




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.com 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 <u>deductible</u>?	<u>In-Network</u> : \$3,200 Individual / \$6,400 Family <u>Out-of-Network</u> : \$3,200 Individual / \$6,400 Family Does not apply to services listed below as “No Charge”.	Generally, you must pay all of the costs from providers 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.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive Care</u> is 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 annual <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 services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>In-Network</u> : \$6,900 Individual / \$13,800 Family <u>Out-of-Network</u> : \$6,900 Individual / \$13,800 Family per calendar year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain pre-notification for services.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.rrd.bswift.com or call 1-877-773-4236 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . 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 charge</u> and what your <u>plan</u> 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.

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	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; deductible does not apply	40% <u>Coinsurance</u> after <u>deductible</u>	Includes preventive health services specified in the health care reform law. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	None
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% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	Retail: 20% <u>Coinsurance</u> Mail Order: 20% <u>Coinsurance</u>	None
	Preferred brand drugs (Tier 2)	Retail: 30% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	Retail: 30% <u>Coinsurance</u> Mail Order: 30% <u>Coinsurance</u>	None
	Non-preferred brand drugs (Tier 3)	Retail: 40% <u>Coinsurance</u> Mail Order: 40% <u>Coinsurance</u>	Retail: 40% <u>Coinsurance</u> Mail Order: 40% <u>Coinsurance</u>	None
	Specialty drugs (Tier 4)	Retail: 40% <u>Coinsurance</u> Mail Order: 40% <u>Coinsurance</u>	Retail: 40% <u>Coinsurance</u> Mail Order: 40% <u>Coinsurance</u>	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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	None
	Physician/surgeon fees	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>Coinsurance</u> after deductible	20% <u>Coinsurance</u> after deductible	<u>Out-of-Network provider</u> : If true emergency 20%, otherwise 40%
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u> after deductible	20% <u>Coinsurance</u> after deductible	None
	<u>Urgent care</u>	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	<u>Preauthorization</u> required or \$500 penalty applies
	Physician/surgeon fees	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	None
	Inpatient services	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	<u>Preauthorization</u> required or \$500 penalty applies
If you are pregnant	Office visits	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	Routine pre-natal is covered at no charge. Depending on the type of service, <u>coinsurance</u> or <u>deductible</u> may apply. <u>Preauthorization</u> may be required or \$500 penalty applies.
	Childbirth/delivery professional services	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	
	Childbirth/delivery facility services	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u> after deductible	40% <u>Coinsurance</u> after deductible	120 visits per calendar year, in <u>network</u> and out of <u>network</u> combined with private duty nursing

*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)	
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	90 visits per calendar year, in <u>network</u> and out of <u>network</u> combined. Visits combined includes Occupational Therapy, Speech Therapy, Physical Therapy, Pulmonary Therapy, and Cognitive Therapy visits.
	<u>Habilitation services</u>	Not Covered	Not Covered	None
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	90 Days per calendar year, in <u>network</u> and out of <u>network</u> combined. <u>Preauthorization</u> required or \$500 penalty applies.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	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).
	<u>Hospice services</u>	20% <u>Coinsurance</u> after <u>deductible</u>	40% <u>Coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Adult routine vision exam (i.e. refraction) Child dental check-up Child routine vision exam (i.e. refraction) 	<ul style="list-style-type: none"> Child vision glasses Cosmetic Surgery Dental Care (Adult) 	<ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. Weight loss programs

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

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)

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, kwijigo holne' 1-877-773-4236.

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

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 <u>plan's</u> overall deductible	\$3,200
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
Deductibles	\$3,200
Copayments	\$0
<u>Coinsurance</u>	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,160

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall deductible	\$3,200
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
Deductibles	\$3,200
Copayments	\$0
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$4,260

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall deductible	\$3,200
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
Deductibles	\$2,000
Copayments	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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