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.rrd.bswift or call 1-877-773-4236. 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.rrd.bswift.com or call 1-877-773-4236 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $3,200 Individual / $6,400 Family Out-of-Network: $3,200 Individual / $6,400 Family Does not apply to copays, pharmacy drugs, and services listed below as "No Charge".	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. Preventive Care and categories with copay are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual 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 services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No, there are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $6,900 Individual / $13,800 Family Out-of-Network: $6,900 Individual / $13,800 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?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain pre-notification for services.	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.rrd.bswift.com or call 1-877-773-4236 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.

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

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
		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	40% Coinsurance after deductible	None
	Specialist visit	$40 Copay/visit; deductible does not apply	40% Coinsurance after deductible	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% Coinsurance after deductible	Includes preventive health services specified in the health care reform law. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance after deductible	40% Coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance after deductible	40% Coinsurance after deductible	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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.caremark.com**	Generic Drugs (Tier 1)	Retail: 20% Coinsurance deductible does not apply Mail Order: 20% Coinsurance deductible does not apply	Retail: 20% Coinsurance deductible does not apply Mail Order: 20% Coinsurance deductible does not apply	Retail: $10 minimum, $40 maximum. Mail Order: $25 minimum, $100 maximum
	Preferred brand drugs (Tier 2)	Retail: 30% Coinsurance deductible does not apply Mail Order: 30% Coinsurance deductible does not apply	Retail: 30% Coinsurance deductible does not apply Mail Order: 30% Coinsurance deductible does not apply	Retail: $40 minimum, $$75 maximum. Mail Order: $100 minimum, $185 maximum
	Non-preferred brand drugs (Tier 3)	Retail: 40% Coinsurance deductible does not apply Mail Order: 40% Coinsurance deductible does not apply	Retail: 40% Coinsurance deductible does not apply Mail Order: 40% Coinsurance deductible does not apply	Retail: $55 minimum, $125 maximum. Mail Order: $140 minimum, $315 maximum
	Specialty drugs (Tier 4)	Retail: $150 Copay	Retail: $150 Copay	Mail Order not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance after deductible	40% Coinsurance after deductible	None
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$500 Copay/visit 20% Coinsurance deductible does not apply	$500 Copay/visit 20% Coinsurance deductible does not apply	Copay waived if admitted. 40% coinsurance after deductible if NOT a true emergency as determined by the claims administrator.
	Emergency medical transportation	20% Coinsurance after deductible	20% Coinsurance after deductible	None
	Urgent care	20% Coinsurance after deductible	40% Coinsurance after deductible	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance after deductible	40% Coinsurance after deductible	Preauthorization required or $500 penalty applies
	Physician/surgeon fees	20% Coinsurance after deductible	40% Coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office:$25 Copay/visit Facility: 20% coinsurance after deductible	40% Coinsurance after deductible	None
	Inpatient services	20% Coinsurance after deductible	40% Coinsurance after deductible	Preauthorization required or $500 penalty applies
If you are pregnant	Office visits	$25 Copay/visit; deductible does not apply	40% Coinsurance after deductible	Routine pre-natal is covered at no charge. Depending on the type of service, coinsurance or deductible may apply. Preauthorization may be required or $500 penalty applies.
	Childbirth/delivery professional services	20% Coinsurance after deductible	40% Coinsurance after deductible	
	Childbirth/delivery facility services	20% Coinsurance after deductible	40% Coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance after deductible	40% Coinsurance after deductible	120 visits per calendar year, in network and out of network combined with private duty nursing.
	Rehabilitation services	$40 Copay/visit; deductible does not apply	40% Coinsurance after deductible	90 visits per calendar year, in network and out of network combined. Visits combined includes Occupational Therapy, Speech Therapy, Physical Therapy, Pulmonary Therapy, and Cognitive Therapy visits.
	Habilitation services	Not Covered	Not Covered	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% Coinsurance after deductible	40% Coinsurance after deductible	90 Days per calendar year, in network and out of network combined. Preauthorization required or $500 penalty applies.
	Durable medical equipment	20% Coinsurance after deductible	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 purchase price).
	Hospice services	20% Coinsurance after deductible	40% Coinsurance after deductible	Preauthorization required or $500 penalty applies
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Vision benefit may be available through separate plan.
	Children's glasses	Not Covered	Not Covered	Vision benefit may be available through separate plan.
	Children's dental check-up	Not Covered	Not Covered	Dental benefit may be available through 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
- Adult routine vision exam (i.e. refraction)
- Child dental check-up
- Child routine vision exam (i.e. refraction)
- Child vision glasses
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (limitations may apply)
- Hearing aids (limited to 1 new aid per ear per 36-month period up to $5,000 maximum)
- Private-duty nursing (with the exception of inpatient).
- Routine foot care
- Infertility treatment (covered only to diagnose infertility)

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

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 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: 1-877-773-4236 or visit www.rrd.bswift.com or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-877-773-4236.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-773-4236.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-877-773-4236.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-773-4236.

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

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

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	$3,200
■ Specialist copayment	$40
■ 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:

Cost Sharing	
Deductibles	$3,200
Copayments	$80
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,240**

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

■ The plan's overall deductible	$3,200
■ Specialist copayment	$40
■ 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	$3,200
Copayments	$300
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,360**

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

■ The plan's overall deductible	$3,200
■ Specialist copayment	$40
■ 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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

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