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 BCBSM at 1-800-854-5901 or Express Scripts at 1-800-711-3459. 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 Aptiv Benefits at 1-888-587-9648 to request a copy. Questions: Call Aptiv Benefits at 1-888-587-9648 or visit benefits.aptiv.com for more information.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$900** Individual / **$1,800** 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 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. Preventive care (in-network) and prescription drugs 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 https://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: **$3,500** Individual / **$7,000** Family. Out-of-Network: **$0**	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, 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.bcbsm.com or www.express-scripts.com or call 1-800-854-5901 (BCBSM) or 1-800-711-3459 (Express Scripts) 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
		In-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	45% coinsurance	Not covered for allergy testing, treatment or injections.
	Specialist visit	25% coinsurance	45% coinsurance	
	Preventive care/screening/ immunization	No charge	45% coinsurance	Deductible does not apply in network. Immunizations received at pharmacies are not covered. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	45% coinsurance	Must be medically necessary. Preauthorization may be required (your provider will contact BCBS).
	Imaging (CT/PET scans, MRIs)	25% coinsurance	45% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	25% coinsurance	Retail: 25% coinsurance + 25% retail coinsurance Mail: Not covered	Deductible does not apply; Counted towards out-of-pocket limit. Covers up to a 34-day supply at retail; up to 90-day supply at mail. Some drugs may not be covered if prior authorization is not obtained. Certain maintenance drugs are not covered at retail after 3 fills (after 1 fill for certain specialty drugs). Drugs not covered for erectile dysfunction (except for certain conditions), non-sedating antihistamines, cosmetic purposes, weight control or to induce pregnancy.
	Preferred brand drugs	25% coinsurance	Retail: 25% coinsurance + 25% retail coinsurance Mail: Not covered	
	Non-preferred brand drugs	25% coinsurance	Retail: 25% coinsurance + 25% retail coinsurance Mail: Not covered	
	Specialty drugs	See above	See above	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	45% coinsurance	Must be medically necessary. Preauthorization may be required (your provider will contact BCBS).
	Physician/surgeon fees	25% coinsurance	45% coinsurance	
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Must be an emergency.
	Emergency medical transportation	25% coinsurance	25% coinsurance	Must be medically necessary. Air/boat ambulance up to 100 miles: 50% coinsurance; 100 miles and over: 100% coinsurance.
	Urgent care	25% coinsurance	25% coinsurance	Facility fees are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	45% coinsurance	Must be medically necessary. Preauthorization may be required (your provider will contact BCBS). 365-day limit at semi-private room rate. Not covered for custodial care, physical therapy, dental surgeries, refractive eye surgery, sterilization reversals, or non-covered plastic, cosmetic or reconstructive surgeries.
	Physician/surgeon fees	25% coinsurance	45% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	45% coinsurance	Preauthorization may be required for inpatient services and outpatient psychological testing (your provider will contact New Directions at 1-800-762-2382).
	Inpatient services	25% coinsurance	45% coinsurance	
If you are pregnant	Office visits	25% coinsurance	45% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% coinsurance	45% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	45% coinsurance	
	Home health care	25% coinsurance	45% coinsurance	3 visit limit for each unused hospital day (except for IV infusion). Not covered for private duty nursing, physician or housekeeping services.
				Physical, occupational and speech therapy: 60 visit limit per condition. Cardiac Rehab: 6-
If you need help recovering or have other special health needs	Rehabilitation services	25% coinsurance	45% coinsurance	month limit immediately following certain conditions, diagnoses and surgeries. Not covered for chronic or congenital conditions.
	Habilitation services	No covered	Not covered	
	Skilled nursing care	25% coinsurance	45% coinsurance	Must be medically necessary. Preauthorization may be required (your provider will contact BCBS). 730-day limit. Not covered for care that is principally custodial or domiciliary in nature.
	Durable medical equipment	25% coinsurance	25% coinsurance + balance-billing (outpatient); 45% coinsurance (provider's office or inpatient)	Limited to items covered under Medicare Part B. Out-of-Network balance (balance billing) not covered.
	Hospice services	25% coinsurance	45% coinsurance	2-day limit for each unused hospital day, up to 210-day lifetime maximum.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Services may be covered under your vision plan (if applicable).
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Covered under your dental plan (if applicable).

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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult & Child)
- Eye exam & glasses (Adult & Child)
- Habilitation services
- Infertility treatment
- Long-term care
- Private duty nursing
- Research, experimental or investigational services, procedures, drugs, equipment
- Routine eye care (Adult)
- Routine foot care
- 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
- Hearing aids
- Non-emergency when traveling outside the U.S.

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: Aptiv Benefits (COBRA for your plan) at 1-888-587-9648 or benefits.aptiv.com, or the 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 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: BCBSM at 1-800-854-5901, Express Scripts at 1-800-711-3459, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a Consumer Assistance Program can help you file your appeal. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:

Para obtener asistencia en Español, llame BCBSM al 1-800-854-5901 o Express Scripts al 1-800-753-2851.

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	$900
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$900
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$1,796
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,751**

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

The plan's overall deductible	$900
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$900
Copayments	$0
Coinsurance	$481
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,381**

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