**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 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $2,800 Individual/$5,600 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 preventative 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?** | $8,000 Individual/$16,000 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.bsbsil.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% coinsurance | 50% coinsurance | Virtual visits: 25% coinsurance/visit: deductible applies. See your benefit booklet* for details. |
| | Specialist visit | 25% coinsurance | 50% coinsurance | SleepCharge is the exclusive network provider for "sleep conditions" (e.g., obstructive sleep apnea, insomnia, restless leg syndrome, and circadian rhythm disorders). There is no coverage if you use other providers. Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd. |
| | 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 | SleepCharge is the exclusive network provider for testing for sleep conditions. There is no coverage if you use other providers. Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd. |
| | Imaging (CT/PET scans, MRIs) | 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. 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. |

* 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) | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.caremark.com. | Generic drugs | 25% coinsurance | 25% coinsurance | Mail-Order must be used after 2 retail fills for maintenance drugs.<br>100% coverage for preventive drugs required by the Affordable Care Act, and certain preventive generics for cholesterol, blood pressure, and diabetes, insulin, and diabetic supplies. Deductible does not apply to these preventive drugs.<br>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).<br>Certain drugs required 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 | 40% Coinsurance | 40% Coinsurance | |
| | Non-preferred brand drugs | 50% coinsurance | 50% coinsurance | |
| | Specialty drugs | If not covered by PrudentRx: 50% coinsurance<br>If covered by PrudentRx: 30% coinsurance | 50% coinsurance | More than 30-day supply not allowed. See preauthorization and step therapy note above.<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. 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 |

* 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) | |
| | | | | 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 | 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. |
| | Physician/surgeon fees | 25% coinsurance | 50% 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: 25% coinsurance<br>ER Physician Charges 25% coinsurance | Facility Charges: 25% coinsurance<br>ER Physician Charges 25% coinsurance | Cost sharing for non-emergency use out-of-network:<br>Facility Charges: 50% coinsurance<br>ER Physician Charges: 50% coinsurance |
| | Emergency medical transportation | 25% coinsurance | 25% coinsurance | Cost sharing for non-emergency use out-of-network: 50% coinsurance |
| | Urgent care | 25% coinsurance | 50% 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) | 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 | In limited circumstances as required by the No Surprises Act, out-of-network services may be covered at in-network coinsurance levels. |

* 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) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient 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. |
| | Inpatient services | 25% coinsurance | 50% coinsurance | |
| **If you are pregnant** | Office visits | 25% coinsurance | 50% coinsurance | Cost sharing does not apply for preventive services. Depending on the type of services, co-insurance 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. |
| **If you need help recovering or have other special health needs** | Home health care | 25% coinsurance | 50% coinsurance | 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 | 25% coinsurance | 50% coinsurance | Cardiac rehabilitation limited to 36 visits per benefit period. Limited to 90 visits total combined per benefit 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 | 25% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 25% coinsurance | 50% 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. |

* 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) | |
| | 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. |
| **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 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)

* 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

**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.***

* 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

## 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** | **$2,800** |
| **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 | $2,800 |
| Copayments | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,260** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,800** |
| **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 | $1,500 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,520** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,800** |
| **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.