



Ford Hourly Medical Plan
National PPO (BCBS) New Entry Level

Web Site Address	www.bluecares.com/healthtravel/finder.html
Find a Plan Doctor or Facility	Members should utilize the PPO provider network. Go to http://www.bcbs.com/healthtravel/finder.html for participating provider information
Health Plan Telephone Number	Call your local BCBS Plan. The number is located on the back of your ID Card.
Disclaimer	The benefits summary contains an explanation of Medical benefits based on the Plan documents, policies and Negotiated Agreements. Any differences between the Plan texts and this summary, the Plan texts and Negotiated Agreements will always govern.
MONTHLY CONTRIBUTIONS	
Single Contract	None
Multiple Party Contract	None
ANNUAL DEDUCTIBLES	
Single Contract	In-Network: \$300 Out-of-Network: \$1,200
Multiple Party Contract (Family)	In-Network: \$600 Out-of-Network: \$2,100
ANNUAL OUT-OF-POCKET LIMITATION	
Single Contract	In-Network: \$1,000 (deductible & In-Network co-insurance applies) Out-of-Network: No annual maximum
Multiple Party Contract (Family)	In-Network: \$2,000 (deductible & In-Network co-insurance applies) Out-of-Network: No annual maximum
HOSPITAL SERVICES	
Semi - Private Room and Board	In-Network: 365 days, renewable after 60 days (Predetermination Required) After the deductible, 10% member co-insurance Out-of-Network: 365 days, renewable after 60 days (Predetermination Required) After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
Surgery, Inpatient and Outpatient	In-Network: After the deductible, 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
Physician Services	In-Network: The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member co-pay (co-pay does not apply to the deductible). Out-of-Network: Not Covered - Member may be responsible for the entire charge.
Inpatient Physical Therapy	In-Network: The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member co-pay. Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
Functional Occupational Therapy	In-Network: After the deductible, 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
OUTPATIENT SERVICES	
Office Visits (Including Urgent Care)	In-Network: The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member co-pay (co-pay does not apply to the deductible). Out-of-Network: Not Covered - Member may be responsible for the entire charge.
Physical Exams	Not Covered
Well-Baby Care	In-Network: Covered up to six (6) visits prior to age two (2) Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS.
Immunizations	In-Network: Covered per Centers for Disease Control guidelines available at: www.cdc.gov/nip/ Related office visit charge 100% co-pay (co-pay does not apply to the deductible). Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS.
Allergy Tests, Injections	Tests and injections not covered, allergy serum covered under Prescription Drug Program
Diagnostic Lab	In-Network: After the deductible, 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
Outpatient Physical Therapy	In-Network: Effective 3/1/09 - Services must be received through TheraMatrix 888-638-8786; www.TheraMatrix.com Outpatient physical, speech, and functional occupational therapy covered up to a combined limit of 60 treatments, per condition, per plan year (deductible and co-insurance do not apply). Out-of-Network: Not Covered
X-Ray & Imaging	In-Network: After the deductible, 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
MATERNITY CARE	
Prenatal, Delivery and Postnatal	In-Network: After the deductible, 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.
EMERGENCY CARE	
Emergency Care	Covered under certain conditions
AMBULANCE	
Ambulance	In-Network: After the deductible, covered for emergencies with a 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these services.

EXTENDED CARE FACILITIES	
Skilled Nursing Facility	In-Network: After the deductible, 10% member co-insurance; 730 days, except psychiatric care 90 days, renewable after 60 days Out-of-Network: Not Covered
Home Health Care	In-Network: After the deductible, 10% member co-insurance; 3 visits for each unused day of hospital care Out-of-Network: Not Covered
Private Duty Nursing	Not covered
PSYCHIATRIC CARE	
Hospital Services	In-Network: Subject to the conditions of the Managed Care Program - 45 days, renewable after 60 days. Out-of-Network: Subject to the conditions of the Managed Care Program.
Outpatient Services	In-Network: Subject to the conditions of the Managed Care Program 35 visits per plan year; Visits 1-20 covered; Visits 21-35 have a 25% copay. Out-of-Network: Subject to the conditions of the Managed Care Program.
SUBSTANCE ABUSE	
Hospital Services	In-Network: Subject to the conditions of the Managed Care Program - 45 days, renewable after 60 days. Out-of-Network: Subject to the conditions of the Managed Care Program.
Outpatient Services	In-Network: Subject to the conditions of the Managed Care Program 35 visits per plan year to 140 visits lifetime maximum. Out-of-Network: Subject to the conditions of the Managed Care Program.
PRESCRIPTION DRUGS	
Retail Pharmacies	In-Network: \$7.50 generic/\$15 brand name co-pay per prescription. NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs are covered only through Home Delivery Program, following the original prescription and two refills at retail. Out-of-Network: 75% Covered after participating pharmacy co-pay. NOTE: Mandatory generic substitute applies.
Mail Order Program	In-Network: \$7.50 generic/\$15 brand name co-pay per prescription. NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs are covered only through Home Delivery Program, following the original prescription and two refills at retail. Out-of-Network: Not Covered
HEARING CARE	
Audiometric Examination	Covered at participating providers
Hearing Aid	Covered at participating providers
Frequency Limitation	36 months
VISION CARE	
Vision Care Contact Information	SVS, Inc. 800-225-3095, www.svsvision.com
Examination	Eligible for annual eye exam only the first month after 3 years of seniority. Contact SVS, Inc.
Lenses and Frames	Eligible for full vision coverage the first month after 5 years of seniority. Contact SVS, Inc.
Contact Lenses	Eligible for full vision coverage the first month after 5 years of seniority. Contact SVS, Inc.
FOOT AND ANKLE CARE	
Foot and Ankle Care - Outpatient Services	In-Network: After the deductible, 10% member co-insurance Out-of-Network: After the deductible, covered with a 35% member co-insurance on Maximum Amount Allowed by BCBS for these 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.
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.
Health Education & Special Programs	Contact your plan for information
SPECIAL SITUATIONS	
When Enrolled in Medicare	Plan coordinates with Medicare