Ford Motor Company
Active Salaried Employees
HSA Plan PPO | HSA Plus Plan PPO
2025 Benefits-at-a-Glance

Blue Cross Blue Shield of Michigan

	HSA Plan PPO		HSA Plus Plan PPO	
	In-network	Out-of-network[1]	In-network	Out-of-network[1]
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: Copays do not accumulate toward deductible Includes Prescription Drug expenses through OptumRx and Fertility treatments through Progyny. **In and out-of-network deductible is combined*	Individual (self-only coverage): $3,500 Family (2+ person coverage): $7,000		Individual (self-only coverage): $1,650 Family (2+ person coverage): $3,300	
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 *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, frequency and other restrictions may apply)				
Benefits				
Health maintenance exam	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Gynecological exam	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Pap smear screening	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Well-baby and childcare exams	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Child and adult immunizations	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Routine screening colonoscopy	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Prostate specific antigen (PSA) screening	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Mammography screening (includes 3D)	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Voluntary female sterilization	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
PrEP for HIV Prevention	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible

[1] *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.*

	HSA Plan PPO		HSA Plus Plan PPO	
	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Physician Office Services				
Benefits				
Office visit (includes telehealth visits)	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Urgent care visit	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Retail health visit	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Virtual Care (formerly Blue Cross Online Visits) – download the app at bcbsm.com/virtualcare	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Emergency Medical Care				
Benefits				
Emergency room	100% Covered after deductible	100% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Ambulance services	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Diagnostic Services				
Benefits				
Laboratory and pathology services	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Diagnostic tests and x-rays	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Therapeutic radiology	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Maternity Services				
Benefits				
Delivery and admission	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Prenatal care visits – as per PPACA, other services such as ultrasounds and labs may be subject to cost share	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Postnatal care	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Hospital Care				
Benefits				
Room and board, hospital services and supplies, general nursing care	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Inpatient physician services	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Chemotherapy	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible

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	HSA Plan PPO		HSA Plus Plan PPO	
	In-network	Out-of-network[1]	In-network	Out-of-network[1]
Alternatives to Hospital Care				
Benefits				
Skilled nursing facility – must be provided through a participating facility	100% Covered after deductible	100% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Hospice care – must be provided through a participating facility	100% Covered after deductible	100% Covered after deductible	80% Covered after deductible	80% Covered after deductible
Home health care – must be provided through a participating facility	100% Covered after deductible	100% Covered after deductible	80% Covered after deductible	80% Covered after deductible
IV infusion therapy – locations include home, office, and ambulatory infusion center	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Surgical Services				
Benefits				
Surgery	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Human organ transplant – *contact human organ transplant program at (800) 242-3504*	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Voluntary male sterilization	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Behavioral Health Services				
Benefits				
Inpatient mental health and substance use disorder treatment	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Outpatient mental health and substance use disorder treatment (includes telehealth visit)	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Autism Spectrum Disorders (ASD)				
Benefits				
Applied behavioral analysis (ABA) treatment – subject to preauthorization	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Outpatient physical therapy, speech therapy and occupational therapy for ASD – unlimited visits with autism diagnosis	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Physical, Speech, and Occupational Therapy Services				
Benefits				
Inpatient services	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Outpatient services – limited to 60 combined visits per condition, per calendar year, per member	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible

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	HSA Plan PPO		HSA Plus Plan PPO	
	In-network	Out-of-network[11]	In-network	Out-of-network[1]
Other Services				
Benefits				
Acupuncture – *limited to 24 visits per calendar year*	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Allergy testing, therapy, and serum	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Chiropractic services – *limited to 24 manipulations per calendar year, per member*	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Diabetes education	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Diabetes supplies/devices (glucometer, diabetic test strips, lancets, etc.)	100% Covered	40% Covered after deductible	100% Covered	60% Covered after deductible
Durable medical equipment (DME)	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Fertility treatments –*contact Progyny at (844) 535-0720 for details*	Services through Progyny 100% covered after deductible	Not covered	Services through Progyny 80% covered after deductible	Not covered
Gender affirming services	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Private duty nursing care	Not covered	Not covered	Not covered	Not covered
Prosthetic and orthotic appliances (P&O)	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible
Hearing care benefits – *hearing aids limited to $2,200 dollar maximum*, every 36 months* **Dollar max does not apply to children up to age 18*	100% Covered after deductible	40% Covered after deductible	80% Covered after deductible	60% Covered after deductible

	HSA Plan PPO		HSA Plus Plan PPO	
	In-network	Out-of-network	In-network	Out-of-network
Prescription Drugs	**Administered by OptumRx[2]: call 1-866-868-0139 for details or visit www.welcome.optumrx.com/ford**			
Benefits				
30-day supply	100% Covered after deductible	Not covered	80% Covered after deductible	Not covered
90-day supply	100% Covered after deductible	Not covered	80% Covered after deductible	Not covered
Specialty: 30-day supply **Contact Optum Specialty[1] at 1-844-515-0251**	100% Covered after deductible	Not covered	80% Covered after deductible	Not covered
Preventive drugs and immunizations as found on Value Rx list[3]	100% Covered	Not covered	100% Covered	Not covered
Diabetes supplies as found on Value Rx list[3] (test strips, lancets, glucometers)	100% Covered	Not covered	100% Covered	Not covered

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[2] *OptumRx and Optum Specialty Pharmacy contract directly with Ford Motor Company and there is no affiliation to Blue Cross Blue Shield of Michigan*

[3] *For the latest version of the Value Rx list, visit www.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.