Nidec Motor Corporation # 75942

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 1-800-783-2197 or visit us at AlabamaBlue.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.bcbsal.org/sbcglossary/ or call 1-800-292-8868 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$600 / individual or $1,200 / family in-network. $1,200 / individual out-of-network.	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 services in-network 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 deductible for specific services.
What is the out–of–pocket limit for this plan?	For in-network $5,200 individual / $12,700 family. For out-of-network $13,275 individual.	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 limit 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, health care this plan doesn't cover, pre-certification penalties and specialty drug manufacturer assistance amounts for provider-administered drugs.	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 AlabamaBlue.com or call 1-800-810-BLUE 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	$35 copay/visit Deductible does not apply	40% coinsurance	Precertification is required for some provider administered drugs; if no precertification is obtained, no benefits are available
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No Charge Deductible does not apply	Not Covered	Please visit AlabamaBlue.com/PreventiveServices; additional services are available. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Benefits listed are physician services; facility benefits are also available; precertification may be required; if no precertification is obtained, no benefits are available
	Imaging (CT/PET scans, MRIs)	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 drugs to treat your illness or condition More information about prescription drug coverage is available at caremark.com or call 1-800-552-8159.	Tier 1 Drugs	$10 copay or 10% coinsurance (maximum of $40) (retail) $25 copay or 10% coinsurance (maximum of $100) (mail) Deductible does not apply	Not Covered	Pharmacy Coverage is provided by CVS Caremark. Certain drugs may require pre-authorization. In addition, you may be required to use a lower-cost drug(s) prior to benefits under your policy being available for certain prescribed drugs. Please note not all drugs are covered. You will need to obtain certain drugs, specialty medications, from a pharmacy designated by CVS Caremark. Preventive drugs based on the preventive drug list are covered at 100% of the allowed amount, no copay for each 30-day prescription. Drugs on the Pharma Copayment Assistance Program List are subject to the greater of the applicable tier copay or the full amount of the available manufacturer cost share assistance program payments.
	Tier 2 Drugs	$30 copay or 25% coinsurance (maximum of $100) (retail) $75 copay or 25% coinsurance (maximum of $250) (mail) Deductible does not apply	Not Covered	
	Tier 3 Drugs	$60 copay or 35% coinsurance (maximum of $400) (retail) $150 copay or 35% coinsurance maximum of $1,000) (mail) Deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Precertification may be required; if no precertification is obtained, no benefits are available
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	Accident: $200 copay/visit & 20% coinsurance Medical Emergency: $200 copay/visit & 20% coinsurance	Accident: $200 copay/visit & 20% coinsurance Medical Emergency: $200 copay/visit & 20% coinsurance	Physician charges will apply; subject to in-network overall deductible
	Emergency medical transportation	20% coinsurance	20% coinsurance	Subject to in-network overall deductible
	Urgent care	$35 copay/visit Deductible does not apply	40% coinsurance	None

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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	In Alabama, out-of-network benefits are only available for accidental injury and medical emergency; precertification is required; if no precertification is obtained, a $500 penalty will apply
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit Deductible does not apply	40% coinsurance	Benefits listed are physician services. Precertification is required for intensive outpatient, partial hospitalization and inpatient hospitalization; if no precertification is obtained, no benefits are available
	Inpatient services	20% coinsurance	40% coinsurance	
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); precertification may be required for some inpatient services; if no precertification is obtained, a $500 penalty will apply
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% 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	Precertification is required; if no precertification is obtained, no benefits are available; benefits are also available for home infusion services
	Rehabilitation services	20% coinsurance	40% coinsurance	Unlimited visits/year; includes occupational, physical and speech therapy; no age or visit limitations for members with an autistic diagnosis
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is required; if no precertification is obtained, no benefits are available
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification may be required; if no precertification is obtained, no benefits are available
	Hospice services	20% coinsurance	40% coinsurance	Precertification is required; if no precertification is obtained, no benefits are available; services must be authorized by a physician
If your child needs dental or eye care	Children's eye exam	Not covered except as required by Health Care Reform	Not Covered	Please visit AlabamaBlue.com/PreventiveServices
	Children's glasses	Not Covered	Not Covered	Not covered; member pays 100%
	Children's dental check-up	Not covered except as required by Health Care Reform	Not Covered	Please visit AlabamaBlue.com/PreventiveServices

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.)		
• Cosmetic surgery	• Hearing aids	• Routine eye care (Adult)
• Dental care (Adult)	• Long-term care	• Routine foot care
• Glasses, child	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery (only for morbid obesity in limited circumstances)	• Infertility treatment (Assisted Reproductive Technology not covered)	

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa or your plan administrator at the phone number listed in your benefit booklet. 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: Your plan administrator at the phone number listed in your benefit booklet. You may also contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa.

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 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.

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 AlabamaBlue.com.

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	$600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other copayment/coinsurance	$200/20%

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	$600
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,070**

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

The plan's overall deductible	$600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other copayment/coinsurance	$200/20%

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	$600
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$40
The total Joe would pay is	**$1,240**

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

The plan's overall deductible	$600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other copayment/coinsurance	$200/20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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

Language Assistance Services, Auxiliary Aids, Services and Notice of Nondiscrimination only apply to administrative services that Blue Cross and Blue Shield of Alabama provides to your employer.

Discrimination is Against the Law

Language Assistance Services, Auxiliary Aids Services and 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 (consistent with the scope of sex discrimination described in 45 CFR § 92.101(a)(2)). We do not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Alabama:

- Provides reasonable modifications and free appropriate auxiliary 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 assistance services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-216-3144 (TTY: 711) or call Customer Service.

Arabic: انتباه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر أيضًا المساعدات والخدمات الإضافية المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل بالرقم 1-855-216-3144. (الهاتف النصي: 711) أو الاتصال بخدمة العملاء

Chinese: 请注意：如果您说 普通话，我们可免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以易读格式向您提供信息。请拨打 1-855-216-3144（TTY 用户请拨 711）或致电客户服务部。

French: À NOTER : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1 855 216 3144 (TTY : 711) ou contactez le service client.

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglichen Formaten sind ebenfalls kostenlos erhältlich. Rufen Sie +1 855 216 3144 (Durchwahl: 711) oder den Kundendienst an.

Gujarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારા માટે નિઃશુલ્ક ભાષા સહાય સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પ્રદાન કરવા માટેની યોગ્ય સહાય અને સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 1-855-216-3144 (TTY: 711) પર અથવા ગ્રાહક સેવા પર કૉલ કરો.

Hindi: ध्यान दें: अगर आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। आसान प्रारूप में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-216-3144 (TTY: 711) पर कॉल करें या ग्राहक सेवा को कॉल करें।

Japanese: ご案内： 日本語を話される方には、無料の言語アシスタントサービスをご用意しております。アクセシブルな形式で情報を提供するため、補助器具や支援サービスも無料で提供しております。1-855-216-3144 (TTY: 711) もしくは、カスタマーサービスにお電話でお問合せください。

Korean: 주의: 한국어을(를) 하시면 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-855-216-3144(TTY: 711)로 전화하거나 고객 서비스에 문의하세요.

Lao: ເອົາໃຈໃສ່: ຖ້າເຈົ້າເວົ້າ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີແມ່ນມີໃຫ້ທ່ານ. ການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການທີ່ເໝາະສົມໃນການສະໜອງຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້ແມ່ນຍັງສາມາດໃຊ້ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-855-216-3144 (TTY: 711) ຫຼື ໂທຫາຝ່າຍບໍລິການລູກຄ້າ.

Portuguese: ATENÇÃO: Se você falar português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-855-216-3144 (TTY: 711) ou ligue para o Atendimento ao Cliente.

Russian: ВНИМАНИЕ. Если ваш язык русский язык, к вашим услугам бесплатная языковая помощь. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-216-3144 (TTY: 711) или обратитесь в службу поддержки клиентов.

Spanish: ATENCIÓN: Si usted habla español, hay disponibles servicios gratuitos de asistencia lingüística. También hay disponibles, de forma gratuita, ayudas y servicios auxiliares adecuados para dar información en formatos accesibles. Llame al 1-855-216-3144 (TTY: 711) o llame a Servicio al cliente.

Tagalog: ATTENTION: Kung nagsasalita ka ng Tagalog, available sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin ang naaangkop na mga pantulong na tulong at serbisyo nang walang bayad para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-216-3144 (TTY: 711) o tumawag sa Serbisyo sa Customer.

Turkish: DİKKAT Konuşmanız durumunda Türkçe, ücretsiz dil yardımı hizmetlerinden yararlanabilirsiniz. Erişilebilir formatlarda bilgi sağlamak için uygun yardımcı araçlar ve hizmetler de ücretsiz olarak sunulmaktadır. 1-855-216-3144 (TTY: 711) nolu telefonu veya Müşteri Hizmetlerini arayın.

Vietnamese: CHÚ Ý: Nếu quý vị nói tiếng việt thì dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Chúng tôi cũng có các hỗ trợ và dịch vụ phụ trợ miễn phí phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận. Vui lòng gọi số 1-855-216-3144 (TTY: 711) hoặc gọi Dịch Vụ Khách Hàng.