

Medical Plan Highlights

Blue Cross - Blue Shield - IN

General Provisions	
Web Site Address	http://www.bcbsa.com/
Find a Plan Doctor or Facility	http://www.bcbsa.com/
Health Plan Telephone Number	Call your local BCBS Plan. The number is located on the back of your ID Card.
Annual Deductibles	
You Only	None
You + 1	None
You +2 or more	None
Annual Out-Of-Pocket Limitation	
Single Contract	In Network: None Out-of-Network: \$250
Multiple Party Contract	In Network: None Out-of-Network: \$500
Hospital Services	
Semi - Private Room and Board	In-Network: 365 days, renewable after 60 days (Predetermination Required) Out-of-Network: 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	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Physician Services	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Inpatient Physical Therapy	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Functional Occupational Therapy	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Outpatient Services	
Office Visits	In-Network: Covered with a \$20 Copayment. Out-of-Network: Not Covered - Member may be responsible for the entire charge.
Urgent Care	In-Network: Covered with a \$50 Copayment. Out-of-Network: Not Covered - Member may be responsible for the entire charge.
Well-Baby Care	In-Network: Covered up to six (6) visits prior to age two (2) Out-of-Network: Not covered
Immunizations	In-Network: Covered per Centers for Disease Control guidelines available at: www.cdc.gov/nip/ Related office visit charge of \$20 co-payment may apply Out-of-Network: Not covered In compliance with the Patient Protection and Affordable Care Act (PPACA), preventive immunizations are available for free effective January 1, 2012.

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Allergy Tests, Injections	In Network: Tests and injections not covered, allergy serum covered under Prescription Drug Program Out-of-Network: Tests and injections not covered; allergy serum covered under Prescription Drug Program
Diagnostic Lab	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Outpatient Physical Therapy	In-Network: Physical Therapy Services must be received through TheraMatrix 888-638-8786 / www.TheraMatrix .com Outpatient physical therapy covered up to a combined limit of 60 treatments, per condition, per plan year; Out of Network: Not Covered If participating provider not within a 25 mile radius of your home, contact TheraMatrix prior to services being rendered to establish arrangements with a physical therapy provider in your area
X-Ray & Imaging	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Maternity Care	
Prenatal, Delivery and Postnatal	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Emergency Care	
Emergency Care	Since the Ford health plan provides benefits for emergency services, the plan: <ul style="list-style-type: none"> • may not require preauthorization, including for emergency services provided out-of-network; • must provide coverage regardless of whether the provider is in- or out-of-network; • may not impose any administrative requirement or coverage limitation that is more restrictive than would be imposed on in-network emergency services; and • must comply with certain cost-sharing requirements. Consequently, both In-Network and Out of Network Emergency services are covered, with a \$100 co-payment per visit. Any applicable co-payment will be waived if the member is admitted to the hospital. Out-of-Network charges must be paid in accord with ACA requirements. While out of Network providers are permitted to balance bill if their charges exceed amounts paid by the Plan, the will defend its payment to the limits provided by the law. Any applicable Emergency Room co-payment is also waived if an employee is sent to an Emergency Room from work in an ambulance by company medical (whether the employee is admitted or not). Under the ACA, an emergency medical condition is one that is evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs, or parts.
Ambulance	
Ambulance	In-Network: Covered Out-of-Network: Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See Footnote 1)
Extended Care Facilities	
Skilled Nursing Facility	PreAuthorization Required In-Network: Covered 730 days, except psychiatric care 365 days renewable after 60 days Out-of-Network: Not Covered
Home Health Care	In-Network: 3 visits for each unused day of hospital care Out-of-Network: Not Covered
Private Duty Nursing	Not Covered

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Psychiatric Care	
Hospital Services	PreAuthorization Required In-Network: Covered Subject to the conditions of the Managed Care Program - 365 days renewable after 60 days. Out-of-Network: Subject to the conditions of the Managed Care Program. Subject to 10% coinsurance.
Outpatient Services	In-Network: Covered Subject to the conditions of the Managed Care Program unlimited visits per plan year. Out of Network: Subject to the conditions of the Managed Care Program Subject to 10% coinsurance.
Substance Abuse	
Hospital Services	PreAuthorization Required In-Network: Covered Subject to the conditions of the Managed Care Program - 365 days renewable after 60 days. Out-of-Network: Subject to the conditions of the Managed Care Program. Subject to 10% coinsurance.
Outpatient Services	In-Network: Covered Subject to the conditions of the Managed Care Program unlimited visits Out of Network: Subject to the conditions of the Managed Care Program Subject to 10% coinsurance.
Prescription Drugs MAINTENANCE PRESCRIPTION DRUGS: 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.)	
Retail Pharmacies	In-Network: \$5 generic/\$11 brand name \$16 ED copay per prescription. Out-of-Network: 75% Covered after participating pharmacy copay. NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program In compliance with the Patient Protection and Affordable Care Act (PPACA), preventive drugs are available for free effective January 1, 2012.
Mail Order Program	In-Network: \$10 copay per generic, \$16 copay per brand-name and \$20 copay for ED drugs up to a 90-day supply. Out-of-Network: Not covered NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program In compliance with the Patient Protection and Affordable Care Act (PPACA), preventive drugs are available for free effective January 1, 2012.
Pharmacy Footnote	Legacy Temporary Part-Time members (hired prior to 11/19/2007) are eligible for hospital, surgical and medical coverage (excluding prescription drug, hearing and vision).
Hearing Care Blue Cross Blue Shield(BCBS) - use the phone number on the back of your BCBS card.	
Audiometric Examination	In-Network: Covered according to plan guidelines at a participating provider Out-of-Network: Not Covered
Hearing Aid	In-Network: Covered according to plan guidelines at a participating provider Out-of-Network: Not Covered
Frequency Limitation	In-Network: Hearing Aid - 36 months must have elapsed between services Out-of-Network: Not Covered
Vision Care	
Vision Care Contact Information	SVS, Inc. 800-225-3095, www.svsvision.com
Examination	Contact SVS, Inc.
Lenses and Frames	Contact SVS, Inc.
Contact Lenses	Contact SVS, Inc.

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Foot And Ankle Care	
Foot and Ankle Care – Outpatient Services	Contact your plan for details on covered services.
Other Services	
Durable Medical Equipment	In-Network: Covered through the SUPPORT Program (800-831-0999) Out-of-Network: Covered with a 20% member co-insurance on Maximum Payment Allowed. (See footnote 3)
Prosthetic and Orthotic Appliances	In-Network: Covered through the SUPPORT Program (800-831-0999) Out-of-Network: Covered with a 20% member co-insurance on Maximum Payment Allowed. (See footnote 3)
Chiropractic Coverage	Limited Chiropractic Coverage contact plan for details
Notes	
Ford Hourly Disclaimer	<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. 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 you eligible dependent(s). For further information about the Traditional/Indemnity Plan, refer to "Your Employee Benefits" handbook. January 2010</p>
Footnote 1	Footnote 1: 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.
Footnote 2	Footnote 2: 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.
Footnote 3	Footnote 3: 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.