



Ford Hourly Medical Plan

National PPO Plan (BCBS) - 2008 - Hourly Retiree (Modified Ford Retiree Plan) (See footnote 1)

GENERAL PROVISIONS		
WEB SITE ADDRESS	http://www.bluecares.com/healthtravel/finder.html	
HEALTH PLAN TELEPHONE NUMBER	Call your local BCBS Plan. The number is located on the back of your ID Card.	
MONTHLY CONTRIBUTION		
Single Person Contract	\$11	
Multiple Party Contract	\$22	
ANNUAL DEDUCTIBLES		
	In Network	Out-of-Network
Single Person Contract	\$159 (See footnote 2)	\$159 (See footnote 2)
Multiple Party Contract	\$318 (See footnote 2)	\$318 (See footnote 2)
ANNUAL OUT-OF-POCKET LIMITATION		
	In Network	Out-of-Network
Single Person Contract	\$265 (deductible and in network co-insurance applies) (See footnote 2)	\$530 (deductible and out-of-network co-insurance applies) (See footnote 2&3)
Multiple Party Contract	\$530 (deductible and in network co-insurance applies) (See footnote 2)	\$1,061 (deductible and out-of-network co-insurance applies) (See footnote 2&3)
HOSPITAL SERVICES		
	In Network	Out-of-Network
Semi - Private Room and Board	365 days, renewable after 60 days (Predetermination Required); after deductible, covered with a 10% member co-insurance (See footnote 5)	365 days, renewable after 60 days (Predetermination Required); After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 4)
Surgery, Inpatient and Outpatient	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
Physician Services	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
Inpatient Physical Therapy	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
Functional Occupational Therapy	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
OUTPATIENT SERVICES		
	In Network	Out-of-Network
Office Visits	The member is responsible only for the Maximum Amount Allowed by BCBS for these services -- 100% member co-insurance.	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% co-insurance.	Not Covered
Allergy Tests, Injections	Tests and injections not covered, allergy serum covered under Prescription Drug Program	Tests and injections not covered, allergy serum covered under Prescription Drug Program
Diagnostic Lab	After deductible, covered with a 10% member co-insurance (See footnote 5)	Non Panel Provider - After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
Outpatient Physical Therapy	After deductible, covered with a 10% member co-insurance; 60 Treatments per condition per calendar year. (See footnote 5)	Non Participating Provider - after deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. 60 Treatments per condition per calendar year. (See footnote 6)
X-Ray & Imaging	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
MATERNITY CARE		
	In Network	Out-of-Network
Prenatal, Delivery and Postnatal	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
EMERGENCY CARE		
	In Network	Out-of-Network
Emergency Care	\$53 unless admitted. (The \$53 does not apply to deductible or out-of-pocket maximum.)	\$53 unless admitted. (The \$53 does not apply to deductible or out-of-pocket maximum.)
AMBULANCE		
	In Network	Out-of-Network
Ambulance	After deductible, covered with a 10% member co-insurance (See footnote 5)	After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. (See footnote 6)
EXTENDED CARE FACILITIES		
	In Network	Out-of-Network
Skilled Nursing Facility	Participating Provider - 730 days, except psychiatric care 90 days, renewable after 60 days; after deductible, covered with a 10% member co-insurance (See footnote 5)	Non-Participating Provider - Not Covered
Home Health Care	Participating Provider - 3 visits for each unused day of hospital care; after deductible, covered with a 10% member co-insurance (See footnote 5)	Non-Participating Provider - Not Covered
Private Duty Nursing	Not covered	Not covered
PSYCHIATRIC CARE		
	In Network	Out-of-Network
Hospital Services	45 days, renewable after 60 days. (See footnote 9)	Covered with restrictions (See footnote 7 & 8)
Outpatient Services	Non-Medicare - 20 visit maximum per calendar year; Medicare - 40 visits maximum per calendar year. Copay for Visit: 1-5 visits covered; 6-10 visits 10% member copay; Additional visits - 25% member co-insurance (See footnote 8)	Non Medicare - Covered with same copay as in-network with an additional 10% member co-insurance sanction. Medicare - Covered services Medicare pays first are covered the same as in-network. (See footnote 8)
SUBSTANCE ABUSE		
	In Network	Out-of-Network
Hospital Services	45 days, renewable after 60 days. (See footnote 8)	Not Covered
Outpatient Services	35 visits per plan year to 140 visits lifetime maximum (See footnote 8)	Not Covered
PRESCRIPTION DRUGS		
	In Network	Out-of-Network
Retail Pharmacy	\$5 copay per generic prescription and \$11 per brand-name prescription \$16 copay for ED drugs. NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program, following original prescription and two refills.	75% covered after participating pharmacy copay. NOTE: Mandatory generic substitute applies. (See footnote 8)
Mail Order Program	\$7 copay per generic prescription, up to a 90-day supply; \$13 copay per brand name drug. \$19 copay for ED drugs. NOTE: Mandatory generic substitute applies. Maintenance/Long-Term drugs available only through Home Delivery Program, following original prescription and two refills. (See footnote 8)	Not Covered

VISION CARE	In Network	Out-of-Network
Examination	Contact SVS, Inc. (See footnote 8)	Contact SVS, Inc. (See footnote 8)
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	Contact SVS, Inc. (See footnote 8)	Contact SVS, Inc. (See footnote 8)
Contact Lenses	Medically necessary: up to \$350; Not medically necessary: \$75 for lenses & \$40 for fit and follow-up (See footnote 8)	Contact SVS, Inc. (See footnote 8)
HEARING CARE	In Network	Out-of-Network
Audiometric Examination	Covered at participating providers (See footnote 8)	Not Covered
Hearing Aid	Covered at participating providers (See footnote 8)	Not Covered
Frequency Limitation	36 months	Not Covered
FOOT AND ANKLE CARE	In Network	Out-of-Network
Foot and Ankle Care - Outpatient Services	After deductible 10% member co-insurance (See footnote 5)	Non Participating Provider - Non-Medicare - after deductible covered with a 30% member co-insurance sanction on the Maximum Amount Allowed. Covered services Medicare pays first are the same as in-network. (See footnote 5)
OTHER SERVICES	In Network	Out-of-Network
Durable Medical Equipment	Covered through the SUPPORT Program (800-831-0999) (See footnote 8)	Covered with a 20% member co-insurance on Maximum Payment Allowed. (See footnote 9)
Prosthetic and Orthotic Appliances	Covered through the SUPPORT Program (800-831-0999) (See footnote 8)	Covered with a 20% member co-insurance on Maximum Payment Allowed. (See footnote 9)
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 3)
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: This plan is available only to Hourly Retirees who have authorized a pension deduction to pay the required monthly contribution for health care coverage.

Footnote 2: Your annual deductibles, plus co-insurance shall count toward the annual out-of-pocket limitation. The maximum amount any one single party can contribute toward the multiple party deductible is the single deductible amount and any in-network co-insurance does not apply to the out-of-network out-of-pocket annual maximum. The following do not apply toward the deductible and out-of-pocket maximum: co-insurance or copays for Prescription Drugs, Office Visits, Emergency Care, Durable Medical Equipment, Prosthetics and Orthotics, Mental Health, Substance Abuse, Dental, Vision & Hearing. Additionally, your monthly contributions and any out-of-network exclusion amounts shall not count toward the deductible or out-of-pocket annual maximum.

Footnote 3: After the deductible has been met – Non-Medicare covered services received from a Non-Panel National PPO Provider will require a 30% co-insurance sanction up to the annual out-of-pocket out-of-network maximum. Then the plan pays 100% of the Maximum Amount Allowed. You will be responsible for any charges above the Maximum Amount Allowed. Covered services Medicare pays first are paid the same as in-network.

Footnote 4: After the annual deductible is met, services at a Non-Panel, Participating Hospital - Non Medicare - are covered with a 30% member co-insurance sanction on the Maximum Amount Allowed by BCBS for these services up to the out-of-pocket out-of-network annual maximum. Then the plan pays 100% of the Maximum Amount Allowed. The Maximum Amount Allowed (\$250 per day) is subject to the deductible, 30% co-insurance and out-of-network out-of-pocket annual maximum. Covered services Medicare pays first are paid the same as in-network.

Footnote 5: 1) First you pay for covered services until the annual deductible. The maximum amount any one single party can contribute toward the multiple party deductible is the single party deductible amount; 2) Then, you pay 10% until the in-network covered services reach the annual in-network out-of-pocket maximum; 3) Then the plan pays 100% to end of the calendar year.

Footnote 6: 1) First you pay for covered services until the annual deductible is met. The maximum amount any one single party can contribute toward the multiple party deductible is the single party deductible amount; 2) Then, you pay 30% until covered services reach the annual out-of-network out-of-pocket maximum; 3) Then the plan pays 100% to the end of the calendar year. All payments (including co-insurance) are based on the BCBS Maximum Amount Allowed.

Footnote 7: Services at Non-Panel, Participating Hospital Non-Medicare are covered with a 10% member co-insurance on the Maximum Amount Allowed by BCBS. Covered services Medicare pays first are paid the same as in network. Services at a Non Network Non-Participating Hospitals - Non-Medicare are covered with a 10% member co-insurance sanction on the Maximum Amount Allowed by BCBS (\$250 per day). Covered services Medicare pays first are paid the same as in-network.

Footnote 8: These services are covered under a separate program which has its own plan design and is not subject to the National PPO Modified Ford Plan's deductibles, co-insurance and out-of-pocket maximums.

Footnote 9: These services are covered under a separate program which has its own plan design and is not subject to the Modified Ford PPO Plan's deductible, co-insurance and out-of-pocket maximums. You will be responsible for the remaining 20% of the Maximum Allowed Amount up to the annual \$500 out-of-pocket limitation applicable to the SUPPORT Program. This 20% does not apply to the annual out-of-network out-of-pocket maximum limitation applicable to the PPO Plan.