



Ford Hourly Medical Plan

National PPO Plan (BCBS) - 2008 - Active Employees and Protected Retirees

WEB SITE ADDRESS	http://www.bluecares.com/healthtravelfinder.html	
HEALTH PLAN TELEPHONE NUMBER	Call your local BCBS Plan. The number is located on the back of your ID Card.	
ANNUAL DEDUCTIBLES	In Network	Out-of-Network
Single Person Contract	None	None
Multiple Party Contract	None	None
ANNUAL OUT-OF-POCKET LIMITATION	In Network	Out-of-Network
Single Person Contract	None	\$250 (see footnote 1)
Multiple Party Contract	None	\$500 (see footnote 1)
HOSPITAL SERVICES	In Network	Out-of-Network
Semi - Private Room and Board	365 days, renewable after 60 days (Predetermination Required)	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 Out patient	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
Physician Services	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
Inpatient Physical Therapy	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
Functional Occupational Therapy	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
OUTPATIENT SERVICES	In Network	Out-of-Network
Office Visits	The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member copay.	Not Covered - Member may be responsible for the entire charge.
Physical Exams	Not Covered	Not Covered
Well-Baby Care	Covered up to six (6) visits prior to age two (2)	Not Covered
Immunizations	Covered per Centers for Disease Control guidelines. Related office visit charge 100% copay	Not Covered
Allergy Tests, Injections	Tests and injections not covered, allergy serum covered under Prescription Drug Program with a \$5 copay	Tests and injections not covered, allergy serum covered under Prescription Drug Program
Diagnostic Lab	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
Outpatient Physical Therapy	60 Treatments per condition per calendar year.	60 treatments per condition per calendar year. Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
X-Ray	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
MATERNITY CARE	In Network	Out-of-Network
Prenatal, Delivery and Postnatal	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
EMERGENCY CARE	In Network	Out-of-Network
In- Plan Area	Covered	Covered
Out-of- Plan Area	Covered	Covered
AMBULANCE	In Network	Out-of-Network
Ambulance	Covered	Covered with a 10% member co-insurance on Maximum Payment Allowed by BCBS for these services. (See footnote 1)
EXTENDED CARE FACILITIES	In Network	Out-of-Network
Skilled Nursing Facility	730 days, except psychiatric care 90 days, renewable after 60 days	Not Covered
Home Health Care	3 visits for each unused day of hospital care	Not Covered
Home Health Aides	Covered under certain conditions	Not Covered
Private Duty Nursing	Not Covered	Not Covered
PSYCHIATRIC CARE	In Network	Out-of-Network
Hospital Services	Active Employees: subject to the conditions of the Managed Care Program - 45 days, renewable after 60 days. Retirees: 45 days, renewable after 60 days.	Active Employees: subject to the conditions of the Managed Care Program. Retirees (see footnote 2)
Outpatient Services	Active Employees: 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. Retirees: Non-Medicare - 20 visit maximum per calendar year; Medicare - 40 visits maximum per calendar year. Copay for Visits: 1-5 visits covered; 6-10 visits 10% member copay; Additional visits 25% member copay.	Active Employees: subject to the conditions of the Managed Care Program. Retirees: Non Medicare - Covered with same as in-network with an additional 10% co-insurance. Medicare - Covered the same as in-network with no additional co-insurance.
SUBSTANCE ABUSE	In Network	Out-of-Network
Hospital Services	Active Employees: subject to the conditions of the Managed Care Program - 45 days, renewable after 60 days. Retirees: 45 days, renewable after 60 days.	Active Employees: subject to the conditions of the Managed Care Program. Retirees: Not Covered
Outpatient Services	Active Employees - subject to the conditions of the Managed Care Program 35 visits per plan year to 140 visits lifetime maximum. Retirees: 35 visits per plan year to 140 visits lifetime maximum.	Active Employees - subject to the conditions of the Managed Care Program Retirees: Not Covered

PRESCRIPTION DRUGS	In Network	Out-of-Network
Retail Pharmacy	Active: \$5 copay, per generic prescription and \$11 per brand-name prescription, \$16 copay for ED drugs. Retiree: \$5 copay, per generic prescription and \$10 per brand-name prescription, NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program, following original prescription and two refills (See Footnote 4)	75% covered after participating pharmacy copay. NOTE: Mandatory generic substitute applies. (See Footnote 5)
Mail Order Program	Active: \$10 copay, per prescription, up to a 90-day supply; \$15 per brand drug, \$19 copay for ED drugs. Retiree: \$2 copay, up to a 90-day supply. NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program, following original prescription and two refills. (See Footnote 6)	Not covered (See Footnote 7)
VISION CARE	In Network	Out-of-Network
Examination	Covered	Contact SVS, Inc.
Vision Care Contact Information	SVS, Inc. 800-225-3095, http://www.svsvision.com	SVS, Inc. 800-225-3095, http://www.svsvision.com
Lenses and Frames	Covered	Contact SVS, Inc.
Contact Lenses	Medically necessary: up to \$350 Not medically necessary: \$75 for lenses & \$40 for fit and follow-up	Contact SVS, Inc.
HEARING CARE	In Network	Out-of-Network
Audiometric Examination	Covered at participating providers	Not Covered
Hearing Aid	Covered at participating providers	Not Covered
Frequency Limitation	36 months	Not Covered
FOOT AND ANKLE CARE	In Network	Out-of-Network
Foot and Ankle Care - Outpatient Services	Contact your plan for details on covered services	Contact your plan for details on covered services
OTHER SERVICES	In Network	Out-of-Network
Durable Medical Equipment	Covered through the SUPPORT Program (800-831-0999)	Covered with a 20% member co-insurance on Maximum Payment Allowed. (See footnote 3)
Prosthetic and Orthotic Appliances	Covered through the SUPPORT Program (800-831-0999)	Covered with a 20% member co-insurance on Maximum Payment Allowed. (See footnote 3)
Health Education & Special Programs	Contact your plan for information	Contact your plan for information
SPECIAL SITUATIONS	In Network	Out-of-Network
When Enrolled in Medicare	Plan coordinates with Medicare	Plan coordinates with Medicare (See footnote 1)
Sponsored Dependent Coverage	Available at subscriber's expense	Available at subscriber's expense

FORD HOURLY DISCLAIMER

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.

This 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 those needs will be met.

The Company reserves the right to end, suspend or amend Plans, subject to the applicable Collective Bargaining Agreement. Amendments also will be made to comply with applicable statutes and regulations. If changes are made, you will be notified.

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 concerns you may have for yourself or your eligible dependent(s). For further information about the Traditional/Indemnity Plan, refer to "Your Employee Benefits" handbook or "Your Retiree Benefits" handbook.

January, 2008

Footnote 1: Out-of-Network - 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 the out-of-network out-of-pocket maximum (\$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: 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: 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.

Footnote 4: In-Network: A Surviving Spouse with a retirement date prior to 1/1/04 has a \$5 copay per prescription. NOTE: Mandatory generic substitute applies.

Footnote 5: Out-of-Network: A Surviving Spouse with a retirement date prior to 1/1/04 - 75% covered after participating pharmacy copay listed above. NOTE: Mandatory generic substitute applies.

Footnote 6: In-Network: A Surviving Spouse with a retirement date prior to 1/1/04 has a \$2 copay per prescription, up to a 90 day supply. NOTE: Mandatory generic substitute applies.

Footnote 7: Out-of-Network: A Surviving Spouse with a retirement date prior to 1/1/04 - Not covered.