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BlueCard[®] PPO Plan Benefits

Nidec Motor Corporation

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56365, 66464, 72449, 74051, 74052,
74053, 74054, 75940, 75941, 75943,
80298, 90629, 94709, 94711, 94713,
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BlueCard[®] PPO

Effective January 01, 2024



**BlueCross BlueShield
of Alabama**

An Independent Licensee of the Blue Cross and Blue Shield Association

Nidec Motor Corporation
BlueCard® PPO
Effective January 01, 2024

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
<i>Benefit payments are based on the amount of the provider's charge that Blue Cross and/or Blue Shield plans recognize for payment of benefits. The allowed amount may vary depending upon the type provider and where services are received.</i>		
SUMMARY OF COST SHARING PROVISIONS (Includes Mental Health Disorders and Substance Abuse)		
Calendar year deductibles and out-of-pocket maximums will be calculated in accordance with applicable Federal law.		
Calendar Year Deductible The in-network and out-of-network calendar year deductibles are separate and do not apply to each other	\$1,200 individual; \$2,400 family	\$2,400 individual; \$4,800 family Does not include the in-network deductible.
Calendar Year Out-of-Pocket Maximum After you reach your individual Calendar Year Out-of-Pocket Maximum, applicable expenses for you will be covered at 100% of the allowed amount for remainder of calendar year	\$5,450 individual; \$12,800 family All deductibles, copays and coinsurance for in-network services and out-of-network mental health disorders and substance abuse emergency services apply to the out-of-pocket maximum, including prescription drugs.	There is no out-of-pocket maximum for out-of-network services.
INPATIENT HOSPITAL AND PHYSICIAN BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
All hospital admissions require preadmission certification, except maternity admissions as required by Federal law. Emergency admissions require certification within 48 hours of admission except as required by Federal law. For preadmission certification, call 1-800-248-2342. If preadmission certification is not obtained, a \$500 penalty is charged.		
Inpatient Hospital (including maternity) and Residential Treatment Facilities	Covered at 80% of the allowed amount, after \$250.00 hospital copay and subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries	Covered at 50% of the allowed amount, after \$250.00 hospital copay subject to calendar year deductible for semi-private room and board, intensive care units, general nursing services and usual hospital ancillaries
Inpatient Physician Visits and Consultations	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
OUTPATIENT HOSPITAL BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList please see your benefit booklet. If precertification is not obtained, no benefits are available.		
Outpatient Surgery	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Emergency Room (Medical Emergency)	Covered at 80% of the allowed amount, after \$200.00 per visit copay (copay waived if admitted) and subject to calendar year deductible. (50% if medical emergency criteria is not met)	Covered at 80% of the allowed amount, after \$200.00 per visit copay (copay waived if admitted) and subject to in-network calendar year deductible. (50% if medical emergency criteria is not met) Out-of-network Mental Health and Substance Abuse services apply to the in-network out-of-pocket maximum
Emergency Room (Accident)	Covered at 80% of the allowed amount, after \$200.00 per visit copay (copay waived if admitted) and subject to calendar year deductible	Covered at 80% of the allowed amount, after \$200.00 per visit copay (copay waived if admitted) and subject to in-network calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Emergency Room (Physician)	Covered at 80% of the allowance subject to the in-network calendar year deductible. (50% if medical emergency criteria is not met).	Covered at 80% of the allowance subject to the in-network calendar year deductible. (50% if medical emergency criteria is not met). Out-of-network Mental Health and Substance Abuse services apply to the in-network out-of-pocket maximum
Chemotherapy, Dialysis, IV Therapy, Outpatient Diagnostic Lab, Pathology, Radiation Therapy & X-ray	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Intensive Outpatient Services and Partial Hospitalization for Mental Health Disorders and Substance Abuse Services Note: Preadmission Certification is required. Call 1-800-248-2342	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

**PHYSICIAN BENEFITS
(Includes Mental Health Disorders and Substance Abuse)**

Precertification is required for some provider-administered drugs; visit AlabamaBlue.com/ProviderAdministeredPrecertificationDrugList please see your benefit booklet. If precertification is not obtained, no benefits are available.

Office Visits and Consultations Includes: > diagnosis for obesity	Covered at 100% of the allowance after \$30.00 copay, no deductible with general practitioner, family practitioner, internist, OB/GYN, pediatrician, nurse practitioner, physician's assistant under the direction of above listed providers	Covered at 50% of the allowed amount, subject to calendar year deductible
Office Visits and Consultations-Specialist Includes: > diagnosis for obesity	Covered at 100% of the allowed amount, after \$50.00 specialist physician copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Urgent Care Clinic	Covered at 100% of the allowed amount, after \$50.00 copay	Covered at 50% of the allowed amount, subject to calendar year deductible
Second Surgical Opinions	Covered at 100% of the allowed amount, no copay or deductible	Covered at 100% of the allowed amount, no copay or deductible
Surgery & Anesthesia	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Maternity Care (Includes Dependents)	Covered at 80% of the allowed amount, subject to calendar year deductible (100% no deductible or copay for routine prenatal services)	Covered at 50% of the allowed amount, subject to calendar year deductible
Chemotherapy, Diagnostic Lab, Dialysis, IV Therapy, Pathology, Radiation Therapy & X-ray	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Applied Behavioral Analysis (ABA) Therapy Note: Preadmission Certification is required. Call 1-800-248-2342	Covered at 100% of the allowance after \$30.00 copay, no deductible for Behavioral Therapy services	Covered at 50% of the allowed amount, subject to calendar year deductible

TELEHEALTH SERVICES

Benefits are provided for Telehealth Services subject to applicable cost-sharing for in-network and out-of-network services, when services rendered are performed within the scope of the health care providers license and deemed medically necessary.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Routine Immunizations and Preventive Services <ul style="list-style-type: none"> See AlabamaBlue.com/PreventiveServices for a listing of immunizations and preventive services or call our Customer Service Department for a printed copy 	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Additional Routine Services <ul style="list-style-type: none"> Urinalysis – limited to one per calendar year Complete Blood Count (CBC) – limited to one per calendar year Cholesterol – limited to one each per calendar year (Includes cholesterol, HDL, LDL, VLDL & Triglycerides) Blood Glucose and Hemoglobin A1C – limited to one each per calendar year 	Covered at 100% of the allowed amount, no copay or deductible	Not Covered
Note: In some cases, office visit copays or facility copays may apply. Blue Cross and Blue Shield of Alabama will process these claims as required by Section 1557 of the Affordable Care Act.		
PRESCRIPTION DRUG BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Prescription Drugs are not administered by Blue Cross and Blue Shield of Alabama.		
BENEFITS FOR OTHER COVERED SERVICES (Includes Mental Health Disorders and Substance Abuse)		
Allergy Testing & Treatment	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Ambulance Service	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 80% of the allowed amount, subject to calendar year deductible
Participating Chiropractic Services Limited to 13 visits per person each calendar year and then subject to medical review	Covered at 80% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Acupuncture	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Biofeedback	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Durable Medical Equipment (DME), Oxygen, Orthotics, Prosthetics and Medical Supplies	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Rehabilitative and Habilitative Physical, Speech and Occupational Therapy	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Occupational, Physical and Speech Therapy for Autism Spectrum Disorders (age and visit limits do not apply) Note: This plan follows the State of Utah's EHB benefits package	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
Hospice Precertification is required. Call 1-800-821-7231. Services must be authorized by physician	Covered at 80% of the allowed amount, no copay or deductible	Covered at 50% of the allowed amount, no copay or deductible
Home Health Precertification is required. Call 1-800-821-7231.	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Home Infusion Precertification is required. Call 1-800-821-7231.	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Skilled Nursing Facility Precertification is required. Call 1-800-821-7231.	Covered at 80% of the allowed amount, subject to calendar year deductible	Covered at 50% of the allowed amount, subject to calendar year deductible
Medical Nutrition Therapy Services For adults and children, limited to 6 hours per member per calendar year	Covered at 100% of the allowed amount, after \$30.00 copay	Covered at 50% of the allowed amount, subject to calendar year deductible
HEALTH MANAGEMENT BENEFITS (Includes Mental Health Disorders and Substance Abuse)		
Individual Case Management	Coordinates care in event of catastrophic or lengthy illness or injury. For more information, please call 1-800-821-7231.	
Chronic Condition Management	Coordinates care for chronic conditions such as asthma, diabetes, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease and other specialized conditions.	
Baby Yourself®	A maternity program; For more information, please call 1-800-222-4379. You can also enroll online at AlabamaBlue.com/BabyYourself .	
Contraceptive Management	Covers contraceptive methods and counseling. FDA approved contraceptive devices are covered under the Preventive Care Services benefits.	

Useful Information to Maximize Benefits

- To maximize your benefits, always use in-network providers for services covered by your health benefit plan. To find in-network providers, check a provider directory, provider finder website (AlabamaBlue.com) or call 1-800-810-BLUE (2583).
- In-network hospitals, physicians and other healthcare providers have a contract with a Blue Cross and/or Blue Shield Plan for furnishing healthcare services at a reduced price (examples: BlueCard® PPO, PMD). In Alabama, in-network services provided by mental health disorders and substance abuse professionals are available through the Blue Choice Behavioral Health Network. Sometimes an in-network provider may furnish a service to you that is not covered under the contract between the provider and a Blue Cross and/or Blue Shield Plan. When this happens, benefits may be denied or reduced. Please refer to your benefit booklet for the type of provider network that we determine to be an in-network provider for a particular service or supply.
- Out-of-network providers generally do not contract with Blue Cross and/or Blue Shield Plans. If you use out-of-network providers, you may be responsible for filing your own claims and paying the difference between the provider's charge and the allowed amount. The allowed amount may be based on the negotiated rate payable to in-network providers in the same area, the average charge for care in the area or in accordance with applicable Federal law.
- Please be aware that providers/specialists may be listed in a PPO directory or provider finder website, but not covered under this benefit plan. Please check your benefit booklet for more detailed coverage information.
- Prime Therapeutics LLC® is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association.

This is not a contract, benefit booklet or Summary Plan Description. Benefits are subject to the terms, limitations, and conditions of the group contract (including your benefit booklet). Check your benefit booklet for more detailed coverage information. Please visit our website, AlabamaBlue.com.

Notice of Nondiscrimination

Blue Cross and Blue Shield of Alabama, an independent licensee of the Blue Cross and Blue Shield Association, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages

If you need these services, contact our 1557 Compliance Coordinator. If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, fax, or email at: Blue Cross and Blue Shield of Alabama, Compliance Office, 450 Riverchase Parkway East, Birmingham, Alabama 35244, Attn: 1557 Compliance Coordinator, 1-855-216-3144, 711 (TTY), 1-205-220-2984 (fax), 1557Grievance@bcbsal.org (email). If you need help filing a grievance, our 1557 Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Foreign Language Assistance

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-216-3144 (TTY: 711)

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-216-3144 (TTY: 711)번으로 전화해 주십시오.

Chinese: 注意: 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-855-216-3144 (TTY: 711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-216-3144 (TTY: 711).

Arabic: انتباه: إذا كنت تتحدث العربية، توجد خدمات مساعدة فيما يتعلق باللغة، بدون تكلفة، متاحة لك. اتصل بـ 1-855-216-3144 (الهاتف النصي: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-216-3144 (TTY: 711).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-216-3144 (ATS: 711).

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-216-3144 (TTY: 711).

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હોય, તો ભાષા સહાયતા સેવા, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-855-216-3144 પર કોલ કરો (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-216-3144 (TTY: 711).

Hindi: ध्यान दें: अगर आपकी भाषा हिंदी है, तो आपके लिए भाषा सहायता सेवाएँ नि:शुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें।

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-216-3144 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-216-3144 (телетайп: 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-216-3144 (TTY: 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-216-3144 (TTY: 711).

Turkish: DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardım hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-216-3144 (TTY: 711) irtibat numaralarını arayın.

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-216-3144 (TTY: 711).

Japanese: 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-855-216-3144 (TTY: 711) まで、お電話にてご連絡ください。