

 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, call 1-800-207-3172 or visit [www.umar.com](http://www.umar.com). 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.umar.com](http://www.umar.com) or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	Duly Providers: \$2,500 Individual/\$5,000 Family UHC Core In-Network <sup>1</sup> : \$2,500 Individual/\$5,000 Family Out-of-Network: \$6,000 Individual/\$12,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Certain <u>preventive care</u> and preventive prescription drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Duly Providers: \$2,500 Individual/\$5,000 Family UHC Core In-Network <sup>1</sup> : \$6,550 Individual/\$13,100 Family Out-of-Network: \$15,000 Individual/\$20,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. For services at Duly, the <u>out-of-pocket limit</u> is reached once the deductible is reached; there is no additional cost to the member. All or one covered individual can meet the family <u>out-of-pocket limit</u> . For UHC in-network services, an individual family member is capped at the single <u>out-of-pocket limit</u> of \$6,550, and the total family is capped at the family <u>out-of-pocket limit</u> of \$13,100.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , penalties, <u>balanced-billed charges</u> , and healthcare this <u>plan</u> doesn't cover. Additionally, Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.umar.com">www.umar.com</a> or call 1-800-207-3172 for a list of <u>network providers</u> .	After your <u>deductible</u> is met, you will pay nothing if you use a Duly <u>provider</u> . You pay more if you use a <u>provider</u> in UHC's Core network <sup>1</sup> . 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

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		plan 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 **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies (unless otherwise noted).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information <sup>2</sup>
		UHC Core <u>In-Network Provider</u> <sup>1</sup>	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> applies.
	<u>Specialist</u> visit	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	Chiropractic and Osteopathic manipulation services are limited to 20 visits per benefit period. Acupuncture will have a per benefit period dollar limit of \$500. <u>Deductible</u> applies.
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply	40% <u>coinsurance</u> after <u>deductible</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Adult immunizations for out-of-network providers are not covered.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> applies.
	Imaging (CT/PET scans, MRIs)	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> applies.

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<sup>2</sup> For more information about limitations and exceptions, see the plan or policy document at [www.umar.com](http://www.umar.com).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information <sup>2</sup>
		Duly Provider	In-Network Provider <sup>1</sup>	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a>	Generic drugs	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	30-day supply at Retail 90-day supply at Mail Order Up to 90-day supply for Maintenance Drugs at Retail  Full coverage will be provided for generic and preferred brand diabetic medications and related supplies, and certain women's preventive services. For a full list of these prescriptions and/or services, please contact Customer Service.  Coverage based on group policy. <u>Prior authorization</u> may be required.  <u>Deductible</u> applies. Duly and In-Network prescription drugs follow the In-network <u>deductible</u> .  <u>Specialty</u> Pharmacy benefits exclusive to Accredited Specialty Pharmacy or Duly Medical Pharmacy. Please see "Important Questions" regarding the plan's out-of-pocket limit.  Preventive meds covered before the deductible subject to Rx cost-share provisions. For a full list of these prescriptions, please contact Customer Service.
	Preferred brand drugs	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Non-preferred brand drugs	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	<u>Specialty drugs</u>	10% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Not covered	

<sup>1</sup> Quincy Medical Group team members pay 10% coinsurance after deductible for prescription drugs received from a participating Express Scripts pharmacy.

<sup>2</sup> For more information about limitations and exceptions, see the plan or policy document at [www.umar.com](http://www.umar.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information <sup>2</sup>
		UHC Core <u>In-Network Provider</u> <sup>1</sup>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	Non emergent use of Emergency room not covered.  There are no emergency room facilities owned and administered by Duly.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>deductible</u>	10% <u>coinsurance</u> after <u>deductible</u>	There is no emergency medical transportation service owned and administered by Duly.
	<u>Urgent care</u>	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	There are no inpatient facilities owned and administered by Duly.  <u>Deductible</u> applies.
	Physician/surgeon fees	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> applies.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information <sup>2</sup>
		UHC Core In-Network Provider <sup>1</sup>	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Deductible</u> applies.
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	There are no inpatient facilities owned and administered by Duly.  <u>Deductible</u> applies.
If you are pregnant	Office visits	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Deductible</u> applies.
	Childbirth/delivery professional services	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after <u>deductible</u> elsewhere.	40% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	There are no inpatient facilities owned and administered by Duly.  <u>Deductible</u> applies.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	Limited to 60 visits per benefit period. <u>Deductible</u> applies. There are no home health care providers owned and administered by Duly.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information <sup>2</sup>
		UHC Core <u>In-Network Provider</u> <sup>1</sup>	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Rehabilitation services</u>	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after deductible elsewhere.	40% <u>coinsurance</u> after deductible	Limited to 60 visits combined per calendar year for occupational therapy and physical therapy. <u>Deductible</u> applies. Duly and In-Network Speech Therapy will be no charge after Duly <u>deductible</u> .
	<u>Habilitation services</u>	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after deductible elsewhere.	40% <u>coinsurance</u> after deductible	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after deductible	40% <u>coinsurance</u> after deductible	Limited to 60 visits per benefit period. <u>Deductible</u> applies. There are no skilled nursing care providers owned and administered by Duly.
	<u>Durable medical equipment</u>	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after deductible elsewhere.	40% <u>coinsurance</u> after deductible	Benefits are limited to items used to serve a medical purpose. <u>DME</u> benefits are provided for both purchase and rental equipment (up to the purchase price). <u>Deductible</u> applies. Wigs are covered.
	<u>Hospice services</u>	No charge after deductible at Duly providers. 20% <u>coinsurance</u> after deductible elsewhere.	40% <u>coinsurance</u> after deductible	<u>Deductible</u> applies.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	No coverage for eye glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental.

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## 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<sup>3</sup>.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Cosmetic surgery</li><li>• Dental care (Adult and Children)</li><li>• Long term care</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing (with the exception of inpatient private duty nursing)</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult and Children)</li><li>• Routine foot care (with the exception of persons with diagnosis of diabetes)</li><li>• Weight loss programs</li></ul> |
|--|--|---|

### 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"><li>• Acupuncture (limited to \$500 per member)</li><li>• Bariatric surgery</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care (20 visit annual maximum)</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Speech therapy</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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.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](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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.HealthCare.gov](http://www.HealthCare.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

### 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 1-800-207-3172.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-207-3172.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-207-3172.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-207-3172.

————— To see examples of how this plan might cover costs for a sample medical situation, see the next section. —————

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## 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 Duly-provided pre-natal care and a UHC Core in-network<sup>1</sup> hospital delivery)

■ The <u>plan's overall UHC Core deductible</u>	\$2,500
■ <u>Duly specialist coinsurance</u>	0%
■ <u>UHC Core Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,060
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,560</b>

### Managing Joe's Type 2 Diabetes

(a year of routine Duly-provided care of a well-controlled condition)

■ The <u>plan's overall Duly deductible</u>	\$2,500
■ <u>Duly specialist coinsurance</u>	0%
■ <u>UHC Core Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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>\$7,400</b>
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#### In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,900</b>

### Mia's Simple Fracture

(UHC Core in-network<sup>1</sup> emergency room visit and Duly-provided follow up care)

■ The <u>plan's overall UHC Core deductible</u>	\$2,500
■ <u>Duly specialist coinsurance</u>	0%
■ <u>UHC Core Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

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

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