Ford Motor Company
Active Salaried Employees
HSA Plan PPO | HSA Plus Plan PPO
2022 Benefits-at-a-Glance

Blue Cross Blue Shield of Michigan

	HSA Plan PPO		HSA Plus Plan PPO	
	In-network	Out-of-network	In-network	Out-of-network
Member's Responsibility (deductibles, coinsurance, and dollar maximums)				
Benefits				
Deductible* Individual deductible for self-only coverage; family deductible may be met by one or more family members Note: Includes Prescription Drug expenses. **In and out-of-network deductible is combined*	Individual (self-only coverage): $3,500 Family (2+ person coverage): $7,000		Individual (self-only coverage): $1,500 Family (2+ person coverage): $3,000	
Coinsurance Member pays coinsurance amount until out-of-pocket maximum is reached	0%	60%	20%	40%
Out-of-pocket maximum Plan pays 100% after the out-of-pocket maximum expense is reached Note: Copays do not accumulate toward deductible or out-of-pocket maximum. Includes Prescription Drug expenses. *Individual (self-only coverage)* *Family (2+ person coverage)*	Individual: $3,500 Family: $7,000	Unlimited	Individual: $3,000 Family: $6,000	Unlimited
Preventive Care Services (age and frequency restrictions may apply)				
Benefits				
Health maintenance exam	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Gynecological exam	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Pap smear screening	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Well-baby and child care exams	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Child and adult immunizations	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Routine screening colonoscopy	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Prostate specific antigen (PSA) screening	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Mammography screening (includes 3D)	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Voluntary female sterilization	Covered at 100%	Covered at 40% after deductible	Covered at 100%	Covered at 60% after deductible
Physician Office Services				
Benefits				
Office visit (includes telehealth visits)	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Urgent care visit	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Retail health visit	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Blue Cross online visits – download the app at bcbsmonlinevisits.com	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible

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Emergency Medical Care				
Benefits				
Emergency room	$200 copay after deductible	$200 copay after deductible	Covered 80% after deductible	Covered at 80% after deductible
Ambulance services	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Diagnostic Services				
Benefits				
Laboratory and pathology services	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Diagnostic tests and x-rays	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Therapeutic radiology	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Maternity Services				
Benefits				
Delivery and admission	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Prenatal care visits – as per PPACA, other services such as ultrasounds and labs may be subject to cost share	Covered 100%	Covered at 40% after deductible	Covered 100%	Covered at 60% after deductible
Postnatal care	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Hospital Care				
Benefits				
Room and board, hospital services and supplies, general nursing care	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Inpatient physician services	Covered 100% after deductible	Covered at 40% after deductible	Covered 100% after deductible	Covered at 60% after deductible
Chemotherapy	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Alternatives to Hospital Care				
Benefits				
Skilled nursing facility – must be provided through a participating facility	Covered 100% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible
Hospice care – must be provided through a participating facility	Covered 100% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible
Home health care – must be provided through a participating facility	Covered 100% after deductible	Covered 100% after deductible	Covered 80% after deductible	Covered 80% after deductible
IV infusion therapy – locations include home, office, and ambulatory infusion center	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Surgical Services				
Benefits				
Surgery	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Human organ transplant – contact human organ transplant program at (800) 242-3504	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Voluntary male sterilization	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible

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Behavioral Health Services				
Benefits				
Inpatient mental health and substance use disorder treatment	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Outpatient mental health and substance use disorder treatment (includes telehealth visit)	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Autism Spectrum Disorders (ASD)				
Benefits				
Applied behavioral analysis (ABA) treatment – covered through age 18, subject to preauthorization	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Outpatient physical therapy, speech therapy and occupational therapy for ASD – unlimited visits with autism diagnosis	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Physical, Speech, and Occupational Therapy Services				
Benefits				
Inpatient services	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Outpatient services – limited to 60 combined visits per condition, per calendar year, per member	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Other Services				
Benefits				
Allergy testing, therapy, and serum	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Chiropractic services – limited to 24 manipulations per calendar year, per member	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Diabetes education	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Diabetes supplies/devices (glucometer, diabetic test strips, lancets, etc.)	Covered 100%	Covered at 40% after deductible	Covered 100%	Covered at 60% after deductible
Durable medical equipment (DME)	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible
Infertility treatments – in vitro fertilization (IVF), intrauterine insemination (IUI), etc.	Not covered	Not covered	Not covered	Not covered
Private duty nursing care	Not covered	Not covered	Not covered	Not covered
Prosthetic and orthotic appliances (P&O)	Covered 100% after deductible	Covered at 40% after deductible	Covered 80% after deductible	Covered at 60% after deductible

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Prescription Drugs	**Administered by OptumRx[1]: call 1-866-868-0139 for details or visit www.welcome.optumrx.com/ford**			
Benefits				
Retail: 30-day supply	Covered 100% after deductible	25% penalty + 40% after deductible	Covered 80% after deductible	25% penalty + 60% after deductible
Home delivery or Walgreens90 Saver Plus: 90-day supply	Covered 100% after deductible	Not covered	Covered 80% after deductible	Not covered
Specialty **Contact OptumSpecialty[1] at 1-844-515-0251**	Covered 100% after deductible	25% penalty + 40% after deductible	Covered 80% after deductible	25% penalty + 60% after deductible
Preventive drugs: 30-day or 90-day supply as found on ValueRx list[2]	Covered 100%	Not covered	Covered 100%	Not covered
Diabetes supplies as found on ValueRx list[2] (test strips, lancets, glucometers)	Covered 100%	25% penalty + 40% after deductible	Covered 100%	25% penalty + 60% after deductible
Preventive immunizations as found on ValueRx list[2]	Covered 100%	25% penalty + 40% after deductible	Covered 100%	25% penalty + 60% after deductible

[1]OptumRx and OptumSpecialty contract directly with Ford Motor Company and there is no affiliation to Blue Cross Blue Shield of Michigan.
[2] For the latest version of the ValueRx list, visit myfordbenefits.com.

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable cost sharing. For a complete description of benefits, please reference your group Summary Plan Description, Summary of Benefit Coverage, or reference **myfordbenefits.com**. If there is a discrepancy between this *Benefits-at-a-Glance* and any applicable plan document, the plan document will prevail.