




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 or 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 or call 1-888-295-9299 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible ? | \$1,600 person / \$3,200 family Tier 1 \$2,000 person / \$4,000 family Tier 2 \$3,000 person / \$6,000 family Tier 3 \$6,000 person / \$12,000 family Tier 4 | Generally, you must pay all 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 . Tier 1, Tier 2 and Tier 3 deductibles cross-apply. |
| Are there services covered before you meet your deductible ? | Yes. Preventive care services are covered before you meet your deductible. | 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? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$3,000 person / \$6,000 family Tier 1 \$4,500 person / \$9,000 family Tier 2 \$6,500 person / \$13,000 family Tier 3 \$10,500 person / \$21,000 family Tier 4 | 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. Tier 1, Tier 2, Tier 3 and prescription out-of-pocket maximums cross-apply. |
| What is not included in the out-of-pocket limit ? | Penalties, premiums , balance billing charges, 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.ardentcarecoordinators.com or call 1-888-295-9299 for a list of network 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 (a 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|---|
| 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 |
|---|--|--|------------------------------|------------------------------|-----------------|--|
| | | Tier 1 | Tier 2 | Tier 3 | Tier 4 | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | None |
| | Specialist visit | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | |
| | Preventive care/screening/immunization | No charge; deductible waived | No charge; deductible waived | No charge; deductible waived | Not covered | 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 | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Cost sharing does not apply to certain preventive services. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required. 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 prescription drug coverage is available through OptumRx at www.OptumRX.com | Generic drugs | Retail: 20% copay per prescription after calendar year deductible Mail order or 90-day maintenance: 20% copay per prescription after calendar year deductible | | | | \$6,500 person / \$13,000 family annual maximum out-of-pocket per calendar year (cross-applies to networks medical out-of-pocket). 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 per prescription after calendar year deductible Mail order or 90-day maintenance: 20% copay per prescription after calendar year deductible | | | | |
| | Non-preferred brand drugs | Retail: 20% copay per prescription after calendar year deductible Mail order or 90-day maintenance: 20% copay per prescription after calendar year deductible | | | | |
| | Specialty drugs | Retail: 20% copay per prescription after calendar year deductible Mail order: not available | | | | |

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

| Common Medical Event | Services You May Need | What You Will Pay | | | | Limitations, Exceptions, & Other Important Information |
|---|--|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|---|
| | | Tier 1 | Tier 2 | Tier 3 | Tier 4 | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 20% coinsurance | 30% coinsurance | 40% coinsurance | 40% coinsurance | Tier 3 deductible applies to Tier 4 benefits. |
| | Emergency medical transportation | 20% coinsurance | 30% coinsurance | 40% coinsurance | 40% coinsurance | Tier 3 deductible applies to Tier 4 benefits. |
| | Urgent care | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required. For additional facility restrictions review your plan document. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required for Partial hospitalization and Intensive Outpatient Services. |
| | Inpatient services | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required. |
| If you are pregnant | Office visits | 0% coinsurance; deductible waived | 0% coinsurance; deductible waived | 0% coinsurance; deductible waived | 0% coinsurance; deductible waived | 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 | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | |
| If you need help recovering or have | Home health care | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% 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 |
|---|---|-------------------|-----------------|-----------------|-----------------|---|
| | | Tier 1 | Tier 2 | Tier 3 | Tier 4 | |
| other special health needs | Rehabilitation services | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | OT/PT/ST – 50 visit combined maximum per calendar year; does not apply to MH/SUD. |
| | Habilitation services | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | 60 Maximum days per calendar year. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required for all rentals and any purchase over \$1500 |
| | Hospice services | 20% coinsurance | 30% coinsurance | 40% coinsurance | 50% coinsurance | Preauthorization is required. |
| If your child needs dental or eye care | Children’s eye exam | Not covered | Not covered | Not covered | Not covered | None |
| | Children’s glasses | Not covered | Not covered | Not covered | Not covered | None |
| | Children’s dental check-up | Not covered | Not covered | Not covered | Not covered | 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.) | | |
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (adult) | <ul style="list-style-type: none"> • Long-term care • Private-duty nursing | <ul style="list-style-type: none"> • Routine eye care (adult) • Routine foot care |

| | | |
|---|--|---|
| Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none"> • Bariatric surgery (Tier 1 only) • Chiropractic care (20 visit per calendar year) | <ul style="list-style-type: none"> • Hearing aids | <ul style="list-style-type: none"> • Weight loss program |

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 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.

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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.]

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

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Last updated: October 11, 2023

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 **Tier 1 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 | \$1,600 |
| ■ Specialist coinsurance | \$0 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$1,600 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,660 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,600 |
| ■ Primary care physician coinsurance | \$0 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$1,600 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$1,655 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,600 |
| ■ Specialist coinsurance | \$0 |
| ■ Hospital (facility) coinsurance | 20% |
| ■ Other coinsurance | 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:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$1,600 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,600 |

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