copay	N/A	
	Non-preferred brand drugs	$75 copay	N/A	
	Specialty drugs	Greater of $100 or 50% coinsurance to max of $300	N/A	Cerpass RX
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	Deductible waived if service performed in Gregg County
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% after $500 copay and deductible	20% after $500 copay and deductible	Copay waived for first visit per year. Emergency room copay waived if admitted. If admitted, inpatient hospital expenses will

				apply. Non-Emergency 50% coinsurance after deductible
	Emergency medical transportation	20% coinsurance after deductible	50% coinsurance after deductible	Precertification is required for scheduled Air Ambulance transfers
	Urgent care	20% coinsurance after deductible	50% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required – Inpatient and outpatient for services done at the facility
	Inpatient services	20% coinsurance after deductible	50% coinsurance after deductible	
If you are pregnant	Office visits	20% coinsurance after deductible	50% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, [copayment, coinsurance , or deductible] may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Preauthorization required if confinement exceeds 48 hours for normal delivery or 96 hours for c-section delivery
	Childbirth/delivery professional services	20% coinsurance after deductible	50% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required 30 visits per plan year
	Rehabilitation services	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required
	Habilitation services	20% coinsurance after deductible	50% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required 30 visits per plan year
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	Preauthorization required if over $500 DME.
	Hospice services	100% after deductible	50% coinsurance after	Preauthorization required.

			deductible	
If your child needs dental or eye care	Children's eye exam	N/C	N/C	None
	Children's glasses	N/C	N/C	None
	Children's dental check-up	N/C	N/C	None

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
- Infertility Treatment (Surgery/Artificial Insemination)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Care
- Routine Foot Care

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

- Valued Based Benefits
- Ambulance Air
- Chiropractic Care

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 plan at 1-833-841-6710, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323-x 61565 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 on how 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: Healthcare Highways Health Plan at 1-833-841-6710 or visit www.HealthcareHighways.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes

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

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 www.HealthcareHighways.com or call 1-844-365-1645
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa www.HealthcareHighways.com or call 1-844-365-1645
[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 www.HealthcareHighways.com or call 1-844-365-1645
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' www.HealthcareHighways.com or call 844-365-1645

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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)

The plan's overall deductible	**$2000**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,170**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2000**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2000**
Specialist *[cost sharing]*	**20%**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**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:	
Cost Sharing	
Deductibles	$2,000
Copayments	$410
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,490**

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

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact www.HealthcareHighways.com or call 1-844-365-1645

Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" on page 1.