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.umr.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.umr.com or call 1-800-207-3172 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	No deductible when visiting a Duly provider[1] UHC Core In-Network[2]: $700 Individual/$1,400 Family Out-of-Network: $1,400 Individual/$2,800 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. Certain preventive care, services that charge a copay, prescription drugs, and emergency room 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?	Out-of-pocket limit not applicable at Duly providers. UHC Core In-Network[2]: $3,000 Individual/$6,000 Family Out-of-Network: $6,000 Individual/$12,000 Family Prescription drug expense limit: $3,000 Individual/$6,000 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?	Premiums, penalties, balanced-billed charges, and healthcare this plan 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-207-3172 for a list of network providers.	You will pay nothing if you use a Duly provider. You pay more if you use a provider in UHC's Core network[1]. 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

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		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 (unless otherwise noted).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[3]
		UHC Core In-Network Provider[2]	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	No charge at Duly providers[1]. $50 copay/visit elsewhere; deductible does not apply.	40% coinsurance after deductible	None
	Specialist visit	No charge at Duly providers[1]. $100 copay/visit elsewhere; deductible does not apply.	40% coinsurance after deductible	Chiropractic and Osteopathic manipulation services are limited to 20 visits per benefit period. Acupuncture will have a per benefit period dollar limit of $500.
	Preventive care/screening/ immunization	No charge; deductible does not apply	40% coinsurance after deductible	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)	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information[3]
		Duly Provider[1]	In-Network Provider[2]	Out-of-Network 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	$5 copay/ prescription (retail)	$15 copay/ prescription (retail) $30 copay/ prescription (mail order); deductible does not apply	Not covered	30-day supply at Retail 90-day supply at Mail Order Up to 90-day supply for Maintenance Drugs at Retail Rx Out-of-Pocket Expense Limit: $3,000 Individual/$6,000 Family 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. Prior authorization may be required. Any fills for 31-60 days supply will take 2 copays Any fills for 61-90 days supply will take 3 copays Specialty Pharmacy benefits exclusive to Accredo Specialty Pharmacy or Duly Pharmacy. Please see "Important Questions" regarding the plan's out-of-pocket limit.
	Preferred brand drugs	$20 copay/ prescription (retail)	$30 copay/ prescription (retail) $60 copay/ prescription (mail order); deductible does not apply	Not covered	
	Non-preferred brand drugs	$45 copay/ prescription (retail)	$55 copay/ prescription (retail) $110 copay/ prescription (mail order); deductible does not apply	Not covered	
	Specialty drugs	25% coinsurance	25% coinsurance; deductible does not apply	Not covered	

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[2] 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 Script pharmacy.
[3] For more information about limitations and exceptions, see the plan or policy document at www.umr.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[3]
		UHC Core In-Network Provider[2]	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	None
	Physician/surgeon fees	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$250 copay/visit; deductible does not apply	$250 copay/visit; deductible does not apply	Copay waived if admitted. There are no emergency room facilities owned and administered by Duly.
	Emergency medical transportation	No charge	No charge	There is no emergency medical transportation service owned and administered by Duly.
	Urgent care	No charge at Duly providers[1]. $75 copay/visit elsewhere; deductible does not apply.	40% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	There are no inpatient facilities owned and administered by Duly.
	Physician/surgeon fees	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge at Duly providers[1]. $50 copay/visit elsewhere; deductible does not apply.	40% coinsurance after deductible	PCP copay applies to psychotherapy visit only.
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	There are no inpatient facilities 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[3]
		UHC Core In-Network Provider[2]	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge at Duly providers[1]. $50 copay/visit elsewhere; deductible does not apply.	40% coinsurance after deductible	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	There are no inpatient facilities owned and administered by Duly.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 visits per benefit period. There are no home health care providers owned and administered by Duly.
	Rehabilitation services	No charge at Duly providers[1]. $50 copay/office visit elsewhere; deductible does not apply.	40% coinsurance after deductible	Limited to 60 visits combined per calendar year for occupational therapy and physical therapy.
	Habilitation services	No charge at Duly providers[1]. $50 copay/office visit elsewhere; deductible does not apply.	40% coinsurance after deductible	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information[3]
		UHC Core In-Network Provider[2]	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Limited to 60 visits per benefit period. There are no skilled nursing care providers owned and administered by Duly.
	Durable medical equipment	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price). Wigs are covered.
	Hospice services	No charge at Duly providers[1]. 20% coinsurance after deductible elsewhere.	40% coinsurance after deductible	None
If your child needs dental or eye care	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[3].)

- 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)
- Routine foot care (with the exception of persons with diagnosis of diabetes)
- Weight loss programs

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

- Acupuncture (limited to $500 per member)
- Bariatric surgery
- Chiropractic care (20 visit annual maximum)
- Hearing aids
- 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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. 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, kwiijigo 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[2] hospital delivery)

The plan's overall UHC Core deductible	$700
Duly specialist copayment	$0
UHC Core 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$700
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,400**

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

The plan's overall Duly deductible	$0
Duly specialist copayment	$0
UHC Core 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	**$7,400**

In this example, Joe would pay:

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

Mia's Simple Fracture
(UHC Core in-network[2] emergency room visit and Duly-provided follow up care)

The plan's overall UHC Core deductible	$700
Duly specialist copayment	$0
UHC Core 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$500
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

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

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