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 1-877-773-4236 or visit myrrdbenefits.com. 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. 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?	Network: $500 Individual / $1,000 Family Out-of-Network: $1,000 Individual / $2,000 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain in-network 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/preventivecare-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?	Network Medical: $2,500 Individual / $5,000 Family Out-of-Network Medical: $3,000 Individual / $6,000 Family Prescription Drug: $2,500 Individual / $4,500 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, preauthorization penalties, and health care this plan doesn't cover. Medical expenses do not count toward the Prescription Drug out-of-pocket limit or vice versa. Out-of-network Medical expenses do not count toward the Network out-of-pocket limit.	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	20% coinsurance	40% coinsurance	*Virtual visits:* 20% coinsurance; deductible applies.
	Specialist visit	20% coinsurance	40% coinsurance	*Virtual visits:* 20% coinsurance; deductible applies.
	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. See the Summary Plan Description at myrrdbenefits.com for details.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your Summary Plan Description at myrrdbenefits.com for details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cvs.com	Generic drugs	*Retail:* 20% coinsurance; $10 minimum copay *Mail Order:* 20% coinsurance; $30 minimum copay	*Retail:* 20% coinsurance; $10 minimum copay *Mail Order:* 20% coinsurance; $30 minimum copay	Copay applies to a 30 day supply Retail or 31-90 day supply Mail Order. Copay does not apply to preventive care drugs required by the Affordable Care Act.
	Preferred brand drugs	*Retail:* 40% coinsurance; $10 minimum copay *Mail Order:* 40% coinsurance; $30 minimum copay	*Retail:* 40% coinsurance; $10 minimum copay *Mail Order:* 40% coinsurance; $30 minimum copay	
	Non-preferred brand drugs	*Retail:* 50% coinsurance; $10 minimum copay *Mail Order:* 50% coinsurance; $30 minimum copay	*Retail:* 50% coinsurance; $10 minimum copay *Mail Order:* 50% coinsurance; $30 minimum copay	
	Specialty drugs	Follows retail coinsurance	Out-of-Network not allowed	Copay applies to a 30 day supply. More than 30-day supply not allowed. Specialty Drugs only covered when filled by CVS Specialty Pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your Summary Plan Description at myrrdbenefits.com for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	20% coinsurance applies to out-of-network rendered only if a true emergency; for out-of-network services rendered when not a true emergency, 40% coinsurance will apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required; see your Summary Plan Description at myrrdbenefits.com for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required; see your Summary Plan Description at myrrdbenefits.com for details.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	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	Preauthorization may be required; see your Summary Plan Description at myrrdbenefits.com for details. 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 or $500 penalty will apply.
	Childbirth/delivery facility services	20% coinsurance	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)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 120 visits per benefit period combined with private duty nursing.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 90 visits combined per benefits period for physical, occupational, pulmonary, cognitive, and speech therapies.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 90 days per benefit period. Preauthorization may be required; see your Summary Plan Description at myrrdbenefits.com for details.
	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 Summary Plan Description at myrrdbenefits.com for details.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Children are not eligible dependents under the plan.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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)
- Infertility treatment (only diagnosis covered)
- 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 (1 pair every 24 months)
- 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 go to 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: The RRD Benefits Center at 1-877-RRD-4BEN (1-877-773-4236); 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.

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	**$500**
Specialist *coinsurance*	**20%**
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	$500
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	**$500**
Specialist *coinsurance*	**20%**
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	$500
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

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

The plan's overall deductible	**$500**
Specialist *coinsurance*	**20%**
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	$500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1000**

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