

# Medical Plan Highlights

## Blue Cross - Blue Shield – IL

Blue Cross - Blue Shield - IL	
<b>General Provisions</b>	
Web Site Address	<a href="http://www.bcbsa.com/">http://www.bcbsa.com/</a>
Find a Plan Doctor or Facility	<a href="http://www.bcbsa.com/">http://www.bcbsa.com/</a>
Health Plan Telephone Number	Call your local BCBS Plan. The number is located on the back of your ID Card.
<b>Annual Deductibles</b>	
You Only	None
You + 1	None
You + 2 or more	None
<b>Annual Out-Of-Pocket Limitation</b>	
Single Contract	<b>In Network:</b> None <b>Out-of-Network:</b> \$250
Multiple Party Contract	<b>In Network:</b> None <b>Out-of-Network:</b> \$500
<b>Hospital Services</b>	
Semi - Private Room and Board	<b>In-Network:</b> 365 days, renewable after 60 days (Predetermination Required) <b>Out-of-Network:</b> 365 days, renewable after 60 days (Predetermination Required) Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 2)
Surgery, Inpatient and Outpatient	<b>In-Network:</b> Covered <b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)
Physician Services	<b>In-Network:</b> Covered <b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)
Inpatient Physical Therapy	<b>In-Network:</b> Covered <b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)
Functional Occupational Therapy	<b>In-Network:</b> Covered <b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)
<b>Outpatient Services</b>	
Office Visits (Including Urgent Care)	<b>In-Network:</b> The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member co-pay <b>Out-of-Network:</b> Not Covered – Member may be responsible for the entire charge
Physical Exams	<b>In Network:</b> Not Covered <b>Out-of- Network:</b> Not Covered

## Medical Plan Highlights

### Blue Cross - Blue Shield – IL

<b>Well-Baby Care</b>	<p><b>In-Network:</b> Covered up to six (6) visits prior to age two (2)</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Immunizations</b>	<p><b>In-Network:</b> Covered per Centers for Disease Control guidelines available at <a href="http://www.cdc.gov/vaccines/">www.cdc.gov/vaccines/</a> Related office visit charge 100% co-pay</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Allergy Tests, Injections</b>	<p><b>In Network:</b> Tests and injections not covered, allergy serum covered under Prescription Drug Program</p> <p><b>Out-of-Network:</b> Tests and injections not covered; allergy serum covered under Prescription Drug Program</p>
<b>Diagnostic Lab</b>	<p><b>In-Network:</b> Covered</p> <p><b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)</p>
<b>Outpatient Physical Therapy</b>	<p><b>In-Network:</b> Services must be received through TheraMatrix: 1-888-638-8786 <a href="http://www.TheraMatrix.com">www.TheraMatrix.com</a> Outpatient physical, speech, and functional occupational therapy covered up to a combined limit of 60 treatments, per condition, per plan year</p> <p><b>Out of Network:</b> Not Covered</p>
<b>X-Ray &amp; Imaging</b>	<p><b>In-Network:</b> Covered</p> <p><b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)</p>
<b>Maternity Care</b>	
<b>Prenatal, Delivery and Postnatal</b>	<p><b>In-Network:</b> Covered</p> <p><b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)</p>
<b>Emergency Care</b>	
<b>Emergency Care</b>	<p><b>In-Network:</b> Covered</p> <p><b>Out-of-Network:</b> Covered</p>
<b>Ambulance</b>	
<b>Ambulance</b>	<p><b>In-Network:</b> Covered</p> <p><b>Out-of-Network:</b> Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services (See Footnote 1)</p>
<b>Extended Care Facilities</b>	
<b>Skilled Nursing Facility</b>	<p><b>In-Network:</b> 730 days, except psychiatric care 90 days, renewable after 60 days</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Home Health Care</b>	<p><b>In-Network:</b> 3 visits for each unused day of hospital care</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Private Duty Nursing</b>	Not Covered
<b>Psychiatric Care</b>	

## Medical Plan Highlights

### Blue Cross - Blue Shield – IL

<b>Hospital Services</b>	<p><b>In-Network:</b> Subject to the conditions of the Managed Care Program – 45 days, renewable after 60 days</p> <p><b>Out-of-Network:</b> Subject to the conditions of the Managed Care Program</p>
<b>Outpatient Services</b>	<p><b>In-Network:</b> Subject to the conditions of the Managed Care Program – 35 visits per plan year; Visits 1-20 covered; Visits 21-35 have a 25% co-pay</p> <p><b>Out of Network:</b> Subject to the conditions of the Managed Care Program</p>
<b>Substance Abuse</b>	
<b>Hospital Services</b>	<p><b>In-Network:</b> Subject to the conditions of the Managed Care Program – 45 days, renewable after 60 days</p> <p><b>Out-of-Network:</b> Subject to the conditions of the Managed Care Program</p>
<b>Outpatient Services</b>	<p><b>In-Network:</b> Subject to the conditions of the Managed Care Program – 35 visits per plan year to 140 visits lifetime maximum</p> <p><b>Out of Network:</b> Subject to the conditions of the Managed Care Program</p>
<b>Prescription Drugs</b>	<p><b>MAINTENANCE PRESCRIPTION DRUGS:</b> The first three fills may go through a retail pharmacy or Medco By Mail Program. Beginning with the fourth fill, you must go through the Medco By Mail Program or pay a penalty. (You will be charged the plan's full cost of the prescription drug)</p>
<b>Retail Pharmacies</b>	<p><b>In-Network:</b> \$5 generic/ \$11 brand name \$16 ED co-pay per prescription</p> <p><b>Out-of-Network:</b> 75% Covered after participating pharmacy co-pay</p> <p><b>NOTE:</b> Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program</p>
<b>Mail Order Program</b>	<p><b>In-Network:</b> \$10 co-pay per generic, \$16 co-pay per brand-name and \$20 co-pay for ED drugs up to a 90-day supply</p> <p><b>Out-of-Network:</b> Not covered</p> <p><b>NOTE:</b> Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program</p>
<b>Hearing Care</b>	Blue Cross Blue Shield (BCBS) – use the phone number on the back of your BCBS card
<b>Audiometric Examination</b>	<p><b>In-Network:</b> Covered according to plan guidelines at a participating provider</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Hearing Aid</b>	<p><b>In-Network:</b> Covered according to plan guidelines at a participating provider</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Frequency Limitation</b>	<p><b>In-Network:</b> Hearing Aid – 36 months must have elapsed between services</p> <p><b>Out-of-Network:</b> Not Covered</p>
<b>Vision Care</b>	
<b>Vision Care Contact Information</b>	SVS, Inc. 1-800-225-3095 <a href="http://www.svsvision.com">www.svsvision.com</a>
<b>Examination</b>	Contact SVS
<b>Lenses and Frames</b>	Contact SVS
<b>Contact Lenses</b>	Contact SVS
<b>Foot And Ankle Care</b>	

## Medical Plan Highlights

### Blue Cross - Blue Shield – IL

<b>Foot and Ankle Care – Outpatient Services</b>	Contact your plan for details on covered services
<b>Other Services</b>	
<b>Durable Medical Equipment</b>	<p><b>In-Network:</b> Covered through the SUPPORT Program (1-800-831-0999)</p> <p><b>Out-of-Network:</b> Covered with a 20% member co-insurance on Maximum Payment Allowed (See footnote 3)</p>
<b>Prosthetic and Orthotic Appliances</b>	<p><b>In-Network:</b> Covered through the SUPPORT Program (1-800-831-0999)</p> <p><b>Out-of-Network:</b> Covered with a 20% member co-insurance on Maximum Payment Allowed (See footnote 3)</p>
<b>Notes</b>	
<b>Ford Hourly Disclaimer</b>	<p>The health care benefits summary contains an explanation of Medical and/or Dental benefits based on the documents, policies and negotiated Agreements through which these benefits are provided. If there are any differences between the Plan texts and this Summary, the Plan texts and negotiated Agreements will always govern.</p> <p>The health care benefits summary is a summary of basic benefits of the coverage options which may be available to you. Benefit policies, limitations and exclusions vary from plan to plan. If you or your eligible dependent(s) have specific medical needs, it is important that you check with the plan you are considering to find out how these needs will be met.</p> <p>The company reserves the right to end, suspend or amend Plans, subject to the applicable Collective Bargaining Agreement. Agreements also will be made to simply with applicable statues and regulations. If changes are made, you will be notified.</p> <p>Each Health Maintenance Organization and Preferred Provider Organization will provide you with a full description of coverage upon request. Contact the plan to obtain more detailed information about their benefits, policies, limitations and exclusions; a listing of hospitals, pharmacies and other providers who participate with the plan; and any specific health concern you may have for yourself or your eligible dependent(s). For further information about the Traditional/Indemnity Plan, refer to "Your Employee Benefits" handbook. January 2010</p>
<b>Footnote 1</b>	For Non-Medicare claims, if you receive covered health care services from a non-panel PPO provider (an out-of-network provider), you will be required to pay an additional 10% co-insurance for those covered services- up to \$250 per single party or \$500 per multiple party each calendar year. In addition, you will be responsible for any charges above the BCBS maximum allowed amount for these services. For covered services that Medicare pays first, these services are not subject to the 10% member co-insurance for out-of-network services and will be processed the same as in-network.
<b>Footnote 2</b>	Services at non-panel, participating hospital are covered with a 10% member co-insurance on the Maximum Amount Allowed by BCBS for these services. The Maximum Payment is \$250 per day at a non-panel, non-participating hospital.
<b>Footnote 3</b>	You will be responsible for the remaining 20% of the Maximum Payment up to the annual \$500 out-of-pocket maximum applicable to the SUPPORT Program. This 20% does not apply to the \$250 single party or \$500 multiple party annual out-of-pocket maximum applicable to the National PPO Plan (BCBS). In addition, you will be responsible for any additional charges above the BCBS Maximum Amount Allowed.