**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 is 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, 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% coinsurance | 50% coinsurance | Virtual visits: 25% coinsurance/visit; deductible applies. See your benefit booklet* for details. |
| | Specialist visit | 25% coinsurance | 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 preventative 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 | 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 | Retail: 25% coinsurance after deductible<br><br>Mail Order: 25% coinsurance after deductible | Retail: 25% coinsurance after deductible<br><br>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. |
| | Preferred brand drugs | Retail: 40% Coinsurance after Deductible<br><br>Mail Order: 40% Coinsurance after Deductible | Retail: 40% Coinsurance after Deductible<br><br>Mail Order: 40% Coinsurance after Deductible | None |
| | Non-preferred brand drugs | Retail: 50% coinsurance after deductible | Retail: 50% coinsurance after deductible | None |

* 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) | |
| | | Mail Order: 50% coinsurance after deductible | Mail Order: 50% coinsurance after deductible | |
| | Specialty drugs | Retail: 50% coinsurance after deductible<br><br>Mail Order: 50% coinsurance after deductible | Retail: 50% coinsurance after deductible<br><br>Mail Order: 50% coinsurance after deductible | More than 30-day supply not allowed.<br>If you participate in the PrudentRx Copay Program, your out-of-pocket cost for drugs covered by PrudentRx is 0 after your deductible. See https://www.prudentrx.com/prudentes/ for a list of covered medications.<br>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." |
| **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 |

| 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 need immediate medical attention** | Emergency room care | Facility Charges: 25% coinsurance<br>ER Physician Charges: 25% coinsurance | Facility Charges: 25% coinsurance<br>ER Physician Charges: 25% coinsurance | Non-Emergency use of ER: In-Network applies deductible and In-Network coinsurance. Out-of-Network applies deductible and Out-of-Network coinsurance. |
| | 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% coinsurance | 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. |
| **If you are pregnant** | Office visits | 25% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, 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. |

* 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 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 | 25% coinsurance | 50% coinsurance | Limited to 90 visits total combined per benefit period for physical, occupational, pulmonary, cognitive and speech therapies. |
| | Habilitation services | 25% coinsurance | 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 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. |

| 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 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 coinsurance** **25%**
- **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 | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,360** |

### 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 coinsurance** **25%**
- **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 | $0 |
| Coinsurance | $900 |
| *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 coinsurance** **25%**
- **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 | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

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

BlueCross BlueShield of Illinois

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

**Health care coverage is important for everyone.**

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. 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. 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, IL 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/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

| | **To receive language or communication assistance free of charge, please call us at 855-710-6984.** |
|---|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984. |
| 繁體中文 | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。 |
| Français | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an. |
| ગુજરાતી | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો. |
| हिंदी | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni. |
| فارسی | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید. |
| Polski | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984. |
| Русский | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984. |
| Tagalog | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984. |
| اردو | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔ |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984. |