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 visit 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 https://www.healthcare.gov/sbc-glossary or call 1-800-882-5158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Out-of-Network providers: $5,000 Individual/ $10,000 Family	See the Common Medical Events chart below for your costs for services this plan covers. This plan does not have a deductible for in-network providers.
Are there services covered before you meet your deductible?	Not Applicable.	This plan does not have a deductible for in-network providers.
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?	Tier 1, Tier 2 and Tier 3 In-Network providers combined: $8,000/Individual or $16,000/Family Out-of-Network providers: Unlimited/Individual or Unlimited/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 for services, 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.	You pay the least if you use a tier 1 preferred provider. You pay more if you use a tier 2 or tier 3 preferred provider. You will pay the most if you use a 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 preferred 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
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred 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	$30 copayment	$65 copayment	$125 copayment	30% coinsurance after deductible	You will be charged the same rate for virtual visits as office visits.
	Specialist visit	$75 copayment	$150 copayment	$325 copayment	30% coinsurance after deductible	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 out-of-network providers (Tier 4). Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd.
	Preventive care/screening/ immunization	$0 copayment	$0 copayment	$0 copayment	30% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the 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 Telehealth Visit:	PCP Telehealth:	$5 copayment	$5 copayment	$15 copayment	30% coinsurance after deductible	None
	Specialist Telehealth:	$65 copayment	$95 copayment	$155 copayment	30% coinsurance after	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred Provider (You will pay the most)	
					deductible	
	MD Live:	$25 copayment	$25 copayment	$25 copayment	N/A	None
If you have a test	Diagnostic test (x-ray, blood work)	Basic labs $175 copayment; X-rays $150 copayment	Basic labs $175 copayment; X-rays $150 copayment	Basic labs $175 copayment; X-rays $150 copayment	30% coinsurance after deductible	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 out-of-network providers (Tier 4). Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd.
	Imaging (CT/PET scans, MRIs)	CT $150 copayment Freestanding/ $535 Outpatient; MRI $200 copayment Freestanding/ $535 Outpatient; PET $400 copayment Freestanding/ $535 Outpatient			30% coinsurance after deductible	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 and is a Tier 1 provider. 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 treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or call 1-866-644-7527	Generic drugs	Retail: 25% coinsurance (min $10 - max $45) Mail Order: 25% coinsurance (min $25 - max $115)				Copay applies to a 30-day supply Retail and 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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred Provider (You will pay the most)	
	Preferred brand drugs	Retail: 40% coinsurance (min $40 - max $100) Mail Order: 40% coinsurance (min $100 - max $250)				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.
	Non-preferred brand drugs	Retail: 50% coinsurance (min $75 - max $150) Mail Order: 50% coinsurance (min $185 - max $375)				

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred Provider (You will pay the most)	
	Specialty drugs	If not covered by PrudentRx $210 copayment If covered by PrudentRx 0% coinsurance				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 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 after deductible for medications that are "non-essential health benefits."

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,750 copayment; $2,500 copayment for outpatient hospital setting			30% coinsurance after deductible	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	$0 copayment	$0 copayment	$0 copayment	30% coinsurance after deductible	The Plan may not pay all expenses for an assistant or co-surgeon.
If you need immediate medical attention	Emergency room care	$1,200 copayment				Copay waived if admitted.
	Emergency medical transportation	$815 Ground Transport and $1,190 Air Transport				Must be medically necessary.
	Urgent care	$150 copayment	$150 copayment	$150 copayment	30% coinsurance after deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$5,800 copayment for inpatient stay; 8,000 copayment for inpatient surgery			30% coinsurance after deductible	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	$0 copayment	$0 copayment	$0 copayment	30% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment			30% coinsurance after deductible	Preauthorization may be required; see your benefit booklet* for details. Failure to obtain a required preauthorization will result in a $500 penalty.
	Inpatient services	$5,800 copayment			30% coinsurance after deductible	
If you are pregnant	Office visits	$30 copayment	$65 copayment	$125 copayment	30% coinsurance after deductible	Copay applies to first prenatal visit (per pregnancy) only. Cost sharing does not apply for preventive services. Depending on the type of services and which tier, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	$0 copayment	$0 copayment	$0 copayment	30% coinsurance after deductible	
	Childbirth/delivery facility services	$5,800 copayment non-surgical; $8,000 copayment surgical			30% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	$25 copayment Home Health Visit $115 copayment Private Duty Nursing			30% coinsurance after deductible	Home health care visits and private duty nursing 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	$100 copayment for Office $150 copayment for Outpatient facility			30% coinsurance after	Cardiac rehabilitation limited to 36 visits per benefit period. Limited to 90 visits total combined per benefits period for

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Top Preferred Provider (You will pay the least)	Preferred Provider (You will pay the least)	Core Provider (You will pay the least)	Out-of-Network Nonpreferred Provider (You will pay the most)	
					deductible	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	$150 copayment for Office $190 copayment for Outpatient facility			30% coinsurance after deductible	
	Skilled nursing care	$5,800 facility copayment			30% coinsurance after deductible	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.
If you need help recovering or have other special health needs (continued)	Durable medical equipment	$65 copayment	$220 copayment	$625 copayment	30% coinsurance after deductible	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	$125 copayment Home Hospice $5,800 copayment Inpatient Hospice			30% coinsurance after deductible	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	Not covered	Not covered	Vision benefits may be available through a separate plan.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	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
- Dental care (Adult and Children)
- Routine foot care (with the exception of person with

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• 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)	• Long-term care • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult and Children)	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 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, limited to $2,000 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, 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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' 1-800-882-5158.
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 (Tier 1 preferred provider)	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$5,800**
Other copayment	**$1,500**

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	$0
Copayments	$5,875
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,935**

Managing Joe's Type 2 Diabetes

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

The plan's overall (Tier 1 preferred provider)	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$5,800**
Other copayment	**$1,500**

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	$0
Copayments	$660
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$680**

Mia's Simple Fracture

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

The plan's overall (Tier 1 preferred provider)	**$0**
Specialist copayment	**$75**
Hospital (facility) copayment	**$5,800**
Other copayment	**$1,200**

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	$0
Copayments	$1,780
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,780**

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