

# Ford Motor Company Standard PPO | Choice PPO 2026 Benefits-at-a-Glance



		Standard PPO		Choice PPO	
		In-network	Out-of-network <sup>1</sup>	In-network	Out-of-network <sup>1</sup>
<b>Member's Responsibility (deductibles, coinsurance, and dollar maximums)</b>					
<b>Benefits</b>					
<b>Weekly Payroll Contribution</b>		Employee: \$20 Employee + Spouse: \$50 Employee + Children: \$40 Employee + Family: \$70		\$0 (None)	
<b>Deductibles</b> <i>In and out-of-network deductible is combined</i>		\$0 (None)		\$1,000 individual \$2,000 family	
<b>Coinsurance</b> <i>Member pays coinsurance amount until out-of-pocket maximum is reached.</i>  Some examples of services applicable to coinsurance include diagnostic services, surgical services, delivery services, physical therapy, and durable medical equipment. See the rest of this document for more details.		0%  (100% covered)	40%  (60% covered)	20% after deductible  (80% covered after deductible)	40% after deductible  (60% covered after deductible)
<b>Out-of-pocket maximums</b> Plan pays 100% after the out-of-pocket maximum expense is reached.		Not applicable	Individual: \$250 Family: \$500	Individual: \$2,000 Family: \$4,000	Unlimited
<b>Copays</b>  <i>Note: Copays do not accumulate toward plan deductibles or out-of-pocket maximums.</i>	<b>Primary Care Office Visits</b>	\$25 copay	40% after deductible	\$25 copay	40% after deductible
	<b>Specialist Office Visits</b>	\$35 copay	40% after deductible	\$35 copay	40% after deductible
	<b>Urgent Care</b>	\$50 copay	40% after deductible	\$50 copay	40% after deductible
	<b>Emergency Room Copay waived, if admitted</b>	\$150 copay	\$150 copay	\$150 copay	\$150 copay
	<b>Hospital Admission</b>	\$200 copay	40% after deductible	\$200 copay	40% after deductible
	<b>Prescription Drugs</b>	Copays outlined below	Not covered	Copays outlined below	Not covered

<b>Preventive Care Services (age, frequency and other restrictions may apply)</b>					
<b>Benefits</b>					
Health maintenance exam	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible	
Annual gynecological exam – <i>in addition to health maintenance exam</i>	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible	
Pap smear screening	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible	
Mammography screening – <i>includes 3D mammography</i>	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible	
Contraceptive methods and counseling	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible	
Prostate specific antigen (PSA) screening	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible	

<sup>1</sup> Covered services rendered by non-participating providers are subject to the out-of-network cost share. However, members may also be responsible for the balance of the bill.

	Standard PPO		Choice PPO	
	In-network	Out-of-network <sup>1</sup>	In-network	Out-of-network <sup>1</sup>
<b>Preventive Care Services (age, frequency and other restrictions may apply) - Continued</b>				
Endoscopic exams	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible
Well child care	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible
Immunizations – pediatric and adult	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible

<b>Physician Office Services</b>				
<b>Benefits</b>				
Primary care office visits <i>Includes online visits</i>	\$25 copay	60% Covered after deductible	\$25 Copay	60% Covered after deductible
Specialist office visits <i>Includes online visits</i>	\$35 copay	60% Covered after deductible	\$35 copay	60% Covered after deductible
Outpatient behavioral health services <i>Includes online visits</i>	\$25 copay	60% Covered after deductible	\$25 copay	60% Covered after deductible
Retail health visit	\$25 copay	60% Covered after deductible	\$25 copay	60% Covered after deductible
Virtual Care (formerly Blue Cross Online Visits) – download the app at <a href="http://bcbsm.com/virtualcare">bcbsm.com/virtualcare</a>	\$25 copay	60% Covered after deductible	\$25 Copay	60% Covered after deductible

<b>Emergency Medical Care</b>				
<b>Benefits</b>				
Emergency room <i>Not covered if not a qualified medical emergency Copay waived, if admitted</i>	\$150 copay	\$150 copay	\$150 copay	\$150 copay
Urgent care visits	\$50 copay	60% Covered after deductible	\$50 copay	60% Covered after deductible
Ambulance services	100% Covered	100% Covered	80% Covered after deductible	80% Covered after deductible

<b>Diagnostic Services</b>				
<b>Benefits</b>				
MRI, MRA, PET and CAT scans and nuclear medicine	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Diagnostic tests, x-rays, laboratory & pathology	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Radiation therapy	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Chemotherapy	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible

<b>Maternity Services</b>				
<b>Benefits</b>				
Prenatal care visits	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible
Postnatal care visits	100% Covered	60% Covered after deductible	100% Covered	60% Covered after deductible
Delivery and nursery care	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Infertility treatment <i>Provided to employee and spouse only; limited to a \$5,000 annual maximum per member per calendar year, prescription drugs included in annual max</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible

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<b>Hospital Care</b>				
<b>Benefits</b>				
Hospital admission <i>Preauthorization required</i>	\$200 copay per admission	60% Covered after deductible <i>Participating Providers Only</i>	\$200 copay per admission	60% Covered after deductible <i>Participating Providers Only</i>
Inpatient medical services (Professional services)	100% Covered	60% Covered after deductible <i>Participating Providers Only</i>	80% Covered after deductible	60% Covered after deductible <i>Participating Providers Only</i>

<b>Alternatives to Hospital Care</b>				
<b>Benefits</b>				
Hospice care	100% Covered	100% Covered <i>Participating Providers Only</i>	80% Covered after deductible	80% Covered after deductible <i>Participating Providers Only</i>
Home health care	100% Covered	100% Covered <i>Participating Providers Only</i>	80% Covered after deductible	80% Covered after deductible <i>Participating Providers Only</i>
Skilled nursing <i>Preauthorization required</i>	100% Covered	100% Covered <i>Participating Providers Only</i>	80% Covered after deductible	80% Covered after deductible <i>Participating Providers Only</i>
Private duty nursing care	Not covered	Not covered	Not covered	Not covered

<b>Surgical Services</b>				
<b>Benefits</b>				
Surgery	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Bariatric surgery	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Sterilization – males <i>excludes reversal sterilization</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Sterilization – females <i>excludes reversal sterilization</i>	100% Covered	60% Covered after deductible	Covered 100%	60% Covered after deductible

<b>Human Organ Transplants</b>				
<b>Benefits</b>				
Specified organ transplants – <i>contact the BCBSM Human Organ Transplant Program (800-242-3504)</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Kidney, cornea, bone marrow, and skin	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible

<b>Behavioral Health Services (Mental Health and Substance Use Disorder)</b>				
<b>Benefits</b>				
Inpatient mental health and substance use disorder treatment	100% Covered	60% Covered after deductible <i>Participating Providers Only</i>	80% Covered after deductible	60% Covered after deductible <i>Participating Providers Only</i>
Outpatient mental health and substance use disorder treatment <i>Includes online visits</i>	\$25 copay	60% Covered after deductible	\$25 copay	60% Covered after deductible

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	Standard PPO		Choice PPO	
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<b>Autism Spectrum Disorders (ASD)</b>				
<b>Benefits</b>				
Applied behavior analysis (ABA) treatment – <i>Preauthorization required</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Outpatient physical therapy, speech therapy and occupational therapy for ASD <i>Unlimited visits with autism diagnosis</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible

<b>Other Services</b>				
<b>Benefits</b>				
Outpatient physical, speech, and occupational therapy services – <i>limited to a combined 60 visits per condition, per calendar year, per member</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Chiropractic services – <i>limited to 24 manipulations per calendar year, per member</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Allergy testing, therapy, and serum	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Cardiac rehabilitation	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Durable medical equipment (DME)	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Prosthetic and orthotic devices	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Facility clinic visits	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Hearing care benefits – <i>up to \$2,200 maximum every 36 months</i> <i>Must use participating provider</i>	100% Covered	60% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Medical Travel Reimbursement <i>Preauthorization required</i>	<b>Contact BCBSM customer service for details and assistance.</b>			

	Standard PPO	Choice PPO
	<b>Prescription Drugs</b>	<b>Administered by OptumRx<sup>2</sup>: call 1-800-765-7429 for details.</b>
<b>Benefits</b>		
30-day supply	Generic: \$10 copay Preferred brand: \$30 copay Non-preferred brand: \$60 copay	Generic: \$20 copay Preferred brand: \$40 copay Non-preferred brand: \$70 copay
90-day supply – OptumRx Home Delivery or Walgreens90 <i>Discounted copay</i>	Generic: \$25 copay Preferred brand: \$75 copay Non-preferred brand: \$150 copay	Generic: \$50 copay Preferred brand: \$100 copay Non-preferred brand: \$175 copay
90-day supply – Retail	Generic: \$30 copay Preferred brand: \$90 copay Non-preferred brand: \$180 copay	Generic: \$60 copay Preferred brand: \$120 copay Non-preferred brand: \$210 copay
Specialty <i>Contact Optum Specialty at 1-844-265-1750</i>	\$150 copay Must be obtained through Optum Specialty	\$200 copay Must be obtained through Optum Specialty
Certain preventive drugs <i>Check optumrx.com</i>	100% Covered	100% Covered

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<sup>2</sup> OptumRx contracts directly with Ford Motor Company and there is no affiliation to Blue Cross Blue Shield of Michigan. This is intended as an easy-to-read summary and provides only a general overview of your benefits. Additional limitations and exclusions may apply. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.