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 1-800-537-9765 or at www.bcbsil.com/RRD. 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.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,900 Individual/$5,800 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain preventive care, services that charge a copay, Specialty 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 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?	$7,600 Individual/$15,200 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, balance-billing charges, coinsurance for Specialty Drugs that are non-essential health benefits, 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.bcbsil.com/RRD or call 1-800-537-9765 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 (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.
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
		In-Network Provider (You will pay the least)	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	$25 copay/visit; deductible does not apply	50% coinsurance	Virtual visits: $25/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$50 copay/visit; deductible does not apply	50% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	50% 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. Certain women's preventive services will be covered with no cost to the member. For a full list of these prescriptions and/or services, please contact Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	Retail: 25% coinsurance after deductible Mail Order: 25% coinsurance after deductible	Retail: 25% coinsurance after deductible Mail Order: 25% coinsurance after deductible	100% coverage for certain generic cholesterol and blood pressure medications, diabetes supplies and insulin on the CVS formulary. Deductible does not apply to these preventive drugs. Retail: $10 minimum – $45 maximum Mail Order: $25 minimum – $115 maximum

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/RRD or https://myrrdbenefits.com/forms-docs/#spd||formtabs|1

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Preferred brand drugs	Retail: 40% coinsurance Mail Order: 40% coinsurance	Retail: 40% coinsurance Mail Order: 40% coinsurance	Retail: $40 minimum - $100 maximum Mail Order: $100 minimum - $250 maximum
	Non-preferred brand drugs	Retail: 50% coinsurance after deductible Mail Order: 50% coinsurance after deductible	Retail: 50% coinsurance after deductible Mail Order: 50% coinsurance after deductible	Retail: $75 minimum - $150 maximum Mail Order: $185 minimum - $375 maximum
	Specialty drugs	If not covered by PrudentRx: $210; no deductible If covered by PrudentRx: 30%; no deductible	$210	More than 30-day supply not allowed. If you participate in the PrudentRx Copay Program, your out-of-pocket cost for drugs covered by PrudentRx is 0. See https://www.prudentrx.com/prudentes/ for a list of covered medications. The Plan and the PrudentRx Copay Program categorize specialty medications as either “essential health benefits” or “non-essential health benefits.” Specialty medications that are “non-essential health benefits” are denoted with a “1” on the list at the hyperlink above. Employee cost sharing for “essential health benefits” counts toward the Plan out-of-pocket maximum but does not count toward the Plan deductible. Employee cost sharing for “non-essential health benefits” does not count toward either the Plan deductible or out-of-pocket maximum. If you opt out of the PrudentRx Copay Program, then even if you reach your Plan out-of-pocket maximum, you will still be responsible for the 30% coinsurance for medications that are “non-essential health benefits.”

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/RRD or https://myrrdbenefits.com/forms-docs/#spd||formtabs|1

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$600 copay/visit plus 25% coinsurance; deductible does not apply	$600 copay/visit plus 25% coinsurance; deductible does not apply	Copay waived if admitted. Non-Emergency use of ER: In-Network pays at $600 copay, no deductible and In-Network coinsurance applies. Out-of-Network pays at $600 copay, no deductible and Out-of-Network coinsurance applies.
	Emergency medical transportation	25% coinsurance	25% coinsurance	None
	Urgent care	25% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit; deductible does not apply; 25% coinsurance for other outpatient services	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/RRD or https://myrrdbenefits.com/forms-docs/#spd||formtabs|1

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 PCP/$50 SPC copay/visit; deductible does not apply	50% coinsurance	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty. You or someone who calls on your behalf must notify the Claim Administrator no later than 48 hours or as soon as reasonably possible after the admission has occurred; $500 penalty for failure to notify.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	Limited to 120 visits per benefit period combined with private duty nursing.
	Rehabilitation services	$50 copay/visit; deductible does not apply	50% coinsurance	Limited to 90 visits total combined per benefit period for physical, occupational, pulmonary, cognitive and speech therapies.
	Habilitation services	$50 copay/visit; deductible does not apply	50% coinsurance	
	Skilled nursing care	25% coinsurance	50% coinsurance	Limited to 90 days per benefit period. Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.
	Durable medical equipment	25% coinsurance	50% coinsurance	Benefits are limited to items used to serve a medical purpose. Durable Medical Equipment benefits are provided for both purchase and rental equipment (up to the

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				purchase price).
	Hospice services	25% coinsurance	50% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Vision benefits may be available through a separate plan.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	Dental benefits may be available through a separate plan.

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.)

- Acupuncture
- Cosmetic surgery (except as required under the Women's Health and Cancer Rights Act, or for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases)
- Dental care (Adult and Children)
- Long term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Children)
- Routine foot care (with the exception of person 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.)

- Bariatric surgery
- Chiropractic care (Chiropractic and Osteopathic manipulation limited to 20 visits per calendar year)
- Hearing aids (Adults (19 and up) will receive 1 pair every 24 months. Children under 18 to receive 1 pair every 12 months)
- Infertility treatment (ART $2,000 maximum per benefit period)
- Private-duty nursing (with the exception of inpatient private duty nursing) (limited to 120 visits combined with Coordinated Home Care per benefit period)

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: the plan at 1-800-537-9765, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.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: Blue Cross and Blue Shield of Illinois at 1-800-537-9765 or visit www.bcbsil.com/RRD, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. 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 1-800-537-9765.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-537-9765.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-537-9765.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-537-9765.

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 deductible	$2,900
Specialist copayment	$50
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,900
Copayments	$30
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,390**

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

The plan's overall deductible	$2,900
Specialist copayment	$50
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$2,900
Copayments	$300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

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

The plan's overall deductible	$2,900
Specialist copayment	$50
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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:

Cost Sharing	
Deductibles	$1,400
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,200**

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

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age,sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator 300 E. Randolph St. 35th Floor Chicago, Illinois 60601	Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services 200 Independence Avenue SW Room 509F, HHH Building 1019 Washington, DC 20201	Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

A Division of Health Care Sevice Corporation, a Mutual Legal Reserve Company

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده اسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.