

GENERAL PROVISIONS	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Web Site Address	<a href="http://www.bluecares.com/healthtravel/finder.html">http://www.bluecares.com/healthtravel/finder.html</a>	<a href="http://www.pacificare.com">http://www.pacificare.com</a>	<a href="http://www.bluecares.com/healthtravel/finder.html">http://www.bluecares.com/healthtravel/finder.html</a>
Health Plan Telephone Number	Call your BCBS Plan. The number is located on the back of your ID Card.	800-825-9355	Call your local BCBS Plan. The number is located on the back of your ID Card.
NCQA Accreditation Status	Not Applicable	Excellent	Not Applicable

CARS Ratings (quality report card)	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Dr. Communication and Service	Not Applicable	☆☆☆	Not Applicable
Access and Service	Not Applicable	☆☆☆	Not Applicable
Staying Healthy	Not Applicable	☆☆	Not Applicable
Getting Better/Living with Illness	Not Applicable	☆☆☆	Not Applicable

MONTHLY CONTRIBUTIONS	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Single Contract	<b>In-Network: \$10</b>	<b>\$10</b>	None
Multiple Party Contract	<b>In-Network: \$21</b>	<b>\$21</b>	None

ANNUAL DEDUCTIBLES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Single Contract	<b>In-Network: \$150</b> See Footnote #1	None	<b>In-Network: \$1,250</b> See Footnote #2
	<b>Out-of-Network: Same as In-Network</b> See Footnote #1		<b>Out-of-Network: Same as In-Network</b> See Footnote #2
Multiple Party Contract	<b>In-Network: \$300</b> See Footnote #1	None	<b>In-Network: \$2,500</b> See Footnote #2
	<b>Out-of-Network: Same as In-Network</b> See Footnote #1		<b>Out-of-Network: Same as In-Network</b> See Footnote #2

ANNUAL OUT-OF-POCKET LIMITATION	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Single Contract	<b>In-Network: \$250</b> </b> See Footnote #1	None	<b>In-Network: \$2,500 (deductible &amp; in-network co-insurance applies)</b> See Footnote #2
	<b>Out-of-Network: \$500</b> See Footnote #3		<b>Out-of-Network: \$5,000 (deductible &amp; out-of-network co-insurance applies)</b> See Footnote #4
Multiple Party Contract	<b>In-Network: \$500</b> See Footnote #1	None	<b>In-Network: \$5,000 (deductible &amp; in-network co-insurance applies)</b> See Footnote #2
	<b>Out-of-Network: \$1,000</b> See Footnote #3		<b>Out-of-Network: \$10,000 (deductible &amp; out-of-network co-insurance applies)</b> See Footnote #4

OUTPATIENT SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Office Visits	<b>In-Network:</b> The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member copay.	\$10 copay	<b>In-Network:</b> The member is responsible only for the Maximum Payment Allowed by BCBS for these services -- 100% member copay.
	<b>Out-of-Network:</b> Not Covered - Member may be responsible for the entire charge.		<b>Out-of-Network:</b> Not Covered - Member may be responsible for the entire charge.
Physical Exams	<b>In-Network:</b> Not Covered	Covered	<b>In-Network:</b> Not Covered
	<b>Out-of-Network:</b> Same as In-Network		<b>Out-of-Network:</b> Same as In-Network
Well-Baby Care	<b>In-Network:</b> Covered up to six (6) visits prior to age two (2)	Covered	<b>In-Network:</b> Covered up to six (6) visits prior to age two (2)
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered
Immunizations	<b>In-Network:</b> Covered per Centers for Disease Control guidelines. Related office visit charge 100% copay	Covered	<b>In-Network:</b> Covered per Centers for Disease Control guidelines. Related office visit charge 100% copay
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered
Allergy Tests, Injections	<b>In-Network:</b> Tests and injections not covered, allergy serum covered under Prescription Drug Program	Covered	<b>In-Network:</b> Tests and injections not covered, allergy serum covered under Prescription Drug Program
	<b>Out-of-Network:</b> Same as In-Network		<b>Out-of-Network:</b> Same as In-Network

OUTPATIENT SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Diagnostic Lab	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #5	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #6
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #7		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8
Outpatient Physical Therapy	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> 60 Treatments per condition per calendar year See Footnote #5	Covered, 60 visits per condition, per plan year	<b>In-Network: 60 Treatments per condition per calendar year.</b> See Footnote #6
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> 60 Treatments per condition per calendar year. See Footnote #9		<b>Out-of-Network: 60 Treatments per condition per calendar year. After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8

OUTPATIENT SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
X-Ray & Imaging	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #5	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #6
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #9		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8

MATERNITY CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Prenatal, Delivery and Postnatal	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #5	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #9		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8

EMERGENCY CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Emergency Care	<b>In-Network: \$50 unless admitted. (The \$50 does not apply to deductible or out-of-pocket maximum.)</b> See Footnote #11	<b>\$50 unless admitted</b>	<b>In-Network: \$100 waived if admitted.(The \$100 does not apply to deductible or out-of-pocket maximum.)</b> See Footnote #12
	<b>Out-of-Network:</b> Same as In-Network <i>See Footnote #11</i>		<b>Out-of-Network:</b> Same as In-Network <i>See Footnote #12</i>

AMBULANCE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Ambulance	<b>In-Network: After deductible, covered for emergencies with a 10% member co-insurance.</b> See Footnote #13	Covered	<b>In-Network: After the deductible, covered for emergencies with a 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered for emergencies with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> <i>See Footnote #9</i>		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> <i>See Footnote #8</i>

EXTENDED CARE FACILITIES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Skilled Nursing Facility	<b>In-Network:</b> After deductible, covered with a 10% member co-insurance. 730 days, except psychiatric care 90 days, renewable after 60 days See Footnote #13	Covered	<b>In-Network:</b> After the deductible, 10% member co-insurance; 730 days, except psychiatric care 90 days, renewable after 60 days See Footnote #10
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered
Home Health Care	<b>In-Network:</b> After deductible, covered with a 10% member co-insurance. 3 visits for each unused day of hospital care See Footnote #13	Covered	<b>In-Network:</b> After the deductible, 10% member co-insurance; 3 visits for each unused day of hospital care See Footnote #10
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered
Private Duty Nursing	<b>In-Network:</b> Not covered	Covered	<b>In-Network:</b> Not covered
	<b>Out-of-Network:</b> Same as In-Network		<b>Out-of-Network:</b> Same as In-Network

PSYCHIATRIC CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Hospital Services	<b>In-Network:</b> 45 days, renewable after 60 days. See Footnote #11	45 days	<b>In-Network:</b> Retirees: 45 days, renewable after 60 days. See Footnote #14
	<b>Out-of-Network:</b> Covered see footnote See Footnote #15		<b>Out-of-Network:</b> Covered See Footnote #16

PSYCHIATRIC CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Outpatient Services	<p><b>In-Network: Non-Medicare</b> - 20 visit maximum per calendar year;  <b>Medicare</b> - 40 visits maximum per calendar year. Copy for Visit: 1-5 visits covered; 6-10 visits 10% member copay; Additional visits - 25% member co-insurance.            See Footnote #11</p>	35 visits per plan year	<p><b>In-Network: Non-Medicare</b> - 20 visit maximum per calendar year;  <b>Medicare</b> - 40 visits maximum per calendar year. Co-insurance for Visits: 1-5 visits covered; 6-10 visits 10% member co-insurance ;            Additional visits - 25% member co-insurance.            See Footnote #14</p>
	<p><b>Out-of-Network: Non-Medicare</b> - Covered with same copay as in-network with an additional 10% member co-insurance sanction.  <b>Medicare</b> - Covered services when Medicare pays first are covered the same as in-network. The 10% member co-insurance does not apply.            See Footnote #11</p>		<p><b>Out-of-Network: Non Medicare</b> - Covered the same as in-network with an additional 10% member co-insurance sanction.  <b>Medicare</b> - Covered services Medicare pays first are covered the same as in-network.            See Footnote #12</p>

PRESCRIPTION DRUGS	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Participating Pharmacies	<p><b>In-Network:</b> \$5 copay per generic prescription and \$10 per brand-name prescription. <b>\$15 copay for ED drugs.</b></p> <p><b>NOTE:</b> Mandatory generic substitute applies. See Footnote #11</p>	<p>\$5 generic/\$10 brand name copay per prescription</p>	<p><b>In-Network: \$15 copay per generic prescription and \$35 copay per brand-name prescription. \$50 copay for ED drugs.</b></p> <p>NOTE Mandatory generic substitute applies. See Footnote #12</p>
	<p><b>Out-of-Network:</b> 75% covered after participating pharmacy copay listed above.</p> <p><b>NOTE:</b> Mandatory generic substitute applies. See Footnote #11</p>		<p><b>Out-of-Network:</b> 75% covered after participating pharmacy copay listed above.</p> <p>NOTE: Mandatory generic substitute applies. See Footnote #12</p>
Mail Order Program	<p><b>In-Network: \$7 copay per prescription, up to a 90-day supply; \$12 copay per brand drug, \$18 copay for ED drugs.</b></p> <p><b>NOTE:</b> Maintenance/ Long-Term drugs available only through Home Delivery Program, following original prescription and two refills. See Footnote #11</p>	<p>Contact your plan for specific co-payment information.</p>	<p><b>In-Network: \$30 copay per prescription, up to a 90-day supply for generic and \$70 copay per brand name prescription. \$100 copay for ED drugs.</b></p> <p>Maintenance/ Long-Term drugs available only through Home Delivery Program, following original prescription and two refills. See Footnote #12</p>
	<p><b>Out-of-Network:</b> Not Covered</p>		<p><b>Out-of-Network:</b> Not covered</p>

HEARING CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Audiometric Examination	<b>In-Network:</b> Covered at participating providers See Footnote #11	Covered	<b>In-Network:</b> Covered at participating providers See Footnote #12
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered
Hearing Aid	<b>In-Network:</b> Covered at participating providers See Footnote #11	Covered	<b>In-Network:</b> Covered at participating providers See Footnote #12
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered
Frequency Limitation	<b>In-Network:</b> 36 months See Footnote #11	36 months w/Hearing Aid	<b>In-Network:</b> 36 months
	<b>Out-of-Network:</b> Not Covered		<b>Out-of-Network:</b> Not Covered

VISION CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Vision Care Contact Information	<b>In-Network:</b> SVS, Inc. 800-225-3095, <a href="http://www.svsvision.com">http:// www. svsvision.com</a>	SVS, Inc. 800-225-3095, <a href="http://www.svsvision.com">http:// www. svsvision.com</a>	<b>In-Network:</b> SVS, Inc. 800-225-3095, <a href="http://www.svsvision.com">http:// www. svsvision.com</a>
	<b>Out-of-Network:</b> Same as In-Network		<b>Out-of-Network:</b> Same as In-Network
Examination	<b>In-Network:</b> Covered See Footnote #11	In-network: covered Out-of-network: Contact SVS, Inc.	<b>In-Network:</b> Covered See Footnote #12
	<b>Out-of-Network:</b> Contact SVS, Inc. See Footnote #11		<b>Out-of-Network:</b> Contact SVS, Inc. See Footnote #12

VISION CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Lenses and Frames	<b>In-Network:</b> Covered  See Footnote #11	In-network: covered Out-of-network: Contact SVS, Inc.	<b>In-Network:</b> Covered See Footnote #12
	<b>Out-of-Network:</b> Contact SVS, Inc. <i>See Footnote #11</i>		<b>Out-of-Network:</b> Contact SVS, Inc. <i>See Footnote #12</i>
Contact Lenses	<b>In-Network:</b> Medically necessary: up to \$350 Not medically necessary: \$75 for lenses & \$40 for fit and follow-up  See Footnote #11	In-network: medically necessary: up to \$350 Not medically necessary: \$75 for lenses & \$40 for fit and follow-up Out-of-network: Contact SVS, Inc.	<b>In-Network:</b> Medically necessary: up to \$350 Not medically necessary: \$75 for lenses & \$40 for fit and follow-up  See Footnote #12
	<b>Out-of-Network:</b> Contact SVS, Inc. <i>See Footnote #11</i>		<b>Out-of-Network:</b> Contact SVS, Inc. <i>See Footnote #12</i>

FOOT AND ANKLE CARE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Foot and Ankle Care - Outpatient Services	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #13	Contact your plan for details on covered services	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> <i>See Footnote #9</i>		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> <i>See Footnote #8</i>

OTHER SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Durable Medical Equipment	<b>In-Network:</b> Covered through the SUPPORT Program (800-831-0999) See Footnote #11	Covered	<b>In-Network:</b> After the deductible, 10% member co-insurance See Footnote #10
	<b>Out-of-Network:</b> Covered with a 20% member co-insurance on Maximum Payment Allowed. See Footnote #17		<b>Out-of-Network:</b> After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. See Footnote #8
Prosthetic and Orthotic Appliances	<b>In-Network:</b> Covered through the SUPPORT Program (800-831-0999) See Footnote #11	Covered	<b>In-Network:</b> After the deductible, 10% member co-insurance See Footnote #10
	<b>Out-of-Network:</b> Covered with a 20% member co-insurance on Maximum Payment Allowed. See Footnote #17		<b>Out-of-Network:</b> After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services. See Footnote #8
Health Education & Special Programs	<b>In-Network:</b> Contact your plan for information	Covered	<b>In-Network:</b> Contact your plan for information
	<b>Out-of-Network:</b> Same as In-Network		<b>Out-of-Network:</b> Same as In-Network

SPECIAL SITUATIONS	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
When Enrolled in Medicare	<b>In-Network:</b> Plan coordinates with Medicare	Plan coordinates with Medicare	<b>In-Network:</b> Plan coordinates with Medicare
	<b>Out-of-Network:</b> Same as In-Network <i>See Footnote #18</i>		<b>Out-of-Network:</b> Same as In-Network <i>See Footnote #6</i>
Sponsored Dependent Coverage	<b>In-Network:</b> Available at subscriber's expense	Available at subscriber's expense	<b>In-Network:</b> Available at subscriber's expense
	<b>Out-of-Network:</b> Same as In-Network		<b>Out-of-Network:</b> Same as In-Network

HOSPITAL SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Semi - Private Room and Board	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> 365 days, renewable after 60 days (Predetermination Required) <i>See Footnote #13</i>	Covered	<b>In-Network:</b> 365 days, renewable after 60 days (Predetermination Required) <b>After the deductible, 10% member co-insurance</b> <i>See Footnote #10</i>
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> 365 days, renewable after 60 days (Predetermination Required) <i>See Footnote #9</i>		<b>Out-of-Network:</b> 365 days, renewable after 60 days (Predetermination Required) <b>After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> <i>See Footnote #6</i>

HOSPITAL SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Surgery, Inpatient and Outpatient	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #13	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #9		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8
Physician Services	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #13	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #9		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8
Inpatient Physical Therapy	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #13	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #9		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8

HOSPITAL SERVICES	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Functional Occupational Therapy	<b>In-Network: After deductible, covered with a 10% member co-insurance.</b> See Footnote #13	Covered	<b>In-Network: After the deductible, 10% member co-insurance</b> See Footnote #10
	<b>Out-of-Network: After deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #9		<b>Out-of-Network: After the deductible, covered with a 30% member co-insurance on Maximum Amount Allowed by BCBS for these services.</b> See Footnote #8

SUBSTANCE ABUSE	National PPO Plan (BCBS) Multi-State Amended Retiree	Pacificare (HMO) - OK (Modified Ford Retiree Plan)	National Catastrophic PPO Plan - General Retiree
Hospital Services	<b>In-Network:</b> 45 days, renewable after 60 days. See Footnote #11	45 days	<b>In-Network:</b> 45 days, renewable after 60 days. See Footnote #12
	<b>Out-of-Network:</b> Not covered		<b>Out-of-Network:</b> Not covered
Outpatient Services	<b>In-Network:</b> 35 visits per plan year to 140 visits lifetime maximum. See Footnote #11	35 visits per plan year	<b>In-Network:</b> 35 visits per plan year to 140 visits lifetime maximum. See Footnote #12
	<b>Out-of-Network:</b> Not covered		<b>Out-of-Network:</b> Not covered

#1: The annual deductibles (\$150 single party and \$300 multiple party), plus co-insurance (\$100 single party and \$200 multiple party) shall count toward the annual out-of-pocket maximum (single party: \$250 in-network and \$500 out-of-network; multiple party: \$500 in-network and \$1000 out-of-network.) The maximum amount any single party can contribute toward the multiple party deductible is \$150 and any in-network co-insurance does not apply to the annual out-of-network out-of-pocket maximum. The following do not apply toward the deductible and out-of-pocket maximum: co-insurance or cost sharing for Prescription Drugs, Office Visits, Emergency Care, Mental Health, Substance Abuse, Durable Medical Equipment, Prosthetics and Orthotics, Dental, Vision and hearing. Additionally, your monthly contributions and any out-of-network sanction or exclusion amounts shall not count toward the deductible or out-of-pocket annual maximum.

#2: The annual deductibles (\$1,250 single party and \$2,500 multiple party), plus co-insurance (\$1,250 single party and \$2,500 multiple party) shall count toward the annual out-of-pocket maximum (single party: \$2,500 in-network and \$5,000 out-of-network; multiple party: \$5,000 in-network and \$10,000 out-of-network.) The maximum amount any single party can contribute toward the multiple party deductible is \$1,250

and any in-network co-insurance does not apply to the annual out-of-network out-of-pocket maximum. The following do not apply toward the deductible and out-of-pocket maximum: co-insurance or cost sharing for Prescription Drugs, Office Visits, Emergency Care, Mental Health, Substance Abuse, Dental, Vision, and Hearing. Additionally, your monthly contributions and any out-of-network sanction or exclusion amounts shall not count toward the deductible or out-of-pocket annual maximum.

#3: The annual deductibles (\$150 single party and \$300 multiple party), plus co-insurance (\$100 single party and \$200 multiple party) shall count toward the annual out-of-pocket maximum (single party: \$250 in-network and \$500 out-of-network; multiple party: \$500 in-network and \$1000 out-of-network.) The maximum amount any single party can contribute toward the multiple party deductible is \$150 and any in-network co-insurance does not apply to the annual out-of-network out-of-pocket maximum. The following do not apply toward the deductible and out-of-pocket maximum: co-insurance or cost sharing for Prescription Drugs, Office Visits, Emergency Care, Mental Health, Substance Abuse, Durable Medical Equipment, Prosthetics and Orthotics, Dental, Vision and hearing. Additionally, your monthly contributions and any out-of-network sanction or exclusion amounts shall not count toward the deductible or out-of-pocket annual maximum. After the deductible (\$150 single party and \$300 multiple party), has been met - Non-Panel National PPO Provider - Non-Medicare - covered services will require a 30% co-insurance sanction up to the annual out-of-pocket out-of-network maximum (\$500 per single party or \$1,000 per multiple party). 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.

#4: The annual deductibles (\$1,250 single party and \$2,500 multiple party), plus co-insurance (\$1,250 single party and \$2,500 multiple party) shall count toward the annual out-of-pocket maximum (single party: \$2,500 in-network and \$5,000 out-of-network; multiple party: \$5,000 in-network and \$10,000 out-of-network.) The maximum amount any single party can contribute toward the multiple party deductible is \$1,250 and any in-network co-insurance does not apply to the annual out-of-network out-of-pocket maximum. The following do not apply toward the deductible and out-of-pocket maximum: co-insurance or cost sharing for Prescription Drugs, Office Visits, Emergency Care, Mental Health, Substance Abuse, Dental, Vision, and Hearing. Additionally, your monthly contributions and any out-of-network sanction or exclusion amounts shall not count toward the deductible or out-of-pocket annual maximum. After the deductible (\$1,250 single party and \$2,500 multiple party) has been met - Non-Network PPO Provider - Non-Medicare - covered services will require a 30% co-insurance sanction up to the annual out-of-pocket out-of-network maximum (\$5,000 single party and \$10,000 multiple party). 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.

#5: 1) First you pay for covered services until the annual deductible (single party \$150 or multiple party \$300) is met (The maximum amount any single party can contribute toward the multiple party deductible is \$150); 2) Then you pay 10% up to \$100 single party or \$200 multiple party) until the in-network covered services reach the annual in-network out-of-pocket maximum (\$250 single party or \$500 multiple party coverage); 3) Then the plan pays 100% to end of the calendar year.

#6: After the deductible (\$1,250 single party and \$2,500 multiple party) has been met - Non-Network PPO Provider - Non-Medicare - covered services will require a 30% co-insurance sanction up to the annual out-of-pocket out-of-network maximum (\$5,000 single party and \$10,000 multiple party). 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.

#7: 1) First you pay for covered services until the annual deductible (single party \$150 or multiple party \$300) is met (The maximum amount any single party can contribute toward the multiple party deductible is \$150); 2) Then you pay 30% (up to \$350 single party or \$700 multiple party) until covered services reach the annual out-of-network out-of-pocket maximum (\$500 for single party or \$1000 for multiple party coverage); 3) Then the plan pays 100% to the end of the calendar year. All payments are based on the BCBS Maximum Amount Allowed.

#8: 1) First you pay for covered services until the annual deductible (\$1,250 single party and \$2,500 multiple party) is met (The maximum amount any one single party can contribute toward the multiple party deductible is \$1,250); 2) Then you pay 30% ( up to \$3,750 single party

or \$7,500 multiple party) until covered services reach the annual out-of-network out-of-pocket maximum (\$5,000 for single party or \$10,000 for multiple party coverage); 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.

#9: 1) First you pay for covered services until the annual deductible (single party \$150 or multiple party \$300) is met (The maximum amount any single party can contribute toward the multiple party deductible is \$150); 2) Then you pay 30% (up to \$350 single party or \$700 multiple party) until covered services reach the annual out-of-network out-of-pocket maximum (\$500 for single party or \$1000 for multiple party coverage); 3) Then the plan pays 100% to the end of the calendar year. All payments are based on the BCBS Maximum Amount Allowed.

#10: 1) First you pay for covered services until the annual deductible (\$1,250 single party and \$2,500 multiple party) is met. (The maximum amount any one single party can contribute toward the multiple party deductible is \$1,250); 2) Then you pay 10% (up to \$1,250 single party and \$2,500 multiple party) until the in-network covered services reach the annual in-network out-of-pocket maximum (\$2,500 single party or \$5,000 multiple party coverage); 3) Then the plan pays 100% to end of the calendar year. All payments (including co-insurance) are based on the BCBS Maximum Amount Allowed.

#11: 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.

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

#13: 1) First you pay for covered services until the annual deductible (single party \$150 or multiple party \$300) is met (The maximum amount any single party can contribute toward the multiple party deductible is \$150); 2) Then you pay 10% up to \$100 single party or \$200 multiple party) until the in-network covered services reach the annual in-network out-of-pocket maximum (\$250 single party or \$500 multiple party coverage); 3) Then the plan pays 100% to end of the calendar year.

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

#15: 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. 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.

#16: 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-Panel, Non-Participating Hospital - 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. These services are covered under a separate program which has its own plan design and is not subject to the National Catastrophic PPO Plan's deductibles, co-insurance and out-of-pocket maximums.

#17: 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% member co-insurance does not apply to the annual deductible (single party \$150 or multiple party \$300) or the annual out-of-network out-of-pocket maximum (\$500 for single party or \$1000 for multiple party coverage) applicable to the National Modified Ford Plan.

#18: After the deductible (\$150 single party and \$300 multiple party), has been met - Non-Panel National PPO Provider - Non-Medicare - covered services will require a 30% co-insurance sanction up to the annual out-of-pocket out-of-network maximum (\$500 per single party or \$1,000 per multiple party). 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.