Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Duly Health and Care: PPO MEDICAL PLAN

Coverage Period: 01/01/2024-12/31/2024
Coverage for: Individual, Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.myblueelementil.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 https://www.healthcare.gov/sbc-glossary or call 1-855-760-3135 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Duly Provider: None. BCBS Preferred Provider[1]: $700 Individual / $1,400 Family per calendar year. BCBS Nonpreferred Provider: $1,400 Individual / $2,800 Family per calendar year.	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. Prescription drugs, and the following services by a Duly Provider and/or BCBS Preferred Provider[1]: Preventive care, emergency room care, urgent care, rehabilitative services, habilitative services, specialist, and primary care physician visits 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?	Duly Provider: Not applicable. BCBS Preferred Provider[1]: $3,000 Individual / $6,000 Family per calendar year. BCBS Nonpreferred Provider: $6,000 Individual / $12,000 Family per calendar year. Prescription Drugs: $3,000 Individual / $6,000 Family per calendar year	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?	Penalties for failure to obtain preauthorization for services, premiums, balance-billing charges, and health care this plan doesn't cover. Additionally, certain specialty prescription drugs are considered non-essential health benefits and the cost for them will not be applied towards satisfying your out-of-pocket limits.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.myblueelementil.com or call 1-855-760-3135 for a list of network providers.	You pay nothing if you visit a Duly Provider. You pay more if you use a BCBS Preferred Provider[1].You will pay the most if you use a BCBS Nonpreferred 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 Duly Provider or BCBS Preferred Provider[1] might use a Nonpreferred 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
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred 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 deductible does not apply	$50 copayment deductible does not apply	40% coinsurance	None.
	Specialist visit	0% coinsurance deductible does not apply	$100 copayment deductible does not apply	40% coinsurance	Chiropractic care limited to 20 visits per benefit period. Benefits for acupuncture care is limited to $500 per year.
	Preventive care/screening/ immunization	0% coinsurance deductible does not apply	0% coinsurance deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.

[1]BlueCross BlueShield of Illinois' national network includes access to providers across the country.

* For more information about limitations and exceptions, see the plan or policy document at www.myblueelementil.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	Express Scripts Preferred Provider[1] (You will pay more)	Express Scripts Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic drugs	Retail: $5 copayment Mail order: Not Applicable	Retail: $15 copayment deductible does not apply Mail order: $30 copayment deductible does not apply	Retail: Not covered Mail order: Not covered	Copayment applies to a 30-day supply Retail and 90-day supply for Mail-Order prescription, or a 90-day supply for Maintenance Drugs at Retail Copayment does not apply to preventive drugs required by the Affordable Care Act. Separate Prescription Drug Out-of-Pocket Limit: $3,000/individual or $6,000/family per calendar year Specialty drugs must be obtained by Accredo Specialty Pharmacy or Duly Pharmacy. Full coverage provided for generic and preferred brand diabetic medications and related supplies, and for certain women's preventive services. Prior authorization may be required.
	Preferred brand drugs	Retail: $20 copayment Mail order: Not Applicable	Retail: $30 copayment deductible does not apply Mail order: $60 copayment deductible does not apply	Retail: Not covered Mail order: Not covered	
	Non-preferred brand drugs	Retail: $45 copayment Mail order: Not Applicable	Retail: $55 copayment deductible does not apply Mail order: $110 copayment deductible does not apply	Retail: Not covered Mail order: Not covered	
	Specialty drugs	25% coinsurance	Retail: 25% coinsurance deductible does not apply Mail order: 25% coinsurance deductible does not apply	Retail: Not covered Mail order: Not covered	

[1]Quincy Medical Group team members pay Retail copays equal to those paid at Duly providers and Mail Order at 2x those paid at Duly providers for prescription drugs received from a participating Express Scripts pharmacy.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
	Physician/surgeon fees	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	Not applicable	$250 copayment deductible does not apply	Preferred Provider benefit applies	Copay waived if admitted. Non-emergency use of the emergency room is not covered. There are no facilities owned and administered by Duly.
	Emergency medical transportation	Not applicable	No charge	No charge	There is no emergency medical transportation service owned and administered by Duly.
	Urgent care	0% coinsurance deductible does not apply	$75 copayment deductible does not apply	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no inpatient facilities owned and administered by Duly.
	Physician/surgeon fees	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance deductible does not apply	$50 copayment deductible does not apply	40% coinsurance	PCP copay applies to psychotherapy visit only.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
	Inpatient services	Not applicable	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no inpatient facilities owned and administered by Duly.
If you are pregnant	Office visits	0% coinsurance deductible does not apply	$50 copayment deductible does not apply	40% coinsurance	Dependent daughters are covered for this benefit. Copay applies to first prenatal visit (per pregnancy).Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). There are no inpatient facilities owned and administered by Duly. Preauthorization is required for high risk maternity. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
	Childbirth/delivery professional services	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	Not applicable	20% coinsurance	40% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Not applicable	20% coinsurance	40% coinsurance	Home health care visits limited to 60 visits per benefit period. Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no home health care providers owned and administered by Duly.
	Rehabilitation services	0% coinsurance deductible does not apply	$50 copayment deductible does not apply	40% coinsurance	Physical and occupational therapy combined limited to 60 visits per benefit period. Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
	Habilitation services	0% coinsurance deductible does not apply	$50 copayment deductible does not apply	40% coinsurance	None.
	Skilled nursing care	Not applicable	20% coinsurance	40% coinsurance	Skilled nursing care limited to 60 days per benefit period. Preauthorization is required. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. There are no skilled nursing care providers owned and administered by Duly.
If you need help recovering or have other special health needs	Durable medical equipment	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. Preauthorization may be required when visiting a non-Duly provider. Failure to obtain prior authorization may result in penalty or increased out-of-pocket costs.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Duly Provider (You will pay the least)	BCBS Preferred Provider[1] (You will pay more)	BCBS Nonpreferred Provider (You will pay the most)	
	Hospice services	0% coinsurance deductible does not apply	20% coinsurance	40% coinsurance	Preauthorization is required when visiting a non-Duly provider. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

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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.)

- Cosmetic surgery
- Dental care (Adult and Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult and Children)
- Weight loss programs
- Routine foot care (with the exception of persons with diagnosis of diabetes)

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

- Acupuncture (max: $500 per member)
- Bariatric surgery (max: 1 per lifetime)
- Chiropractic care (max: 20 visits per benefit period)
- Hearing aids (max: $2,500 per benefit period)
- Infertility treatment
- Speech therapy

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 1-855-760-3135.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-760-3135.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-760-3135.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-760-3135.

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 in-network pre-natal care and a hospital delivery)

■ The plan's overall in-network /Preferred Provider) deductible	$700
■ Specialist (Duly) coinsurance	0%
■ Hospital (Preferred Provider 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:

Cost Sharing	
Deductibles	$700
Copayments (Duly providers)	$0
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,100**

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

■ The plan's overall in-network/Preferred Provider) deductible	$700
■ Specialist (Duly) coinsurance	0%
■ Hospital (Preferred Provider 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:

Cost Sharing	
Deductibles	$300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$300**

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

■ The plan's overall in-network/Preferred Provider) deductible	$700
■ Specialist(Duly) coinsurance	0%
■ Hospital (Preferred Provider facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments (Emergency Room and BCBS Preferred Specialist)	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$750**