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.myrrdbenefits.com, contact the RRD Benefits Center at 1-877-RRD-4BEN (1-877-773-4236) or https://rrd.bswift.com, or contact BCBSIL at 1-800-537-9765 or 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 1-855-765-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $1,700 Individual/$3,400 Family Out-of-Network providers: $3,400 Individual/$6,800 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?	In-Network providers: $8,700 Individual/$17,400 Family Out-of-Network providers: $17,400 Individual/$34,800 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?	Penalties for failure to obtain preauthorization, 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
		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	Virtual visits: $25/visit; deductible does not apply. See your benefit booklet* for details.
	Specialist visit	$40 copay/visit; deductible does not apply	40% coinsurance	SleepCharge is the exclusive network provider for "sleep conditions" (e.g., obstructive sleep apnea, insomnia, restless leg syndrome, and circadian rhythm disorders). All SleepCharge services have a combined $100 copayment per benefit period. All other providers are considered out-of-network providers. Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	40% 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	SleepCharge is the exclusive network provider for testing for sleep conditions. All SleepCharge services have a combined $100 copayment per benefit period. All other providers are considered out-of-network providers. Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty. OneImaging is the exclusive provider for non-emergency/non-urgent MRIs and CT scans. The Plan provides no coverage for MRIs or CT scans provided by other providers (except in the case of urgent care or emergency services). Call or text 1-833-619-0837, email help@oneimaging.com or visit www.join.oneimaging.com/RRD.
If you need drugs to	Generic drugs	Retail:		Copay applies to a 30-day supply Retail and

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com		20% coinsurance deductible does not apply ($10 min – $40 max) Mail Order: 20% coinsurance; deductible does not apply ($25 min - $100 max)		Specialty drugs or 31-90 day supply Mail-Order prescription. Mail-Order must be used after 2 retail fills for maintenance drugs. 100% coverage for preventive drugs required by the Affordable Care Act. Deductible does not apply to these preventive drugs. If you purchase a brand name drug when a generic is available, you must pay the Cost Sharing listed plus the difference in cost between the drugs (unless taking the brand is medically necessary). Certain drugs require preauthorization or step therapy and are noted in the Check Drug Cost tool on the Caremark website with a "PA" notation. The list is subject to change from time to time and may not be all-inclusive. You can log onto www.caremark.com to check your specific medicine coverage or call Customer Care toll-free at 1-888-528-7457.
	Preferred brand drugs	Retail: 30% coinsurance deductible does not apply ($40 min - $75 max) Mail Order: 30% coinsurance; deductible does not apply ($100 min - $185 max)		
	Non-preferred brand drugs	Retail: 40% coinsurance deductible does not apply ($55 min - $125 max) Mail Order: 40% coinsurance deductible does not apply ($140 min - $315 max)		
	Specialty drugs	If not covered by PrudentRx: $150, deductible does not apply If covered by PrudentRx:	$150	More than 30-day supply not allowed. See preauthorization and step therapy note above. 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

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)	
		$0, deductible does not apply		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)	20% coinsurance	40% coinsurance	You must use a "Blue Distinction Specialty Care" facility for five surgical specialties: bariatric, cardiac, knee and hip replacement, spine and transplant surgeries, otherwise in-network coinsurance is increased to 45%. Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty. NOTE: If you use Carrum Health you are not required to use a "Blue Distinction Specialty Care" facility; see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	The Plan does not pay expenses for an assistant or co-surgeon in excess of 20% of the primary surgeon's allowable charge.
If you need immediate medical attention	Emergency room care	Facility Charges: $500 copay/visit plus 20% coinsurance; deductible does not apply ER Physician Charges: 20% coinsurance	Facility Charges: $500 copay/visit plus 20% coinsurance; deductible does not apply ER Physician Charges: 20% coinsurance	Copay waived if admitted. Cost sharing for non-emergency use out-of-network: Facility Charges: $500 copay/visit no deductible plus 40% coinsurance; deductible does not apply ER Physician Charges: 40% coinsurance

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)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Cost sharing for non-emergency use out-of-network: 40% coinsurance
	Urgent care	20% coinsurance	40% coinsurance	In limited circumstances as required by the No Surprises Act, out-of-network emergency services may be covered at in-network coinsurance levels.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	In limited circumstances as required by the No Surprises Act, out-of-network services may be covered at in-network coinsurance levels.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $25 copay; deductible does not apply Other services: 20% coinsurance	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	$25 PCP/$40 SPC copay/visit; deductible does not apply	40% coinsurance	Copay applies to first prenatal visit (per pregnancy) only. 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% 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	Home health care	20% coinsurance	40% coinsurance	Home health care visits and private duty nursing

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)	
recovering or have other special health needs				combined limited to 120 visits 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.
	Rehabilitation services	$40 copay/visit; deductible does not apply	40% coinsurance	Cardiac rehabilitation limited to 36 visits per benefit period. Limited to 90 visits total combined per benefits period for physical, occupational, pulmonary, cognitive, and speech therapies. Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.
	Habilitation services	$40 copay/visit; deductible does not apply	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 90 days per benefit period total combined for inpatient skilled nursing and/or inpatient stay at rehabilitation facility. 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	20% coinsurance	40% 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	20% coinsurance	40% 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
- Routine eye care (Adult and Children)
- Non-emergency care when traveling outside the U.S.
- 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 benefit period)
- 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 RRD Benefits Center at 1-877-RRD-4BEN (1-877-773-4236) or https://rrd.bswift.com, 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 on how 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 1-800-882-5158.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-882-5158.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-882-5158.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-537-9765.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-882-5158 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-882-5158.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-882-5158.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-882-5158.

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 plan's overall deductible	**$1,700**
Specialist coinsurance	**$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	$1,700
Copayments	$25
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,985**

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

The plan's overall deductible	**$1,700**
Specialist coinsurance	**$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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$490**

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

The plan's overall deductible	**$1,700**
Specialist coinsurance	**$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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,700
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

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