




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, visit [www.ardentcarecoordinators.com](http://www.ardentcarecoordinators.com) or [www.optumrx.com](http://www.optumrx.com) or call 1-888-295-9299. 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.ardentcarecoordinators.com](http://www.ardentcarecoordinators.com) or call 1-888-295-9299 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$700 person / \$1,400 family Domestic \$1,000 person / \$2,000 family ADP \$3,000 person / \$6,000 family Open Access	Generally, you must pay all the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . Domestic and ADP Network Deductibles cross apply.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Preventive care services are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000 person / \$6,000 family Domestic \$3,900 person / \$7,800 family ADP \$6,000 person / \$12,000 family Open Access	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. Domestic, ADP Network and prescription maximum out-of-pockets cross-apply.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Penalties, <a href="#">premiums</a> , <a href="#">balance billing</a> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ardentcarecoordinators.com">www.ardentcarecoordinators.com</a> or call 1-888-295-9299 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (a <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the specialist you choose without a referral.
 All <a href="#">copayment</a> and <a href="#">coinsurance</a> costs shown in this chart are after your <a href="#">deductible</a> has been met, if a <a href="#">deductible</a> applies.		

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic	ADP	Open Access	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$0 copay	\$30 copay	\$40 copay	Check what your plan covers in the plan document available or by calling 1-888-295-9299.
	<a href="#">Specialist</a> visit	\$0 copay	\$45 copay	\$60 copay	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	No charge	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Office visit setting no charge; \$25 copay outpatient	Office visit setting no charge; \$35 copay outpatient	Office visit setting no charge; \$75 copay outpatient	Cost sharing does not apply to certain preventive services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required for MRI/MRA/PET scans. All Outpatient Advance Imaging done within Smith County must be done at UT Health.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available through <b>OptumRx</b> at <a href="http://www.OptumRX.com">www.OptumRX.com</a>	Generic drugs	Retail: \$15 copay per prescription Mail order or 90-day maintenance: \$30 copay per prescription			<b>\$6,000</b> person / <b>\$12,000</b> family annual maximum out-of-pocket per calendar year. Covers up to: a 30-day supply (retail); 1-90 day supply (mail order & maintenance medications); a 30-day supply (specialty). Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication.
	Preferred brand drugs	Retail: 20% copay, up to maximum of \$70 per prescription Mail order or 90-day maintenance: 20% copay, up to maximum of \$140 per prescription			
	Non-preferred brand drugs	Retail: 30% copay, up to maximum of \$225 per prescription Mail order or 90-day maintenance: 30% copay, up to maximum of \$450 per prescription			
	<a href="#">Specialty drugs</a>	Retail: 30% copay, up to maximum of \$250 per prescription Mail order: not available.			

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ardentcarecoordinators.com](http://www.ardentcarecoordinators.com).]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic	ADP	Open Access	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 copay	\$300 copay	\$300 copay	Copay may be waived if admitted.
	<a href="#">Emergency medical transportation</a>	10% coinsurance	20% coinsurance	20% coinsurance	None
	<a href="#">Urgent care</a>	\$0 copay	\$40 copay	\$60 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required. For additional facility restrictions review your plan document.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 copay Office visits; 10% coinsurance outpatient	\$30 copay Office visits; 20% coinsurance outpatient	\$40 copay Office visits; 30% coinsurance outpatient	Preauthorization is required for Partial hospitalization and Intensive Outpatient Services.
	Inpatient services	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	\$0 copay	\$0 copay	\$0 copay	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	30% coinsurance	
If you need help recovering or have	<a href="#">Home health care</a>	10% Coinsurance	20% Coinsurance	30% Coinsurance	Preauthorization is required. 100 visits per calendar year.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic	ADP	Open Access	
other special health needs	<a href="#">Rehabilitation services</a>	\$30 copay	\$45 copay	\$60 copay	OT/PT/ST – 50 visit combined maximum per calendar year; does not apply to MH/SUD.
	<a href="#">Habilitation services</a>	\$30 copay	\$45 copay	\$60 copay	
	<a href="#">Skilled nursing care</a>	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required. 60 Maximum days per calendar year.
	<a href="#">Durable medical equipment</a>	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required for all rentals and any purchase over \$1,500
	<a href="#">Hospice services</a>	10% coinsurance	20% coinsurance	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children’s eye exam	Not covered	Not covered	Not covered	None
	Children’s glasses	Not covered	Not covered	Not covered	None
	Children’s dental check-up	Not covered	Not covered	Not covered	None

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (adult)</li> <li>• Routine foot care</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Bariatric surgery (Domestic Network only)</li> <li>• Chiropractic care (20 visit per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Weight loss program</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: Ardent Care Coordinators at 1-888-295-9299. 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](http://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: [www.ardentcarecoordinators.com](http://www.ardentcarecoordinators.com).

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.ardentcarecoordinators.com](http://www.ardentcarecoordinators.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 1-888-295-9299.

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

**Last updated: October 3, 2024**

## 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 and assumes use of **Domestic facilities and providers**.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$700
- [Specialist copayments](#) \$0
- Hospital (facility) [coinsurance](#) 10%
- Other [copayments/coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$510
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,270</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$700
- Primary care physician [copayments](#) \$0
- Hospital (facility) [coinsurance](#) 10%
- Other [copayments/coinsurance](#) 10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$865
<a href="#">Coinsurance</a>	\$716
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,336</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$700
- [Specialist copayments](#) \$0
- Hospital (facility) [coinsurance](#) 10%
- Other [copayments/coinsurance](#) 10%

This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$145
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$645</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.