



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.bsbsil.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 <u>deductible</u> ?	\$2,800 Individual/\$5,600 Family	Generally, you must pay all of the costs from <u>providers</u> 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. Certain <u>preventative 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 <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 preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	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> ?	\$8,000 Individual/\$16,000 Family	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> ?	Penalties for failure to obtain <u>preauthorization</u> , <u>premiums</u> , <u>balance-billing</u> charges, <u>coinsurance</u> for <u>Specialty Drugs</u> that are non-essential health benefits, and health care this <u>plan</u> doesn't cover.	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.bsbsil.com/RRD or call 1-800-537-9765 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Virtual visits: 25% <u>coinsurance</u> /visit: <u>deductible</u> applies. See your benefit booklet* for details.
	<u>Specialist</u> visit	25% <u>coinsurance</u>	50% <u>coinsurance</u>	SleepCharge is the exclusive <u>network provider</u> for "sleep conditions" (e.g., obstructive sleep apnea, insomnia, restless leg syndrome, and circadian rhythm disorders). All other <u>providers</u> are considered <u>out-of-network providers</u> . Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd .
	<u>Preventive care/screening</u> /immunization	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Certain women's <u>preventative services</u> 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	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	SleepCharge is the exclusive <u>network provider</u> for testing for sleep conditions. All other <u>providers</u> are considered <u>out-of-network providers</u> . Call 1-877-615-7257, option 2 or visit www.sleepcharge.com/rrd .
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> will result in a \$500 penalty. OneImaging is the exclusive <u>provider</u> for non-emergency/non-urgent MRIs and CT scans. The <u>Plan</u> provides no coverage for MRIs or CT scans provided by other <u>providers</u> (except in the case of urgent care or <u>emergency services</u>). 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 More information about prescription drug coverage is available at www.caremark.com.	Generic drugs	25% <u>coinsurance</u>	25% <u>coinsurance</u>	Mail-Order must be used after 2 retail fills for maintenance drugs. 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. <u>Deductible</u> 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).
	Preferred brand drugs	40% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
	Non-preferred brand drugs	50% <u>coinsurance</u>	50% <u>coinsurance</u>	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.
	Specialty drugs	If not covered by PrudentRx: 50% <u>coinsurance</u> If covered by PrudentRx: 30% <u>coinsurance</u>	50% <u>coinsurance</u>	More than 30-day supply not allowed. See <u>preauthorization</u> and step therapy note above. If you participate in the PrudentRx <u>Copay</u> Program, your out-of-pocket cost for drugs covered by PrudentRx is 0 after your <u>deductible</u>. See https://www.prudentrx.com/prudentes/ for a list of covered medications. The <u>Plan</u> and the PrudentRx <u>Copay</u> 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 <u>cost sharing</u> for "essential health benefits" counts toward the <u>Plan</u> out-of-pocket maximum but does not count toward

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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 <u>Plan deductible</u> . Employee <u>cost sharing</u> for “non-essential health benefits” does not count toward either the <u>Plan deductible</u> or out-of-pocket maximum. If you opt out of the PrudentRx <u>Copay</u> Program, then even if you reach your <u>Plan</u> out-of-pocket maximum, you will still be responsible for the 30% <u>coinsurance</u> for medications that are “non-essential health benefits.”
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	You must use a “Blue Distinction Specialty Care” facility for five surgical specialties: bariatric, cardiac, knee and hip replacement, spine and transplant surgeries, otherwise <u>in-network</u> coinsurance is increased to 45%. <u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> will result in a \$500 penalty.
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	The <u>Plan</u> 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% <u>coinsurance</u> ER Physician Charges 25% <u>coinsurance</u>	Facility Charges: 25% <u>coinsurance</u> ER Physician Charges 25% <u>coinsurance</u>	<u>Cost sharing</u> for non-emergency use <u>out-of-network</u> : Facility Charges: 50% <u>coinsurance</u> ER Physician Charges: 50% <u>coinsurance</u>
	Emergency medical transportation	25% <u>coinsurance</u>	25% <u>coinsurance</u>	<u>Cost sharing</u> for non-emergency use <u>out-of-network</u> : 50% <u>coinsurance</u>
	Urgent care	25% <u>coinsurance</u>	50% <u>coinsurance</u>	In limited circumstances as required by the No Surprises Act, <u>out-of-network emergency services</u> may be covered at <u>in-network coinsurance</u> levels.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> will result in a \$500 penalty.
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	In limited circumstances as required by the No Surprises Act, <u>out-of-network</u> services may be covered at <u>in-network</u> coinsurance levels.

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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% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> will result in a \$500 penalty.
	Inpatient services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you are pregnant	Office visits	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>co-insurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). <u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> 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.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Home health care visits and private duty nursing combined limited to 120 visits per benefit period. <u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> will result in a \$500 penalty.
	Rehabilitation services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	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. <u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> will result in a \$500 penalty.
	Habilitation services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Skilled nursing care	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 90 days per benefit period total combined for inpatient skilled nursing and/or inpatient stay at rehabilitation facility. <u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> 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% <u>coinsurance</u>	50% <u>coinsurance</u>	Benefits are limited to items used to serve a medical purpose. <u>Durable Medical Equipment</u> benefits are provided for both purchase and rental equipment (up to the purchase price)
	Hospice services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required; see your benefit booklet* for details. Failure to obtain a required <u>preauthorization</u> 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 <u>plan</u> .
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Dental benefits may be available through a separate <u>plan</u> .

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, kwijigo holne' 1-800-537-9765.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, 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, a'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	\$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
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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
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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
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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.